Norfolk Health & Wellbeing Board

Date: **Wed 12 July 2017**

Time: **Part A in public 9:30am**
Venue: **Edwards room, County Hall, Norwich**

Membership	Substitute	Representing
William Armstrong	Alex Stewart	Healthwatch Norfolk
Cllr Yvonne Bendle	Cllr Florence Ellis	South Norfolk District Council
Cllr David Bills		Norfolk County Council
Cllr Bill Borrett	Cllr Shelagh Gurney	Adult Social Care Committee, Norfolk County Council
James Bullion	Catherine Underwood	Adult Social Services, Norfolk County Council
Dr Hilary Byrne	Antek Lejk	South Norfolk Clinical Commissioning Group
Cllr Penny Carpenter	Cllr Stuart Dark	Children's Services Committee, Norfolk County Council
Cllr Paul Claussen	Cllr Trevor Carter	Breckland District Council
Dr Anoop Dhesi	Antek Lejk	North Norfolk Clinical Commissioning Group
Matt Dunkley	Don Evans	Children's Services, Norfolk County Council
Simon Evans-Evans		NHS England, East Sub Region Team
Cllr Andy Grant		Great Yarmouth Borough council
Lorne Green	Dr Gavin Thompson	Police and Crime Commissioner
Joyce Hopwood	Laura Bloomfield	Voluntary Sector Representative
Dr Ian Mack	John Webster	West Norfolk Clinical Commissioning Group
Dan Mobbs	Elly Wilson	Voluntary Sector Representative
Cllr Elizabeth Nockolds		Borough Council of King's Lynn and West Norfolk
Cllr Maggie Prior		North Norfolk District Council
Cllr Andrew Proctor	Cllr Roger Foulger	Broadland District Council
Janka Rodziewicz	Jon Clemo	Voluntary Sector Representative
Cllr Roger Ryan	Adam Clark	Norwich City Council
ACC Paul Sanford		Norfolk Constabulary
Dr Louise Smith		Public Health, Norfolk County Council
Dr John Stammers	Melanie Craig	NHS Great Yarmouth & Waveney CCG
Dr Wendy Thomson		Norfolk County Council
Dr Tracy Williams	Jo Smithson	Norwich Clinical Commissioning Group

Standing invitation to attend Board meetings:

Christine Allen	Anna Davidson	James Paget University Hospital
John Bacon		Norfolk Independent Care
Mark Davies	John Fry	Norfolk & Norwich University Hospital
Roisin Fallon-Williams	Geraldine Broderick	Norfolk Community Health & Care
Jon Green	Edward Libbey	Queen Elizabeth Hospital
Michael Scott	Gary Page	Norfolk & Suffolk NHS Foundation Trust
Jonathan Williams	Paul Steward	East Coast Community Healthcare

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:
Karen Haywood on 01603 228913 or email committees@norfolk.gov.uk

1	**Apologies**	Clerk
2	**Election of Chair**	Clerk
3	**Election of Vice Chairs**	Chair
4	**Chairman's opening remarks**	Chair
5	**Minutes**	Chair
6	**Action points arising from the minutes**	Chair
7	**Members to declare any interests**	Chair

Items for discussion/action

Integration and transformation

8	Sustainability & Transformation Plan (STP) update	Wendy Thomson
9	Better Care Fund (BCF) Plan and Improved BCF (IBCF)	Sera Hall

Wider health and wellbeing

10	Joint Health and Wellbeing Strategy: a) Joint Health & Wellbeing Strategy 2014-17 Final Evaluation Report b) Developing our future Joint Health & Wellbeing Strategy: key themes from our stakeholder event – verbal update	Louise Smith
11	Proposal for a Pharmaceutical Needs Assessment (PNA)	Suzanne Meredith
12	Suicide Prevention Conference	Nadia Jones

Information updates

- **Further information about the Health and Wellbeing Board** – can be found on the Health and Wellbeing Board page on our website: Norfolk Health and Wellbeing Board
- **Healthwatch Norfolk** – you can access the most recent HWN Board minutes at the following link: http://www.healthwatchnorfolk.co.uk/reports-and-papers/board-papers/
- **Norfolk Health Overview & Scrutiny Committee** – you can access the most recent NHOSC papers at the following link

Norfolk County Council

Health and Wellbeing Board
Minutes of the meeting held on Wednesday 26th April at 9.30am
in the Edwards Room, County Hall

Present:

William Armstrong	Healthwatch Norfolk
Cllr Yvonne Bendle	South Norfolk District Council
Hilary Byrne	South Norfolk Clinical Commissioning Group
James Bullion	Norfolk County Council
Cllr. Penny Carpenter	Great Yarmouth Borough Council
Cllr Paul Claussen	Breckland District Council
Don Evans	Norfolk County Council
Cllr. Roger Foulger	Broadland District Council
Joyce Hopwood	Voluntary Sector Representative
Chris Humphries	Kings Lynn and West Norfolk CCG
Emma McKay	Norfolk and Norwich University Hospital
Dan Mobbs	Voluntary Sector representative
Cllr. Elizabeth Nockolds	Borough Council of King's Lynn and West Norfolk
Cllr Maggie Prior	North Norfolk District Council
Dr. Janka Rodziewicz	Voluntary Sector Representative
Dr. Louise Smith	Norfolk County Council
Temp. ACC Paul Sanford	Norfolk Constabulary
Dr. John Stammers	Great Yarmouth and Waveney Clinical Commissioning Group
Alex Stewart	Health Watch Norfolk
Cllr. Roger Smith	Chairman, Children's Services Committee
Cllr. Vaughan Thomas	Norwich City Council
Dr. Gavin Thompson	Office of the Police and Crime Commissioner
Catherine Underwood	Norfolk County Council
Cllr. Brian Watkins (in the Chair)	Norfolk County Council
Tracy Williams	Norwich CCG

Also present:

Jane Harper Smith	N&W STP Programme Director, Norfolk County Council
Nadia Jones	Norfolk County Council
Michael Lozano	Patient Safety and Complaints Lead, NSFT
Sam Revell	Healthwatch Norfolk
Tim Winters	Norfolk County Council

1 Apologies

1.1 Apologies were received from Mark Davies (Norfolk and Norwich University Hospital), Cllr Andrew Proctor (Broadland District Council), Jonathon Williams (East Coast Community healthcare), Pip Coker (Voluntary Sector Representative), Dr Wendy Thomson (Norfolk County Council), Christine Allen (James Paget University Hospital), David Bills (South Norfolk District Council), Edward Libbey (Queen Elizabeth Hospital), Mike Fawcett (Norfolk Constabulary) and Dennis Bacon (Norfolk Independent Care).

2. Chairman's Opening Remarks

2.1 The Chairman welcomed Cllr Maggie Prior and Temp. ACC Paul Sanford to their first meeting of the Board.

2.2 The Board were provided with an update from the NHS South Norfolk Primary Care Commissioning Committee. It was noted that during 2016/17 the CCG applied for and was successful in its application to NHS England for undertaking Full Delegated Commissioning as of 1 April 2017.

2.3 It was noted that during the development year Cllr. Yvonne Bendle had represented the Health and Wellbeing Board on the joint co-commissioning committee and, on behalf of the Board, the Chairman had confirmed her representation on the Primary Care Commissioning Committee for the year ahead.

3. Minutes

3.1 The minutes of the Health and Wellbeing Board (HWB) held on 8th February 2017 were agreed as a correct record and signed by the Chairman.

4. Matters Arising

4.1 The Chairman reminded members that the Health and Wellbeing Board's Stakeholder Engagement Event would be held on 21st June 2017 and that this would be a joint event with the Norfolk and Waveney Sustainability & Transformation Plan. The purpose of the event was for the further development of the future Health and Wellbeing Strategy and for engagement around the STP. A wide range of stakeholders had been advised of the date and invitations and further information would be sent out at a later date.

5. Declaration of Interests

5.1 There were no interests declared.

6. Urgent Business

6.1 There were no items of urgent business received.

7. Health and Wellbeing Index and Health Inequalities

7.1 The Board received a presentation from the Head of Public Health Information, Public Health, Norfolk County Council, which provided them with information about health and wellbeing measures for Norfolk. The presentation included examples of the potential difference that could be made to the health and wellbeing of the people of Norfolk including, reducing the number of people killed and seriously injured on roads, reducing the risk of stroke in our population and improving dementia diagnosis rate for older people. During the ensuing discussion the following issues were raised:

- The data presented incorporated the most recent nationally published data however, in some cases these figures were from 2015/16. Data would be refreshed on an on-going basis when national data was released.

- Austerity measures had had a significant impact on some areas of health

inequalities, particularly around health and mental wellbeing and admissions for alcohol abuse. There were some areas where improvements had been made in health services, such as reducing the number of cases of coronary heart disease.

- The Board discussed key areas where preventative action could make a difference in improving outcomes. It was agreed that the analysis of the data would be a valuable part of the evidence base for the developing Health and Wellbeing Strategy and would be used to inform the stakeholder engagement event in June.

8. Norfolk and Waveney Sustainability and Transformation Plan (STP)

8.1 The Board received the report from the N&W STP Nominated lead, which was introduced by the STP Programme Director. The report provided information on key elements of the STP, including governance, the focus for delivery, bids to the Transformation Fund and communications and engagement. It also outlined the main shift in services that the STP workstreams were focused on in order to deliver the changes necessary to achieve a sustainable health and social care system in Norfolk and Waveney.

8.2 Members discussed some of the current challenges facing system partners such as engagement with the public, including children and young people. Members heard that a rolling programme of workshops were underway, that a Stakeholder Board had been established and that a key appointment had been made with the Communications and Engagement Lead for the Norfolk & Waveney STP appointed and in post.

8.3 Resources was a key challenge and members discussed the outcome of local bids to the Transformation Fund which were being pursued to provide some of the investment required to deliver the necessary changes. It was recognised that whilst nationally the funding available was limited, across the Norfolk and Waveney 'footprint' we have significant resources and that the key was to look at how best we use it.

8.4 It was noted that the District Councils had a key role to play in focusing the STP on the prevention agenda and the wider health determinates of employment and housing, etc, and it was important to ensure that they were fully engaged in the process.

8.5 The Chairman updated the Board on the recently established STP Chairs Governance group set up to provide 'non-executive' oversight of the delivery of the STP. Members noted that the Group was in the process of recruiting an Independent Chair.

8.6 The Board **resolved** to:

- Consider and comment on the report

- Identify actions that the HWB/member organisations could take to accelerate progress on delivering the changes necessary to deliver sustainable services.

9. Norfolk Integration and Better Care Fund 2017-19: Planning and approval

9.1 The Board received the report from the Executive Director of Adult Social Services which set out the key areas for consideration contained within Norfolk's BCF Plan for 2017-19, in addition to summarising national guidance.

9.2 It was noted that whilst the national Integration BCF Policy Framework had been

released, further, more detailed guidance documents and allocations were still awaited. It was noted that in light of this, the 2017-19 Plan was not yet available for approval by the Board.

9.3 The Board **resolved** to:

- Note the overview of the key points addressed in the BCF Policy and Framework provided (Section 4 of the report)

- Comment on and note the proposed content of the plan (section 5 of the report)

10. Healthwatch Norfolk Strategy 2017-20 and focus for business 2017/18

10.1 The Board welcomed the Chief Executive and Project Manager from Healthwatch Norfolk (HWN) to the meeting. Following a brief introduction by the Chair of HWN, the Chief Executive and Project Manager gave a presentation which outlined Healthwatch Norfolk's Strategy for 2017-2020, how the strategic priorities were developed and the focus and projects for the year ahead. Members heard that speaking to underrepresented groups about the services that they accessed was one of HWN's areas of focus and capturing the 'lived experience' of local people.

10.2 It was noted that public expectations of health and social care were increasing all of the time, particularly regarding the speed of access to services. Board members discussed the wide-ranging nature of the work and the way in which HWN approached priority-setting, based on the wealth of information and insights gained from a very wide range of engagement techniques and through working closely with other organisations

10.3 The HWB welcomed the work and the contribution that HWN was making to improving services and noted the future priorities and projects for the year ahead.

11. Suicide Prevention in Norfolk

11.1 The Board received a report which outlined the work being carried out by partners to reduce the number of suicides in Norfolk. It presented the county-wide Suicide Prevention Strategy and action plan 2016-2021, which had been developed using a multi-agency approach and in consultation with a range of agencies and service users. The report also provided the Norfolk and Suffolk Foundation Trust (NSFT) Suicide Prevention Strategy 2017-2022, recently agreed by NSFT Board.

11.2 The Board recognised that no one agency was responsible for suicide prevention – it involved collective commitment and responsibility and was a whole system issue. The Board also noted the inequalities evidenced by the outcome of the suicide audit and the need to try to reach the biggest group of those at risk. Social and economic deprivation was one of the biggest risk factors and the rates were relatively high in Norfolk, and were often linked to mental health problems.

11.3 Members discussed the two Strategies and the opportunities they presented, across the system, for making a difference. Preventative approaches were discussed and examples included awareness training for those likely to come into contact with those at risk at an early stage, and through guidance and support for people who have been bereaved. The role of families and carers in providing support for those at risk of suicide was discussed and the need for clear information and practical advice to be available. The need to reduce the stigma around suicide was raised and the Director of Public Health spoke of

the importance of language in influencing this.

11.4 Members also discussed the data analysis supporting the county-wide plan and possibilities for further developing that analysis to support further preventative action. Some of the difficulties in obtaining data was discussed, in particular around children and young people, and there were offers of assistance from the Police around some recent analysis of national data.

11.5 The Board **resolved** to:

- Endorse the Norfolk Suicide Prevention Strategy and action plan
- Note the Suicide Prevention Strategy developed and agreed by the Norfolk and Suffolk NHS Foundation Trust.
- Note how HWB partners are participating in the work to reduce the number of suicides in the county and identify what else can be done.

12. Smoking in Norfolk

12.1 The Board received two reports – the first outlined the work of the Norfolk Tobacco Control Alliance, which brought together partners across Norfolk to address the causes of tobacco use, raise the profile of the harm caused by smoking to communities, reduce smoking prevalence, monitor progress and publish the results. The first report also outlined the key elements of the Tobacco Control Alliance Strategy, including the vision and the three priorities, and action plan developed to deliver progress against the priorities. The second report was on the NHS Smokefree initiative and the recent letter from Chief Executive of Public Health England (PHE) to all NHS trust chief executives inviting them to go completely smokefree in all NHS buildings and grounds.

12.2 Members welcomed the two reports and discussed the need to ensure that the prevention strategy was reaching children and young people - making use of available mechanisms, together with understanding what makes them start smoking in the first place. It was recognised that young people were often aware of the health risks associated with smoking however they often started as a result of peer pressure. The key was to talk to young people who smoked and ask them why they had initially started.
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12.2 The Board also discussed some of the difficulties faced by NHS organisations in working towards a smoke free environment, with a view to sharing the learning across HWB partner organisations.

12.3 The Board **resolved** to:

- Endorse the Norfolk Tobacco Control Strategy and action plan

- Commit to promoting the strategic priorities within their organisations and to identifying what actions their organisations could take to help drive improvement in the wider community

- Request that the Norfolk Tobacco Control Alliance review the smoking policies across the HWB system with a view to co-ordinating and aligning approaches.

The meeting concluded at 12.15pm

Chairman

Report title:	**Norfolk & Waveney Sustainability & Transformation Plan (N&W STP) update**
Meeting date:	**12 July 2017**
Sponsor:	**Dr Wendy Thomson, Nominated Lead, N&W STP**

Reason for the report

The purpose of this paper is to provide members of the Health & Wellbeing Board (HWB) with an update on the developing N&W STP.

Report summary

This report provides information on key elements of the STP, including governance and the focus for delivery, and it outlines the main shifts in services that the STP workstreams are focused on.

Action

The Health & Wellbeing Board is asked to:

- Consider and comment on the report
- Identify actions that the HWB/member organisations could take to accelerate progress on delivering the changes necessary to deliver sustainable services.

1. Background

1.1 STPs are place-based, system-wide plans for health and social care and cover integration with local authority services "including, but not limited to, prevention and social care, reflecting locally agreed health and wellbeing strategies". They cover the period up to March 2021 and they are seen as blueprints for accelerating implementation of the Five Year Forward View (5YFV). Guidance and support is available on the NHS website at the following link: https://www.england.nhs.uk/stps/.

1.2 The approach for STPs is on planning at an area level, rather than organisationally, and the focus is on addressing three national challenges or 'gaps':

- **Health and wellbeing gap** - inequalities in health
- **Care and quality gap** - ensuring quality and performance of health and social services
- **Finance and efficiency gap** - ensuring a financially sustainable health and social care system

1.3 Norfolk and Waveney is one of 44 STP 'footprint' areas and all are required to determine and make proposals for how areas will address the gaps in population health, service quality and system finances.

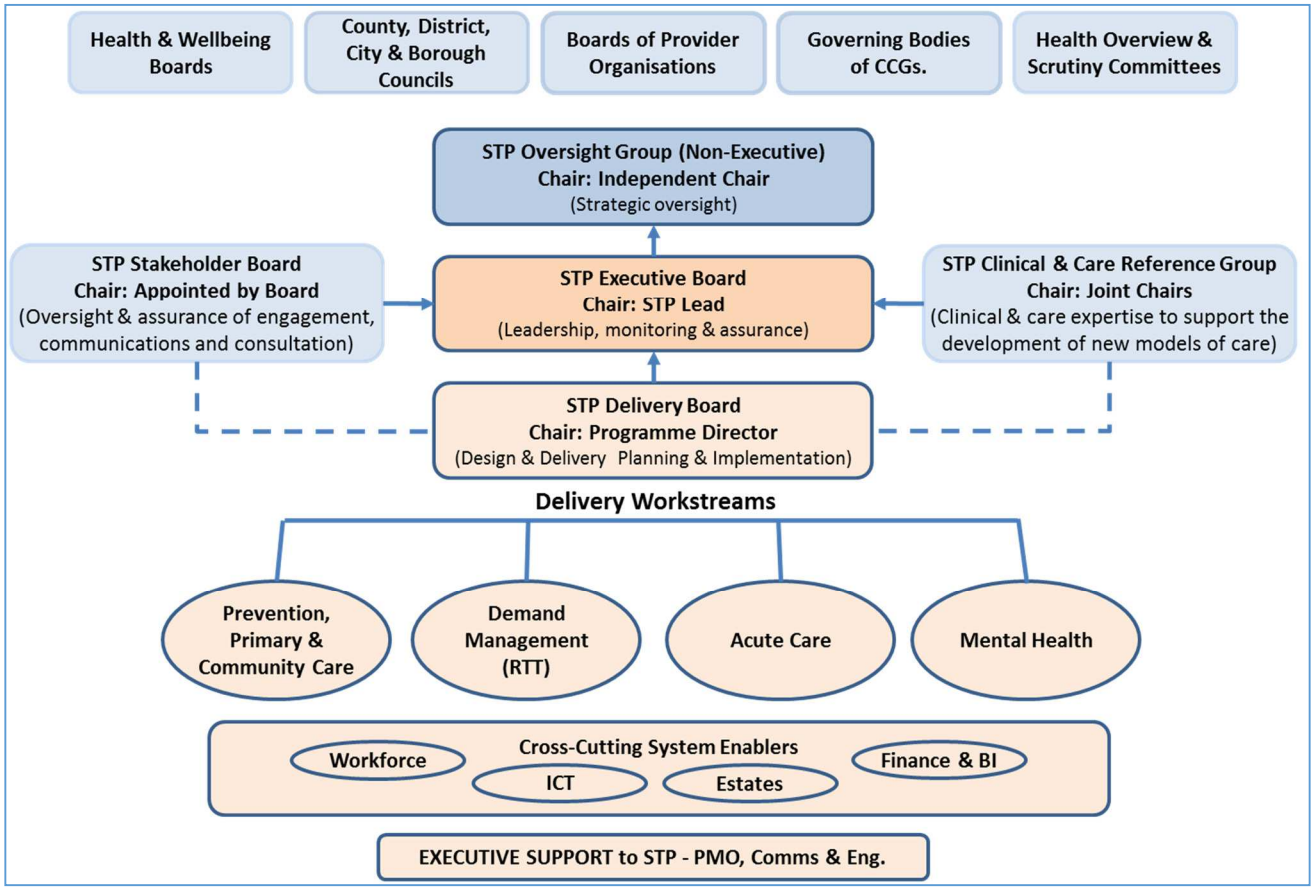
1.4 The HWB considered key elements of the N&W STP throughout its development and provided comments on the draft STP before its submission to NHS England on 21 October. The N&W STP submission was published on 18 November 2016, alongside a more accessible summary document tailored for a wider audience. Key documents including the October submission and supporting summary documents are available on the Healthwatch Norfolk website: www.healthwatchnorfolk.co.uk/ingoodhealth.

1.5 On 31 March 2017, the NHS published 'Next steps on the NHS Five Year Forward View'. The report outlines progress on the ambitions set out in the Five Year Forward View since its original publication in October 2014, defines what still needs to be achieved over the next two years, and how this will be achieved. It also outlines five priorities for the NHS as follows:

1. Taking pressure off urgent and emergency care
2. Better resourced and accessible general practice
3. Improve rates of cancer survival
4. More people to receive mental health services, including children and young people, and
5. Helping frail and older people stay healthy and independent.

2. Update on governance

2.1 The agreed governance arrangements that are being established for the Norfolk & Waveney STP are set out in the diagram below.



2.2 The arrangements will ensure effective decision-making in combination with clear strategic oversight, strong stakeholder engagement, and robust lines of accountability and transparency.

2.3 The NHS CCG and Trust Chairs established an **STP Chairs Oversight Group** in April to support the governance of the STP and to provide 'non-executive' oversight of the delivery of the STP and the STP Executive Board. Its membership comprises the Chairs of the NHS provider Trusts and Commissioners together with the Chair of the Health & Wellbeing Board and the Chairs of the County Council's Adult Social Care and Children's Services Committees.

2.4 As reported in April the oversight group agreed that in line with other STPs they wished to appoint an Independent Chair. We are delighted to confirm that following a competitive recruitment campaign the Oversight Group have appointed Patricia Hewitt, who took up post earlier this month.

2.5 The **STP Executive** continues to meet on a monthly basis to provide Executive leadership on a range of issues including strengthening our strategy with learning from other STPs, and ensuring a continued focus upon improving quality and our financial position.

2.6 The **Care and Clinical Reference Group** has been established to ensure that our transformation plans have a strong clinical evidence base and that expert clinicians are involved at every stage of the planning and delivery of service transformation.

2.7 The **STP Stakeholder Board**, chaired by Graham Creelman, has now met monthly since April and provides an overview of engagement and communication plans to ensure that effective engagement and consultation takes place. The Board engages with key stakeholders from District councils, the voluntary and community sector and Healthwatch Norfolk plus other key stakeholder groups in Norfolk & Waveney. To date they have reviewed and commented on our plans for Social Prescribing and mental health service developments, including our new perinatal mental health service, which is one of the first in the country.

3. STP workstreams

3.1 The Executive Group decided to do the planning and delivery of the STP predominantly through its existing institutional resources and systems, and maintain a very small additional STP pooled resource. There are 4 key STP work streams each led by a Senior Responsible Officer (SRO) and supported by a Work stream Lead. These are as follows;

- **Prevention, & Community Care** - Roisin Fallon-Williams, Chief Executive of Norfolk Community Health and Care, is the Senior Responsible Officer (SRO) and Catherine Underwood, Director of Health Integration at Norfolk County Council, is the Lead for this work stream.
- **Primary Care** - Melanie Craig, Accountable Officer, Great Yarmouth and Waveney, is the senior responsible officer supported by a new Director of Primary Care who is due to commence in post on 3rd July 2017.

- **Demand Management** - Antek Lejk, Chief Officer for North Norfolk and South Norfolk CCGs is the SRO, and Mark Burgis, Chief Operating Officer for North Norfolk CCG, is the lead for this workstream.

- **Acute Care** – Christine Allen, Chief Executive of James Paget University Hospitals is the SRO, and Andrew Palmer, Director of Performance & Planning, James Paget University Hospitals, is the lead for this workstream

- **Mental Health** - Michael Scott, Chief Executive of Norfolk and Suffolk NHS Foundation Trust is the SRO, and Jocelyn Pike, Chief Operating Officer for South Norfolk CCG, is the lead for this workstream.

3.2 The key objectives of each of the workstreams is given in Appendix A.

Main transformation Projects

3.3 Through the **Prevention, Primary & Community Care workstream** system partners are working on a number of projects.

3.4 **Prevention** is a strong focus of our plan with projects being implemented around;

- Expanding the diabetes prevention programme to reduce Type 2 Diabetes
- Optimising care for patients with existing long term conditions
- Implementing a programme of social prescribing
- Reducing smoking and alcohol consumption
- Assisting people to lose weight

3.5 **In Primary and Community care** we are developing and implementing optimal integrated care models known as Multispecialty Community Providers (MCPs) by locality to ensure consistency and reduced variation across Norfolk & Waveney. This represents a key shift in the way services are delivered across Norfolk and Waveney as MCPs involve groups of GPs combining with other services such as community health services, pharmacists and mental health and social care to provide integrated community services.

3.6 The **Acute Care workstream** has several key projects which include;

- Developing the strategic direction for acute services delivery. Some of the main shifts will include moving services out into the community – for example, with service areas such as Ear, Nose and Throat (ENT) and Dermatology, where there are opportunities for more of an emphasis on community-based services.
- Collaborative working across the 3 acute sites, for example, with Radiology, Urology and Cardiology, which will bring about improvements in productivity and efficiencies.
- Implementing some of the recommendations of the Lord Carter review around sharing back office functions
- Delivering improvements to Cancer Services and cancer outcomes
- Delivering the National Strategy around Better Births.

3.7 Through the **Demand Management workstream** system partners are focused on improved management of planned care, ensuring consistent approaches and equitable access to a range of providers to deliver the18 week waiting time standard. This is being driven by close, collaborative working across the 3 acute sites. Another key objective is reducing urgent and emergency activity through improved demand management (supporting the other work streams to deliver admission avoidance schemes) and reduced length of stay.

3.8 Examples of how this will be delivered in Norfolk and Waveney include through the NHS England **Urgent and Emergency Care** 'Must-dos' including the roll-out of the digital 111 service and clinical triage in the 111 service (where we aim for 30% of calls or referrals to be seen by a clinician). Through the national move for GPs to offer appointments 7 days a week and the expansion of urgent treatment centres - with a target of 25% of the population to have access to a centre by March 2018. Work to avoid unnecessary admissions also includes the implementation of the new

ambulance response programme and the new streaming models in Accident & Emergency (A&E). There is also a system focus on improving flows of patients ie discharge processes.

3.9 Some of the key objectives of the **Mental Health workstream** include;

- supporting community and primary care to provide mental health support at an early stage,
- increasing community based treatment for children and young people with mental health problems
- Reducing acute hospital use for people of all ages with reported mental health problems, including children and young people and dementia.
- Re-designing the Mental Health Crisis Pathway to support better access to care in the community and ensure people get the care they need during crisis
- Mental health practitioners to work alongside emergency services in Accident and Emergency Departments providing 24 hour cover.
- Peri-natal mental health (supporting women with post-natal depression and pre-birth depression) which has already secured funding nationally.

3.10 The key challenge for system partners is in fully mobilising our system in developing the detailed plan and in delivering it.

Officer Contact

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

Name	**Tel**	**Email**
Dr Wendy Thomson	01603 222 001	wendy.thomson@norfolk.gov.uk
Jane Harper-Smith	07801-635008	jane.harper-smith@norfolk.gov.uk

Prevention, Primary & Community Care

1.1 The key objectives of the Prevention, Primary & Community Care workstream include:

- Improving the prevention, detection and management of major chronic illnesses
- Increasing individual and community capacity for self-care
- Developing a social prescribing model
- Developing and implementing a primary care provision model that improves access and capacity and addresses retention and recruitment in line with the GP 5 Year Forward View
- Developing and implementing optimal integrated care models (Multispecialty Community Providers) by locality to ensure consistency and reduced variation across Norfolk & Waveney

Roisin Fallon-Williams, Chief Executive of Norfolk Community Health and Care, is the SRO and Catherine Underwood, Director of Health Integration at Norfolk County Council, is the Lead for this workstream.

Demand Management

1.2 The key objectives of the Demand Management workstream include:

- Managing the flows of patients into elective care by:
  - Reviewing procedures of limited clinical value in line with national guidance
  - Ensuring CCGs adopt consistent clinical policies and procedures across the system where appropriate
  - Ensuring effective pathways are in place
  - Ensuring consistent approaches to demand and referral management and reducing unnecessary variation in referral
- Ensuring there is good access to a range of providers and encouraging more delivery in the community where appropriate
- Ensuring our provider infrastructure has the capacity to deliver the care it needs and ensure equitable access
- Ensuring we have good quality, consistent, up to date data systems that help us track, review and adjust patient flows

Antek Lejk, Chief Officer for North Norfolk and South Norfolk CCGs is the SRO, and Mark Burgis, Chief Operating Officer for North Norfolk CCG, is lead for this workstream.

Acute Care

1.3 The key objectives of the Acute Care workstream include:

- Developing the strategic direction for acute services delivery and exploring opportunities for back office efficiencies between the acute, community and mental health providers
- Reducing urgent and emergency activity through improved demand management (supporting the other work streams to deliver admission avoidance schemes) and reduced length of stay

- Ensuring acute clinical service sustainability at an STP footprint level across the key nominated specialty areas and their interdependencies by working collaboratively across the 3 sites

Christine Allen, Chief Executive of James Paget University Hospitals is the SRO, and Andrew Palmer, Director of Performance & Planning, James Paget University Hospitals, is lead for this workstream.

Mental Health

1.4 The key objectives of the Mental Health workstream include:

- Offsetting and reducing the growth in out of area bed days
- Increasing recording of dementia, improving access to support and reducing the use of residential and acute care
- Supporting community and primary care to provide mental health support at an early stage
- Increasing community based treatment for children and young people with mental health problems
- Reducing acute hospital use for people of all ages with reported mental health problems, including children and young people and dementia

Michael Scott, Chief Executive of Norfolk and Suffolk NHS Foundation Trust is the SRO, and Jocelyn Pike, Chief Operating Officer for South Norfolk CCG, is lead for this workstream.

Enabling Workstreams

1.5 Further workstreams have also been established to ensure that the delivery of the STP is supported by system-wide approaches to Workforce, Estates, ICT, Finance and Communications.

Norfolk Health and Wellbeing Board

Item 9

Report title:	**Norfolk Integration and Better Care Fund 2017-19: Initial approval**
Date of meeting:	**12 July 2017**
Sponsor (H&WB member):	**James Bullion, Executive Director of Adult Social Services**

Reason for the Report

The Health & Wellbeing Board is responsible for the strategic plan for the Norfolk Integration and Better Care Fund (BCF) and is accountable, overall, for the Norfolk BCF.

While NHS England (NHSE) has released the Integration BCF Policy Framework document, it has yet to provide definitive planning guidance or the financial allocations for both Clinical Commissioning Groups (CCGs) and NCC. Local BCF advisors and Local Government Association colleagues have confirmed broad funding allocation principles, so we can assume with some confidence our allocations, however confirmation of these is required to formalise proposals to the HWB.

This report asks the Health and Wellbeing Board to agree the delivery plan for the BCF though these commitments remain to some degree "at risk" pending national guidance and assurance.

The Health and Wellbeing Board is also asked to endorse proposals for the additional funding for Adult Social Care announced in the Budget in March. This is a direct grant to Councils and, while it is part of the BCF pool, it is not subject to further planning guidance nor the BCF assurance process.

Report summary

This report seeks to ensure that Members are sighted on the content and detail of the proposed BCF narrative (Appendix 1), that they are aware of proposed delivery mechanisms and how CCGs and NCC will collectively meet the requirements of the newly created High Impact Change Model (HICM). The HICM is a key assessment and action planning tool for ensuring that people are safely and effectively discharged from hospital to an appropriate care setting and a mandated requirement of the 17/18 BCF.

Norfolk's BCF programme is a key mechanism for the transformation required to address the sustainability of the system set out in 'In Good Health' - Norfolk's Sustainability and Transformation Plan (STP).

This report sets out the strategic intention and delivery mechanisms for the two year (2017-19) BCF.

Action/decisions needed:

The Health & Wellbeing Board is asked to:

a) Agree the BCF plan as set out in Appendix 1

b) Agree that, if there is not an appropriate HWB meeting scheduled, sign off of Norfolk's first BCF submission would be delegated to the HWB Chair and Vice Chairs to meet the submission deadlines.

c) Endorse the funding proposals for the additional County Council allocation for Adult Social Care detailed in Section 4.2 and Appendix 3

1. Background

1.1 Since the Better Care Fund Plan for 2016/17 was approved, the Norfolk the Sustainability and Transformation Plan (STP) has been developed and sets out a vision for Health and Social Care for the next five years. The overall direction of travel in the BCF Plan aligns to that of the STP.

1.2 At its meeting on 8 February 2017, the HWB approved the overall strategic direction of BCF for 2017/19, and in April 2017, Adult Social Care Committee agreed the principles and stipulations on the Additional Social Care funding (IBCF).

1.3 Further work has been undertaken to identify how this money will be utilised in Norfolk to meet social care need, reduce pressures on the NHS and stabilise the care market. The County Council's Adult Social Care Committee will further consider these proposals on 10 July 2017. Section 5.2 outlines the proposals here in more detail.

1.4 NHS England published the BCF Policy Framework on 31 March 2017, however, the deadline for submission has yet to be confirmed. Further information about the Policy Framework is given in Appendix 2.

BCF and the STP

1.5 Delivery of the BCF is now supported through the STP Prevention, Primary and Community Care (PPCC) workstream so ensuring consistent join up and collaboration across the health and social care system.

2. Overview of BCF 2016/17

2.1 A review of how Norfolk is performing against the key BCF metrics:

a) We have not reached our targets for decreasing Delayed Transfers of Care (DTOC) for acute hospitals overall, though DTOC remains very low and under the identified target at James Paget and Queen Elizabeth hospitals.

b) Countywide we have reduced Non-Elective Admissions and have reached our target overall, although we continue to have higher admissions, which are above target, in Great Yarmouth and Waveney.

c) Norfolk has consistently exceeded its target for the effectiveness of re-ablement with over 90% people reabled remaining independent after 91 days.

d) Permanent admissions to residential and nursing care have reduced overall in the last two years. However recent increases in admissions have resulted in all localities not meeting their admissions targets in 16/17. A scrutiny process and action plans have been implemented in order to reduce admissions, and sustain that reduction.

2.2 There remains however, significant work to do to improve flow through the system and the overall quality and coherence of care which the BCF Plan seeks to address over the next two years.

3. BCF 2017-19 and the vision, ambition and integration plan

3.1 At its meeting on 26 April 2017, the HWB received a report outlining the developing Norfolk vision, ambition and integration plan, including priority areas of work. Since then the BCF Plan has been aligned with the vision and guiding principles established within the Norfolk and Waveney STP and delivery of the BCF Plan is supported by the PPCC workstream. The content and detail of the proposed BCF narrative is in Appendix 1.

3.2 The April report also outlined the Policy Framework and the need for partners, amongst other things, to agree how this spending will improve performance in the four mandatory metrics. Since that report, Norfolk has agreed to include a local metric on increasing the rate of dementia diagnosis. The metrics are provided in section 8 of the BCF Plan (Appendix 1). An outline of the Policy Framework and the Norfolk response is at Appendix 2.

4. Finance / IBCF

4.1 In 2016-17 NCC agreed two S75 legal agreements with all Norfolk CCGs. A one year agreement to govern overall BCF expenditure and one for the protection of social care (POSC). The three year POSC agreement remains in place until 2018/19. However a new agreement will need to be put in place for the BCF in17/18 when formal allocations are published.

Additional Funding for Adult Social Care

4.2 The Chancellor's Budget in March 2017 announced £2bn additional non-recurrent funding for social care, of which Norfolk can expect £18m in 2017/18, followed by £11m in 2018/19 and £6m in 2019/20. This additional funding is required to be pooled through the BCF but will be paid directly to local authorities from the Department for Communities and Local Government.

4.3 The conditions stipulate that the additional funding for adult social services, paid directly to local authorities, does not replace, and cannot be offset against, the NHS minimum contribution to adult social care. Grant conditions note that the grant can only be used for the purposes of meeting social care needs, reducing pressures on the NHS and ensuring that the local social care provider market is supported.

4.4 Appendix 3 details the proposals for this funding. The additional funding will support management of overall system pressures and will be subject to Norfolk County Council (NCC) agreement through its Adults Social Care (ASC) Committee. In conjunction with partners, funding will be agreed in line with the following priorities:

a) Protection of social care
b) Sustaining the social care framework
c) Investing in social care

5. Governance

5.1 Governance of the BCF is provided by the HWB with support provided through the Prevention, Primary and Community Care workstream of the STP.

5.2 CCG Chief Officers and the Executive Director for ASC provide oversight for the programme and monitor and support delivery.

5.3 The Plan will be taken to the STP Executive Board for information purposes, with the aim of securing a wider understanding and buy-in of providers and partners.

5.4 The HWB continue to provide formal oversight and sign off of the BCF plan, with the HWB Chair and Vice Chairs providing scrutiny of quarterly data collection forms and other any business, as required.

6. Strategic fit

6.1 Norfolk's BCF Plan has a strategic fit with Adult Social Service's Promoting Independence Strategy, emphasising prevention, reduction and delay of the need for formalised care and support. Initiatives are consistent with CCGs operational plans and the NHS 5 Year Forward View.

6.2 There is a clear link with district councils, particularly their role in delivering Disabled Facilities Grants (DFGs), and a wider recognition of the role DFGs play in reducing admissions to and facilitating discharges from hospital. Work will continue with partners, including Districts, to further develop plans for integration and explore synergies in service delivery

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Norfolk Health and Wellbeing Board

Draft Better Care Fund and Integration Plan 2017-19

Table of Contents:

Introduction/Foreword 4
1. **Norfolk Vision and Approach to Health and Social Care Integration 4**
1.1. Vision....4
1.2. Ambition....5
1.3. Integration Plan....6
1.4. Background and Context to the Plan....7
1.4.1.The Norfolk and Waveney Sustainability and Transformation Plan....7
1.4.2.Norfolk Adult Social Care's Promoting Independence Strategy....7
1.4.3.Norfolk and Waveney CCG Commissioning for 17/18 – 18/19....8
1.4.4.District Council Partnership (Including Disabled Facilities Grant (DFG)) 8
1.5. Progress to date – Locality Scheme Review.... 8
1.6. Progress to date: Maintaining progress on the 2016-17 National Conditions....9
1.6.1.Condition 1 Plans to be jointly agreed....9
1.6.2.Condition 2 NHS Contribution to adult social care is maintained in line with inflation....9
i) A&E Frequent Attenders....9
ii) Care Homes....10
iii) Integrated Commissioning Equipment Services (ICES)....11
iv) Continuing Health Care (CHC)....11
v) Reablement....11
vi) Better data sharing between Health and Social Care, based on the NHS number....11
vii) Agreement on consequential impact of the changes on the providers that are predicted to be substantially affected by the plans....12
1.6.3 Condition 3: NHS commissioned Out-of-Hospital services 2016-17....12
2. Evidence Base and the case for change....13
2.1. Managing patient need and demand....13
2.2. Increasing care cost....14
2.3. Geography....14
2.4. Recruitment/Retention....14
2.5. Market Shaping....15
2.6. Inequality and Wider Determinants of Health and Wellbeing....15
2.7. Integrated Personal Commissioning....16
2.8. Carers Support Service....16
3. Norfolk Better Care Fund Plan 2017-19....16
3.1. The Five Priority Areas....16
3.2. Additional Funding for Social Care....23
3.3. Consultation and Engagement of Local Providers in Planning....23
3.4. Risks....24
4. National Conditions 2017-19....24
4.1. Condition 1: Plans are jointly agreed....24
4.2. Condition 2: NHS contribution to Adult Social Care is maintained in line with inflation....24
4.3. Condition 3: NHS commissioned out of Hospital services....25
4.3.1. Delivery of day services....25
4.3.2. Delayed transfers of care (DTOC)....26
4.3.3. Discharge to Assess Schemes....26
4.4. Condition 4: Managing Transfers of Care....27
5. Programme Governance....33
6. Assessment of Risk and Risk Management....33
7. National Metrics....33
8.1. Permanent admissions to residential and care homes....33
8.2. Effectiveness of reablement....34
8.3. NEAs....35
8.4. DTOC....35
8.5. Local Metric: Dementia Diagnosis....36
8. Norfolk's Plan to reduce DTOC for 2017-19....36

9. Approval and sign off……37

Introduction/Foreword

Since the 2016/17 BCF Plan, the introduction of the Sustainability and Transformation Plan (STP) for Norfolk and Waveney – *In Good Health* - has served to reinforce the need to address the sustainability of the health and social care system by promoting wellbeing and self-care, developing community infrastructure to support care being delivered closer to home, reducing hospital admissions and facilitating timely and appropriate discharge.

Integration can aid the delivery of better quality services, support system sustainability and crucially improve the patient experience. The BCF provides an opportunity to really drive integration across health, social care and housing based services.

The Norfolk and Waveney Sustainability and Transformation Plan vision is: ***'To provide high quality services that support more people to live independently at home, especially older people and those with long-term conditions, like heart disease, breathing problems, diabetes or dementia***.'

The STP is available at: www.healthwatchnorfolk.co.uk/ingoodhealth

Realising our vision for Norfolk also means working much more closely with local people and communities, not only listening to their views, but involving them in the design and delivery of new services to support better care, health and wellbeing. *In Good Health makes* this commitment for local services and outlines what this will mean for local people:

- You will have the support you need to keep yourself healthy and well, and in control of your own long-term health.
- You will have good information to help you put in place the support you need.
- When you need care, there will be a greater range of services which can support you at home and near to where you live.
- Your care and support will be coordinated better, and your physical and mental health needs will be considered together.
- Our hospitals will focus on providing you with the specialist and emergency care that is appropriate.

This Plan sets out how Norfolk seeks to jointly further integrate services, to realise the outcomes described above, as well as enabling excellent patient experience and facilitating the delivery of good quality health and care services.

1. Norfolk Vision and Approach to Health and Social Care Integration

1.1. Vision

Our vision for integration is that people will be able to access health, social care, housing and other public services working seamlessly together to meet the outcomes they need for their health and wellbeing. We are committed to integrating care in order to deliver services that better meet people's needs, improve the health and care of local populations and to make efficient use of resources.

Our vision is underpinned by a strong focus on individuals, in other words we will know this is working when people in Norfolk tell us that is how they experience services. We have adopted the National Voices definition of what this will mean:

> "I can plan my care with people who work together to understand me and my carers allowing me control and bringing together services to achieve the outcomes important to me."

The County Council and Norfolk CCGs have well developed collaborative arrangements to seek to maximise resources and the impact on the health and social care system. Current approaches have evolved to respond to changes in national policy, population health and wellbeing but have also built on the strong local relationships and synergies that exist between health, housing and social care in Norfolk.

In Good Health, the Norfolk and Waveney STP, reinforces this approach and sets out Guiding Principles which comprise:

- Preventing illness and promoting wellbeing
- Care closer to home
- Integrated working across physical, social and mental health
- Sustainable acute sector
- Cost effective services

It is recognised that a sustainable plan needs to be delivered which addresses the numerous and significant challenges facing the NHS and social care system. The focus needs to move from short term isolated changes to transformational, system-wide initiatives. To that end, all CCGs, NCC and NHS Providers in Norfolk and Waveney have joined together to deliver a single STP which seeks to:

- Help create and maintain a safe and high quality health and care service
- Balance the NHS and Social Care budgets and improve efficiency and productivity
- Lead a step change in the NHS in preventing ill health and supporting people to live healthier lives
- Improve out of hospital care
- Support research, innovation and growth

This vision is underpinned by:

- The Joint Strategic Needs Assessment (JSNA), which describes the current and future health and wellbeing needs in Norfolk, and is available at www.norfolkinsight.org.uk/jsna.
- The Norfolk and Waveney CCGs Commissioning Intentions for 2017/18 – 2018/19, which for the first time includes commissioning intentions of Norfolk and Suffolk County Councils, and is consistent with the STP footprint. These commissioning intentions are available at http://www.norwichccg.nhs.uk/publications-policies-and-documents/1766-final-draft-commissioning-intentions-16-11-2016/file
- Appendix F- Public Health Outcomes Framework

1.2. Ambition

Norfolk's BCF plan for 2017-19 builds on the progress made in 2016-17. Our ambition for the Better Care Fund 2017-19 is to continue to invest in services which meet the following 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 support 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 health, social care and other services.
- **Support will be shaped around the individual:** Health, social care and other linked support will be built around what individuals need and what works for them. Support will continue to build on a well-established 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 and supported to manage their social care needs and health conditions so that they maintain their own wellbeing as far as possible to enhance quality of life and to reduce the need for formal services.
- **Primary care will be at 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 support services to take place within the natural health and care systems at a local level. For this, our basis is the geography of Clinical Commissioning Groups. However, it is also accepted that some issues may be more appropriately approached on a countywide footprint and, for these, we plan and operate on a county wide level for consistency and efficiency. Also,

acute health care services effectively form three sub systems in Norfolk and engagement with these is led on a co-commissioning basis by individual CCGs.

1.3. Integration Plan

The NHS 5 Year Forward View sets out that whilst the NHS is one of proudest achievements in modern society, it requires transformation to address sustainability going forward. It says that the "traditional divide between primary care, community services and hospitals… is becoming an increasing barrier to personalised and coordinated health services patients need… services need to be integrated around the patient".

Integration is a priority for Norfolk as it is recognised that current health and social care services will become unsustainable given increasing demand and financial pressure. The BCF programme is a key mechanism for the delivery of integration in Norfolk, within the framework of Norfolk and Waveney STP. It provides a vehicle not only for furthering integration between health and social care, but to support transformation and demand management which is required to address the sustainability of the system.

Underpinning its commitment to integration, Norfolk and Waveney has continued to develop its well established Commissioning function and integrated community health and social care provision - working across Norfolk County Council and the CCGs and realising a number of benefits, including:

- Ability to plan pathways for citizens and patients regardless of whether it is a health or social care funded service they require e.g. in planning for dementia
- Ability to make the most effective investment with the available funding rather than making separate investment decisions e.g. by reducing gaps and duplication
- Reducing the burden on providers, particularly for smaller organisations, through being commissioned by multiple agencies
- Being better able to influence local markets and avoid unintended impact e.g. by paying competing rates for individual services
- Making best use of our shared commissioning officer resource by reducing duplication
- Other key components of integration, including leadership, governance, care models and workforce.

Norfolk intends to continue to develop its integration goals and ambitions for 2020. These include:

1. Fully integrated health and care teams in each locality
2. Strong support and prevention in every community
3. Effective 24/7 support in a crisis
4. One efficient commissioning function
5. A clear health and care budget for each area
6. A sufficient, capable and flexible workforce
7. One set of data on citizens and population
8. Governance which supports our outcomes

An 'Integration in Norfolk Plan' setting out ambition, key milestones and the destination for 2020 integration, can be found at Appendix A.

The opportunity provided by the Better Care Fund and the robust plans that are in place for 2017-19, will deliver the ambition of Norfolk's integration vision and reflect the future direction of the health and social care services outlined in the STP. This vision is reflected in Norfolk's Promoting Independence Strategy. Please refer to Section 1.4.2 for further detail.

The integrated Housing Adaptations Team, comprising social care and housing staff and co-located within each of the seven districts, are an example of integration across social care and housing, for the benefit of patient experience.

Norfolk effectively captures and shares learning both regionally and nationally, via participation in regional BCF teleconferences, by keeping abreast of the vanguard sites, particularly related to care homes, and

Norfolk is an active member on the Eastern Region Health Integration network. An NCC Director chairs this. Integration, best practice and shared learning are key priorities for this group.

1.4. Background and Context to the Plan

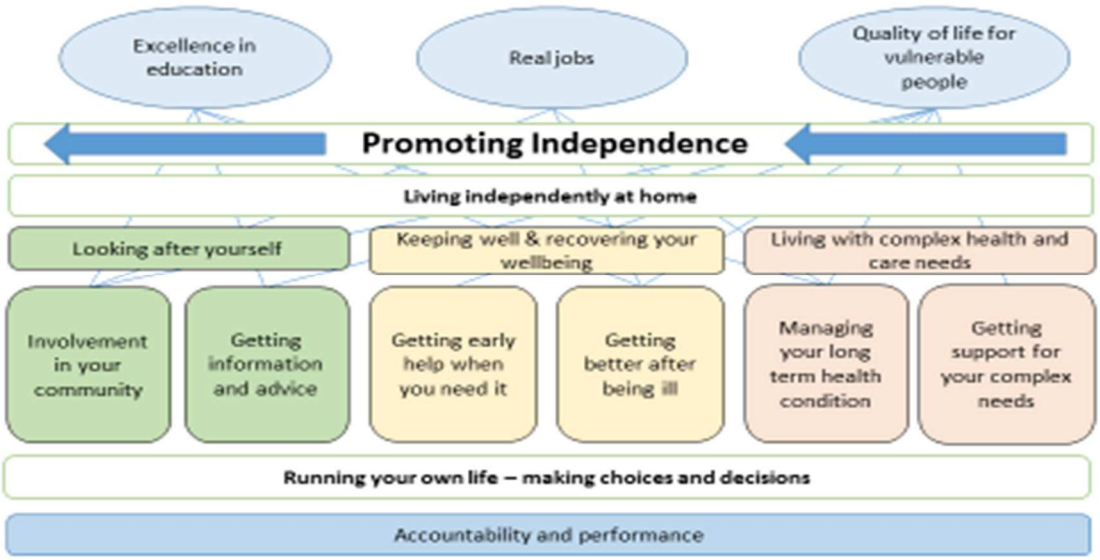
1.4.1. The Norfolk and Waveney Sustainability and Transformation Plan

As described above, Norfolk's BCF vision is aligned to that of the Norfolk and Waveney STP, and reflects the core guiding principles.

Through the mechanism which BCF provides, Norfolk seeks to deliver a sustainable plan which addresses the numerous and significant challenges facing the NHS and social care system. The focus has moved from short term isolated changes to transformational, system wide initiatives.

The schemes which are included within the 2017-19 BCF Plan will achieve the ambition set out in Section 2.

1.4.2. Norfolk Adult Social Care's Promoting Independence Strategy



Norfolk's response to an increase in demand and the need to address the sustainability of the system has been the establishment of Promoting Independence, the Adult Social Services Strategy which has a clear focus on prevention, communities and wellbeing.

It views social care needs in the context of people's lives within families and communities and it flows from this that the Council's response to social care needs should be firmly rooted in maintaining and restoring people's ability to live independently of formal care services.

Underpinned by the Care Act 2014, Promoting Independence is based on a tiered approach which emphasises:

- Looking after yourself within communities (Tier 1)
- Keeping well and recovering your health and wellbeing (Tier 2)
- Living with complex health and social care problems (Tier 3)

Norfolk has a clear focus on moving a greater portion of spend towards Tier 1, to prevent, delay and reduce the need for formalised care and support, whilst it will continue to invest in services for people to enable them to manage long term conditions and complex health and social care needs.

Strategically, Norfolk County Council agreed four priorities in February 2015. These core commitments go beyond our statutory responsibilities and avoid retreating to minimum levels of service. We aim for:

- A well-educated and skilled population
- With 'real' jobs which pay well and have prospects
- Improved infrastructure - air, sea, road, rail, broadband and mobile network coverage
- Vulnerable people supported – more living independently and safely in their communities

1.4.3. Norfolk and Waveney CCGs Commissioning for 2017/18 – 2018/19

The document shows how, as a system, we will commission services to meet the needs of our local populations; it encompasses the intentions of all Norfolk and Waveney CCGs and the commissioning intentions of Norfolk and Suffolk County Councils. These intentions support the delivery of both the STP and the BCF.

This document supports the rapid and transformational change required to deal with the facts: that long term conditions now account for a much larger percentage of the NHS budget, people are living longer, new technologies and drugs are driving new treatments and patients expectations are increasing.

This transformation can only be achieved by continuing to work jointly with colleagues across the care system to bring about improved outcomes for our communities.

The full commissioning intentions are available at: http://www.norwichccg.nhs.uk/publications-policies-and-documents/1766-final-draft-commissioning-intentions-16-11-2016/file

1.4.4. District Council Partnership (including Disabled Facilities Grant (DFG))

The seven district councils set out their approach to Promoting Independence within 'Prevention and Promoting Independence. Creating wellbeing and improving health and social care - a district perspective'. This outlines the approach that the district councils make individually and collectively to promoting independence and preventing ill health; the paper was recently endorsed by the Norfolk Health and Wellbeing Board.

There is a strong partnership operating around the delivering of the district councils' statutory functions and services. An example of this collaborative approach are Integrated Housing Adaptation Teams. These teams, located in each district council comprising social care and housing staff, clearly demonstrate the benefits of joining up services to provide an integrated response to citizens. Their work is overseen by a strategic group that has been exploring how funding and resources can best be used to meet the challenging agendas of health, housing and social care.

1.5. Progress to date: Locality Scheme Review

To support the preparation for developing the Better Care Fund plan, each of the five CCG areas in Norfolk has carried out a self-assessment of the impact and progress of their schemes.

The assessments highlighted some key areas where interventions had the most positive impact. These included:

- Community based care interventions where care and support is delivered closer to, or in, people's homes to prevent avoidable hospital admissions or residential care placements.
- The use of risk profiling, the formation of locality-based integrated care teams with dedicated care coordination, and referral to community-based support have collectively had a positive impact on

maintaining independence and maintaining this following a hospital admission through strong reablement services.

- Development of rapid response services for people who fall also had a positive impact on avoidable hospital admissions.

Assessments revealed that whilst the schemes were designed, developed and implemented in the individual CCG localities, they did seek to deliver similar outcomes and impact. Given the limited resources in each locality, where appropriate, a stronger collaborative approach was taken for 2016-17 to ensure Improved shared learning, and efficiency of resources. The 2017-19 plan has seen the development and implementation of county wide approaches that support and drive positive outcomes across the system.

An overview of the schemes which will progress into 2017-19, with intended outcomes and benefits can be found at Appendix B. These build on strong foundations developed during 2016-17.

1.6. Progress to date: Maintaining progress on the 2016-17 National Conditions

1.6.1. Condition 1 Plans to be jointly agreed- see Section 4.1 below.

1.6.2. Condition 2 NHS Contribution to adult social care is maintained in line with inflation

Agreement on the protection of social care for 2016/17 was achieved and is enacted through a three year S75 agreement until March 2019. This agreement reflects the recognition of the importance of social care provision and its role in supporting the overall system.

Progress was made against the named countywide schemes during 2016-17, summarised as follows:

i) A&E Frequent Attenders

A Central Norfolk project commenced using pseudonymised A&E data over a 12 month period from 1 Nov 2015 – 31 Oct 2016 in North Norfolk. A more detailed examination of the top 20 attenders found that there was a distinct grouping of patients in the age bands 30 – 50 years, with the majority these arriving at A&E by emergency ambulance, who had primary diagnosis codes relating to anxiety, toxic alcohol, self-harm, psychiatric conditions and poisoning including overdose.

This service complemented, rather than replaced existing services, with the objective of reducing avoidable A&E attendances and reducing non-elective admissions. The service will worked with patients to de-escalate issues before a crisis occurred, and established a framework of support with identified stakeholders. This model provided both 'in hours' and 'out of hours' support. Results of various pilots have shown that the best 'person type' for this support role has high emotional intelligence, is an autonomous worker and does not necessarily have to be a qualified medical or mental health practitioner.

In West Norfolk, work has been delegated to QEH and they are at data collection stage. There is a proposal to join up outcomes of this work with homelessness services. The operational hours and days of the Rapid Assessment Team at QEH is being expanded and it is expected that frequent attenders will receive first assessment through this team.

GY&W has an unplanned admission DES in place with all practices focused on admissions for those complex patients who may have multiple admissions. The practice will look at care planning etc. to avoid attendances or admissions to A&E.

GY&W is also looking at some other schemes currently for patients who frequently attend with long term conditions. An example is for people with diabetes and respiratory problems where there will be specialists in the department to see the patients and then look at care plans, meds review, to understand why the patient isn't managing etc. so as to avoid future attendances to A&E.

This work will continue in Norfolk and although will not formally be included as part of Norfolk's BCF Plan for 2017-19 partners will continue to collaborate to build a system wide response and action plan.

ii) **Care Homes**

The aim of this work was to develop a coordinated approach to support the delivery of high quality care in care homes aimed at reducing avoidable hospital admissions and improving the quality of care people receive. Operational transformation was planned across two interlinked footprints - central Norfolk and countywide.

Leads for each of the Central Norfolk CCGs collaborated on, and were accountable for, the central care homes QIPP work and the care homes actions on the NNUHT Urgent Care Transformation Plan. Planned deliverables. These were:

- Development of a care homes dashboard to enable setting of meaningful targets and tracking of work
- Development of a communication tool for care home staff to support them in decision making about who to call, when to call and how to call in emergency
- A Falls prevention tool to support care home staff to predict and reduce the likelihood of falls
- Work with A & E on patient pathways to make sure that people living in care homes have the best experience when they need admission and don't have to stay longer than they need to
- Support for GPs and care home staff around the prevention and management of UTIs

Prioritised activities:

- Work on 30 target homes (10 from each CCG area), including development of training and support packages
- Analysis and development of improvements to hospital transfer procedures
- Improved care planning
  Development of improvements approaches to nutrition, dementia and signposting to appropriate resources

Countywide to share good practice and undertake care homes related work at the whole systems level. Planned deliverables:

- Support good regular care planning for residents in care homes such as anticipatory care planning
- Develop better access for care homes staff to consistent and appropriate training and resources which support their abilities to care for people in ways which reduce avoidable admissions
- Link up initiatives and services which also focus on medical support and quality in care homes (NCHC and primary care) to create a more coherent approach
- Include wider system activities on the plan and contribute to these including workforce development, joining up quality processes between health and social care, prescribing and review, preparing for crisis and understanding Vanguard initiatives and how these can be applied in Norfolk to create better in and out of hours support for care homes.

Prioritised activities:

- Workforce development
- Joining approaches to supporting and monitoring quality
- Medicines management
- Additional support including primary care support (review of best practice GP and matron support, locally and nationally), 'out of hours' support and working up costed support options
- Development of care homes dashboard and ambulance data (by end of Feb)

Significant improvements were recorded in emergency admissions from care homes during this period and work in 2017-19 will build on these successes. Plans for 2017-19 will also adopt Vanguard principles and take a county wide approach to enhance outcomes and improve consistency.

iii) Integrated Community Equipment Service (ICES)

The ICEs service provides an integrated equipment store for and is used by acute hospital, social care and community health staff and represents a significant success for integrated working. While the service is

now well established, new initiatives such as review and recall of equipment provided under the ICES s75 partnership has been trialled in Norwich and North Norfolk and found to be cost effective. CCGs have agreed collectively to continue this work, though there has been delay in agreeing a co-ordinated approach. Norwich has continued its work and this is continuing to produce savings both for social care and health budgets.

The potential savings through reducing 'double-ups' were not realised last year because of recruitment difficulties. A dedicated OT has now been appointed so enabling this project to be progressed in 2017/18.

The ICES contract contains break clauses and partners are engaged in discussions with the provider NRS (led by NCC with support from NCCG as community lead) for a best offer before a decision is taken to either extend the contract or re-procure. The extension or new contract will commence in April 2018 and reductions in cost and /or improvements to the quality of service will be achieved.

The service will continue to develop during 2017-19, providing a vital mechanism for admission avoidance and facilitating hospital discharge in a timely fashion.

iv) Continuing Health Care (CHC)

The impetus provided by the BCF initiative has reinvigorated a review of brokerage work for CHC. After initial scoping meetings, NEL CSU became aware of prospective changes and gave notice on the existing contract and indicated that they would continue only with provision of additional resources. An options appraisal has recommended a federated CHC model based on CCG localities. GYWCCG has an in-house CHC service and so this work has not included the east.

Partners have developed a discharge to assess model based on this initial work which will continue to be explored as part of a co-ordinated approach to transfers of care.

v) Reablement

This countywide work has been led by GY&WCCG and has sought to develop a 'seamless' reablement journey including:

1. Shared vision and operational processes between professionals so that care is better co-ordinated to support the individual achieving their single set of goals
2. Better communication between services to coordinate timings of visits, and sharing of resources
3. Continuity within a patient's journey at key transition points.
4. Making every contacts count for improved independence and wellbeing.

Key principles and enablers were agreed and improvements categorised into 'quick wins', medium term actions and strategic actions. Phase 1 of the project, including identification of the 'quick wins', has been completed and plans for Phase 2 are in place.

A working group has been established to take forward actions and initial agreement will look at how the role of an Integrated Care Co-ordinator (ICC) could be used to co-ordinate care delivery and make improvements to this pathway. This work will continue as part of an integrated approach being taken across the county

vi) Better data sharing between Health and Social Care, based on the NHS number

- Over 95% of individual patient records on the NCC Care First record system have the NHS number recorded
- There are ambitions to increase the percentage of care records with NHS numbers through the digital road mapping project across Norfolk and Waveney which includes all CCGs and NCC.
- Whilst there is interoperability between some ICT systems, and some teams have dual access to systems, there is further work ongoing to improve data sharing. The digital road mapping work includes the commitment to have fully interoperable electronic health records so that patients' records are paperless. A new social care information system has been procured which has the capability to ensure joint data record sharing using mandatory fields.

- Health providers in Great Yarmouth and Waveney have signed up to using the NHS number as the primary identifier. The NHS number is used for direct care purposes with controls operated to secure the Caldicott Principles are adhered to in delivering direct care directly to service users.
- In South Norfolk, North Norfolk, West Norfolk and Norwich, Integrated Care Coordinators have access to both Health and Social Care records. The NHS number can be used on both systems (SystmOne and CareFirst) to search for records. Patient consent to share health records is always obtained and explanation is given in the new ICC patient/service user leaflet.

Norfolk County Council has re-procured its social care record system which, from November 2017, will be provided by Liquid Logic. One of the benefits of Liquid Logic is that it has functionality of integration through open API's which will facilitate integration with other health systems.

Norfolk is in the final stages of revising the Data Exchange Agreement that underpins data sharing across NCC and NCHC. Primarily, this will enable NCC staff to review and record in the NCHC system and vice versa. It will also enable back office sharing of data for reporting and service improvement.
The aim is to have one process for capturing consent across NCC & NCHC.

vii) Joint approach to assessments and care planning

- A range of initiatives have been agreed aimed at ensuring co-ordinated assessment and planning across the health and social care system. This includes the following initiatives:
- Integrated Care Co-ordinators support health and social care practitioners to jointly assess and plan care for vulnerable people. They support GP practices to focus on individuals at high risk of increasing health and social care needs and the capacity of this service will be increased in line with current need and projected demand.
- NCC and NCHC have an integrated approach to managing people's care needs. When referrals come into the joint hubs. Multi-Disciplinary Team consider who is best placed to respond. This approach is adopted with primary care through the Integrated Care Coordinators, who facilitate a joint approach across a range of professionals.
- Improvements in the Learning Disability service have resulted in a single record for learning disability service users and a joined up process across health and social care. This has improved care provided and significantly enhanced the ability to respond effectively in a crisis.

viii) Agreement on consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The Locality Provider Forums in place in each locality are a key mechanism to communicate important messages to support and co-produce with providers' future service offerings. In accordance with best practice, any impact on individual providers will always be held to take advantage of opportunities for co-production. Locality provider forums will continue to enable discussions and networking opportunities for providers throughout 2017/18.

Three CCGs (West, East and North) hold the responsibility for liaison and communication with the three Norfolk acute hospitals through co0commissioning arrangements and activity and plans are co-ordinated through these channels.

- The impact of changes to providers are communicated and agreed with providers on a scheme by scheme basis rather than discussing the impact of the BCF on them as a whole.
- The BCF is increasingly seen as a delivery mechanism for the STP, and providers are engaged through the STP process. One of the roles of the HWB is to take a view and assess the impact of plans on providers. Providers have been invited to the HWB to support this process.

1.6.3. Condition 3: NHS commissioned Out-of-hospital services 2016-17

In addition to locality specific schemes, all partners are committed to explore how community health and social care services such as home care, continuing health care, services for those with a learning difficulty and nursing/residential care homes can work more efficiently, with a person centred focus. There is real ambition to develop plans that, while reflecting locality detail, can operate effectively across the county

producing real system change and benefit. These plans continue to be developed and will feature in proposals going forward.

Five overarching countywide schemes have been identified, as follows:

- Locality Integrated Care Programme Infrastructure
- Care Homes
- Housing Adaptations
- Out of Hospital
- Crisis Response

These are articulated in more detail in Section B above. These areas currently receive funding from both health and social care, therefore it is considered that there is good opportunity for impact on the BCF objectives. Work to enable locality input into these areas will continue during the lifetime of the Plan.

2. Evidence Base and the Case for Change

The Better Care Fund and the associated schemes provide an opportunity to deliver results at a time of high public profile system challenges driven by unprecedented financial and demand pressures nationally on the NHS and social care.

For 2017-19, Norfolk's CCGs and Norfolk Adult Social Services will be no different in facing significant and various challenges. Many of these reflect national challenges, but they are given a distinctive impact by local demographic, workforce and geographical characteristics in Norfolk.

Plans for 2017-19 build on the case for change but also upon the successes of 2016-17. Integrated working is becoming standard practice across the county and the benefits are starting to be seen through the metrics for both health and social care.

2.1. Managing Patient Need and Demand

We have referenced Norfolk's demographic challenges in previous BCF Plans and again in iterations of the STP. As in many other parts of the UK, Norfolk is anticipating population growth over the coming years. However, in Norfolk this growth is forecast to be concentrated among over 65s and particularly over 85s and is projected to be significantly above national averages. By 2025, the already high Norfolk over 75 population is projected to increase by 38% and in North Norfolk, more than one in twenty people will be aged 85 or older by 2021.

This increase in the number of older people is likely to drive increased demand for health and care services if targeted preventative interventions, delivered at the right time, in the right place by the right person (including self-management) are not provided effectively.

The rising demand for services and the impact that this is having on the health and social care system can be illustrated by a number of factors such as an overall rise in non-elective admissions to hospital and increases in demand for home-based care. Policy direction will dictate that more care and support is required in the community to ensure that people stay well in their own communities.

Local health and social care plans reflect the need to actively use preventative interventions in order to manage demand for services. This principle is reflected strongly within Norfolk BCF plans.

Norfolk continues to invest in a number of out of hospital schemes, which seek to reduce avoidable admissions, and services which support this aim and statistics for non-elective admissions appear to show that the rate of increase has slowed.

Development of an intermediate care strategy, jointly with CCGs, as part of the STP will reflect interventions that support safe and effective transfers of care and evidenced prevention initiatives.

2.2. Increasing Care Costs

The Government introduced the National Living Wage on 1 April 2016, for workers aged 25 and over. This increases further with effect from 1 April 2017. This has added pressure to Adult Social Care and health budgets and to all care providers, particularly those which operate within rural areas. Whilst salaries and wage rates for the lowest paid care workers have increased and are therefore more attractive than previously, the rates for competing jobs have also being increased to the same level and so consequently, the relative attractiveness of posts in care has not improved.

Labour availability is a key factor in the provision of services in Norfolk and the care economy forms a large component of the overall economy. Significant work has been undertaken with health partners to understand and support the care sector

The Care Act requires the Council to promote the effective and efficient operation of the care market to secure the sustainable supply of high quality care services for adults in Norfolk. The Council is almost entirely reliant upon hundreds of independent businesses and organisations for the provision of care services in which it invests more than £280m a year through legally binding contracts. Setting and maintaining appropriate fee levels are key to the long term sustainability of this market.

The statutory guidance to the Care Act requires local authorities to commission services having regard to cost effectiveness and value for money. The guidance emphasises the need to ensure that fee levels are sufficient to enable providers to meet their statutory obligations to pay at least the National Minimum Wage and provide effective training and development of staff. Therefore the Adult Social Care Committee agreed to implement fee uplifts ranging from 1.7% to 5.5% for the 2017/18 financial year.

2.3. Geography

Norfolk is predominantly a rural county which poses a significant challenge to the delivery and accessibility of support and services. Ambulance response times are the most evident example of the challenge posed by rural geography, but the impact is felt system-wide and necessitates innovative solutions. In addition, there is an aim to ensure that the right community services can be accessed closer to where people live so as reduce avoidable ambulance conveyance, and hospital and residential care admissions but whilst essential this proves problematic in a rural county such as Norfolk.

2.4. Recruitment/Retention

A further challenge throughout the local system is the difficulty experienced in recruiting and retaining personnel. National challenges in specialties such as Accident & Emergency (A&E) are amplified in the rural environment of Norfolk. For example, the age profile of General Practitioners (GPs) combined with current recruitment levels means primary care is facing a significant challenge in workforce sustainability at a time when it is being asked to play an ever greater role in the system. A Primary Care Transformation Plan has been developed (led by GY&W CCG on behalf of all the Norfolk CCGs) and Norfolk CCGs are in various stages of developing new models of care including the Multi-speciality Community Provider model in accordance with the national NHSE 5 Year Forward View.

In addition, the ability to recruit and retain care staff compounds the difficulties in ensuring that the right community care is available to keep people independent or support them after a time of crisis (e.g. hospital admission). The impact of 'Brexit' on a health and social system currently dependent on foreign born staff is unknown currently, but potentially provides further strain on accessing appropriately qualified and experienced staff.

The recently published King's Fund Policy Alert looks at the potential impact upon the NHS and Social Care:

https://www.nuffieldtrust.org.uk/news-item/nhs-could-face-bill-of-over-half-a-billion-pounds-from-brexit?utm_source=The%20King%27s%20Fund%20newsletters&utm_medium=email&utm_campaign=8347060_NEWSL_HMP%202017-06-02&dm_i=21A8,4YWMS,HQR7VM,IWFIS,1

To add context to the difficulties faced in Norfolk, there are approx. 25,000 jobs in Adult Social Care in Norfolk, with an expected 18% growth in the sector by 2025. The expected turnover rate is 26.3% with an estimated 1,850 vacant roles.

The impact of these issues will in part be reflected in the national increase in Delayed Transfers of Care from hospital and in quality and performance concerns through failure of some providers due to staff shortages. Delayed Transfers of Care have been an area of risk for Norfolk, though recent trends have been encouraging, again indicating that Norfolk's preventative work is starting to bear fruit.

Training, education and leadership development are key in ensuring a well-trained workforce and plans formulated reflect joint work with health, social care and other local authorities to increase recruitment and retention across health and social care sectors. This is reflected in the LEP Sector Skills Plan:

https://www.norfolk.gov.uk/business/supplying-norfolk-county-council/care-providers/the-care-workforce/health-and-social-care-sector-skills-plan

2.5. Market Shaping

The establishment and continued investment in integrated operational teams better enables support to be wrapped around individuals, and ensures that support can be better targeted to those people identified using risk stratification.

There have been several instances of contract return or provider failure in Norfolk in the residential care and home care sectors. In respect of home support services, Norfolk is seeking to establish a framework agreement to rationalise and build resilience and capacity within the care market, currently focusing on Central Norfolk with West and East to follow at a later date. This approach will enable collaboration of providers under a framework contract to co-ordinate care packages within a given area, ensuring efficient and effective deployment of care workers.

Norfolk has established a Market Position Statement, and is currently finalising a revised version for 2017-18. This document seeks to support providers in understanding the market, to set out commissioning intentions to support business planning and to flag upcoming procurement opportunities. Both this, and the LEP Sector Skills Plan, provide data and evidence of the current situation in relation to supply and demand within the sector. The existing MPS can be found here:

https://www.norfolk.gov.uk/business/supplying-norfolk-county-council/care-providers/the-norfolk-care-market/market-position-statement

2.6. Inequality and Wider Determinants of Health and Wellbeing

The STP 'case for change' sets out some areas of health where outcomes are significantly worse than England as a whole, including for example, alcohol admissions and diabetes prevalence.

In addition, it identifies wider inequalities in health determinants that can result in inequality of outcomes. In 2015 more than 150,000 people in Norfolk and Waveney lived in areas categorised as the most deprived 20% in England. These are located mainly in the urban areas of Norwich, Great Yarmouth, Thetford and King's Lynn (plus Lowestoft in Suffolk) together with some identified pockets of deprivation in rural areas, coastal villages and market towns. In 2014 the life expectancy gap across the footprint between the most deprived 20% and least deprived 20% was 7 years for men and 4.5 years for women.

2.7. Integrated Personal Commissioning

Building on work to look at offering personal health budgets (PHBs) to people eligible for Continuing Healthcare, a pilot project was undertaken in Norwich and South Norfolk offering a PHB to a cohort of patients with diabetes.

CCGs and NCC are identifying opportunities for more integrated personalised commissioning as part of the local Transforming Care programme for people with a learning disability. Options are also being explored with a local provider of mental health services to extend personalised approaches, for example within Section 177 aftercare arrangements, and as key component of mental health recovery models.

Norfolk County Council is about the review the delivery models which support people who opt to meet their care needs through a personal budgets or direct payment. Adult Social Care will use the review to ensure that full consideration is given to arrangements which enable holistic personal care, including consideration of value for money. The review outcomes will be built into future delivery models for self-directed support, such as recruitment, HR and payroll for care and support staff, and includes consideration of the use of newer technologies such as pre-payment cards. The personalisation agenda is already strongly established within Adult Social Care. In planning the approach, it will be important to build in an understanding of what level of needs are likely to be best met through integrated personal budgets over the next five years and beyond.

2.8. Carers Support Services

Norfolk County Council and the CCGs have recently set out their commissioning intentions for supporting unpaid carers, with the new service due to commence 1 October 2017.

The provider will be expected to develop a range of solutions, to include:

- Providing carers with resources about being a carers
- Signposting to appropriate resources
- Building on preventative assessments
- Raising the profile of unpaid carers in Norfolk
- Prioritising the way in which services are delivered so that carers reaching crisis, or new to a caring role, are able to access resources quickly
- Referring to NCC for a formal assessment when the carer's wellbeing is adversely impacted upon because of their caring role

Section 3. Norfolk Better Care Fund Plan 2017-19

3.1. The Five Priority Areas

Norfolk's Better Care Fund Plan confirms the five overarching priority areas of work, where it is considered there is the greatest scope for impact and benefit.

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

These areas already benefit from integrated practice and impact will be increased by focus within the BCF. Services and investment that will result from the additional funding to social care will be interwoven into the work streams to ensure synergy with existing initiatives, but also to increase the potential impact of interventions.

Principally, the areas of work comprise services which incorporate elements of health and social care funding where it is perceived that increased benefit will accrue from inclusion within the BCF programme structure. Collaboratively, they seek to reduce hospital admissions, develop and maintain community infrastructure and emphasise promoting independence.

These overarching areas of work are supported by a number of local schemes and initiatives designed to deliver outcomes for individuals.

The views of people who use services are constantly sought, these are summarised in the Norfolk Market Position Statement for 2016/17. We know that people want to:

- be able to find help easily; a sort of one-stop shop
- find reliable help with practical things, including household repairs- to stop those things becoming a worry and overwhelming
- stay in their own home- but do want some practical help or changes to help them manage. This means adapting their homes as their needs change.
- They tell us how important their local neighbourhood is-everything from their local church, social activities, friends and neighbours who can keep an eye of people.

Therefore the 2017-19 BCF will focus on the following county wide initiatives which will be implemented to reflect locality variation.

Priority 1: Locality Integrated Care Programme Infrastructure
In order to fulfil our ambition and vision that people will be able to access effective and co-ordinated care which is delivered at home or in their local community and that support will be shaped around the individual, links across health, social care and the community need to be strong and sustainable. • Integrated community health and social care teams, including mental health frontline teams, work closely with Norfolk General Practices to support people in their homes and benefit through utilising the wider network of community support available in the locality through: district councils; independent providers; community and voluntary sector organisations and informal carers. • Work is underway to standardise pathways across health providers and improve the value of our offer to local populations. This will continue to shift work out of secondary care and closer to patients.

- Risk Stratification of patients through risk profiling is used to identify a number of patients who may benefit from wider community support in managing their health and social care needs.
- Development of the Norfolk Care Record
- A Multi-Disciplinary Team (MDT) approach is delivered through Integrated Care Teams brought together to plan and review the community support provided to those identified at risk.
- Coordination of Care is ensured through actions agreed at the MDT and progressed locally.

Key Milestones

Each locality has their own local delivery plan for integration with key milestones.
Norfolk and Waveney CCG Commissioning Intentions are available:
http://www.norwichccg.nhs.uk/publications-policies-and-documents/1766-final-draft-commissioning-intentions-16-11-2016/file

Priority 2: Care Homes

Care Homes form a large proportion of the social care market in Norfolk. Therefore, we prioritise working with Care Homes to promote engagement with the Enhanced Health Care in Care Homes framework, quality assurance and market sustainability, to impact on key metrics, including reducing avoidable hospital conveyance.

Enhanced Health Care in Care Homes (EHCH).

The Norfolk system is already engaged with the Enhanced Health Care in Care Homes framework as a basis for reducing admissions from care homes to hospital and collaborating to support improvement in the quality of care offered.
The work with care homes extends to developing and enhancing the key relationships with primary care (funding care homes facing posts) and urgent hospital care (improving the experiences of admission and discharge for patients and care homes) reflecting both local pathways and the best practice from the care homes vanguard sites.
The key benefit from this work is a reduction in unplanned admissions to hospital from care homes. The other important benefits being sought include reductions in emergency calls and conveyances, reductions in length of hospital stay by care homes residents and an increase in the number of good CQC ratings.

Quality Improvement Programme: – A coordinated approach is being undertaken to support the delivery of high quality care in care homes which will reduce avoidable hospital admissions and improve the quality of care people receive, by a variety of means, including closer links to Primary Care.

- Urgent Care Tools are available to care home staff to support them in decision making about who to call, when to call and how to call in emergency.
- Work with A & E on patient pathways to make sure that people living in care homes have the best experience when they need admission and don't have to stay longer than they need to.
- Support good regular care planning for residents in care homes such as anticipatory care planning.
- Develop better access for care homes staff to consistent and appropriate training and resources which support their abilities to care for people in ways which reduce avoidable admissions.
- Link up initiatives and services which also focus on medical support and quality in care homes (NCHC / primary care) to create a more coherent approach including falls prevention and UTI management

Key Milestones

- Development of a robust care homes dashboard by June 2017
- Workforce development undertaken - May to September 2017
- Develop and introduce a falls prevention tool for care homes – June to November 2017
- Improve the pathway between hospital and care homes – June to December 2017
- Introduce a communication tool to support decision to support decision making by care home staff by March 2018
- Target support at care homes making the most frequent use of urgent and emergency care – September 2017 to March 2018

Priority 3: The Home Environment

This area of work broadly covers those interventions which focus on the home as a place to support the maintenance of an individual's independence, and contribute to wider health and social care benefits, including reduction of admissions to and facilitate discharges from hospital. The work will be focussing on;

- Housing as an enabler to improved health and wellbeing e.g. by ensuring that the home is a safe and warm place that does not represent unacceptable risks to the occupants
- Making best use of Disabled Facilities Grant (DFG) funding

Use of Disabled Facilities Grant Funding
The contribution that district councils make to the outcomes of the Better Care Fund has been recognised by a year on year increase in the funding allocated for Disabled Facility Grants. This funding will be used by district councils primarily for funding their statutory duties in respect of adaptations.

- Increasing the volume of housing adaptations
- Improving the end to end time of the Disabled Facility Grant (DFG) process for adaptations
- Improving effectiveness and efficiency for repair and maintenance of DFG equipment once installed

Strategic principles for delivery have been agreed by the Norfolk IHAT Strategic Group and joint two-year Locality Plans will examine how funding and resources can more explicitly assist in meeting wider BCF objectives such as reducing pressures on the NHS, including support for people to be discharged from hospital and meeting care needs.
Initiatives being developed within localities include:

- Elective hospital admission adaptions
- Home from hospital packs
- Fast track DFG assessment to assist hospital discharge
- Increasing the number of accredited assessment officers
- Increasing community capacity
- Joint procurement of equipment
- Widening understanding in the health provider system of DFG availability and funding criteria
- Developing innovative means to support people to live independently at home, ensuring approaches to link to other activities such as social prescribing and admission avoidance schemes to deliver improved outcomes

- Working collaboratively to complement other related activity within the BCF plan to avoid duplication and make effective use of the combined resources available
- Ensuring housing staff are appropriately trained to provide services in a dementia friendly way

Key Milestones

- Evaluation of 16/17 DFG activity by May 2017
- Agreement of 17/18 – 18/19 DFG plans by June 2017
- Allocation of DFG – June 2017
- Quarterly monitoring of impact and outcomes of DFGs from July 2017
- Six monthly monitoring of progress on DFG related initiatives contained in Locality Plans

Priority 4: Out of Hospital schemes

Out of hospital schemes comprise admission avoidance schemes, underpinned by an Intermediate Care strategy to support promote independence and reduce avoidable admissions.

Admission Avoidance schemes:- Norfolk County Council and Norfolk CCGs continue to invest in a range of support to prevent avoidable admissions to hospitals, addressing the system sustainability and demand management, enabling individuals to access appropriate preventative measures at an earlier stage.
This is enabling Norfolk to shift work from secondary care to out of hospital. Examples of specialities where work is already taking place include, but are not limited to: dermatology; ophthalmology; audiology and cancer.

- Pathway analysis
- Self-management and Long-Term Condition Patient and Carer Education Programmes, including provision of information, training, specialist clinics, healthy community programmes and extension of a wellbeing Improving Access to Psychological Therapies (IAPT) service to people with long term conditions.
- Specialist Community Nurses provide clinical support to GPs and carers on advice and guidance on care planning and self-management approaches.
- Delivery of generalist and specialist palliative care will be optimised to support people to live and die well in their preferred place of care and prevent avoidable admissions to an acute setting. This will include the phased implementation of Electronic Palliative Care Co-ordination Systems (**EPaCCS**) and consideration of a 24/7 patient/carer helpline.
- Medication Management supports people to remain at home for longer
- Independent living is facilitated via the provision of an Integrated Community Equipment Service
- Re-commissioning of mental health community outreach support with social care and CCG funding to support mainly working age adults with functional mental health needs to recover and reduce crises and hospital admissions.

We have moved some way forward across Norfolk and Waveney with this aim through the commissioning and implementation of the Well-being service. However further steps need to be taken in moving this model even further in terms of integrated approaches and in supporting the implementation of the related Five Year Forward View for Mental Health expectations, namely:

- Enabling increased access to psychological therapies (19% by 2018-19),
- The further integration of these therapies within physical health care
- Ensuring that fully integrated service provision is rolled out from 2018-19
- Improving access to psychological therapies for people with psychosis, bipolar disorder

and personality disorder

The provision of timely dementia diagnosis and community based support is key within future models of primary care focused on integrated support.

Key Milestones

Acute systems Plans

Each of the three acute hospitals have systemic plan, supported by local A & E Delivery Boards, to reduce avoidable admissions.

Information, Advocacy and Advice services, including Independent Mental Capacity Advocacy services, are available via a range of sources aimed at enabling people to remain living independently, within their communities, and without the need to call on more formal sources of care.

Recommissioning of IAA Services

- Development of new delivery model proposal by end of June 2017
- Test proposal and amend – July 2017
- Seek sign of SMT and CCGs July / Aug 2017
- Work through procurements options by end of August 2017
- Procure Sept to Dec 2017
- Transition over to new models from January to March 2018

Other areas for further consideration of how they can be used to support health, social care and housing include:

- Supported living and supported housing
- Sensory support services
- Assistive Technology

Intermediate Care Strategy

Intermediate Care in Norfolk will focus on reablement, and independence preventing unnecessary hospital admission, promoting timely discharge, therefore reducing NHS pressures, and reducing the need for long term residential care.

The strategy will underpin the delivery of intermediate care services and will ensure that resources are focused where they can have most impact.

There are a number of initiatives that will be progressed during 2017-19, including the High Impact Change Model. Options and initiatives will be explored as part of the development of the strategy, incorporating emerging guidance and good practice from Vanguards, including:

- Discharge to assess and trusted assessor models
- Integrated reablement services, including bed based reablement
- Appropriate and adapted housing for older people
- Social prescribing
- Home Support
- Re-commissioning of mental health community outreach support with social care and CCG funding to support hospital discharge, particularly where there are housing related needs and to provide flexible support in the post discharge period. The new service model will be in place from 1st March 2018.
- Seven day hospital social work teams
- Flexible dementia service to be re-commissioned to better support people in crisis and link with health services.
- Rehabilitation services will be reviewed with specific focus on why separate services are delivered in secondary care and the community. This is with a view to the potential rationalisation of such services.

Key Milestones

Intermediate Care Strategy Planning

- Review existing provision - July to December 2017
- Design new pathways – January to June 2018
- Commission new pathways – From January 2018

High Impact Change Model Activity

- D2A - to expand to all the pathways including home access from October 2017
- Trusted Assessor from October 2017
- Crisis Home Care from October 2017
- Supported Care Model Integrated Delivery from April 2018
- Active Assessment Beds from April 2018

Priority 5: Crisis Response

In order to reduce avoidable admissions, an effective suite of crisis response services are available. Crisis response services are generally segmented into preventative interventions and non-emergency services.

Preventative interventions

Services such as, but not limited to:

- flexible dementia provision
- home wards
- services to carers
- Planned and unplanned respite and short breaks which enable people who are risk of crisis or potential crisis situations, to remain in, or return to, their own homes.
- Proactive checks conducted with identified at risk patients via the MDT process (including Learning Difficulty patients)

Non-Emergency

Including, but not limited to:

- In hours emergency social work and triage services (Social Care Centre of Excellence).
- Out of Hours emergency social work service and triage service. (Norfolk Emergency Duty Team).
- Community Alarms provided for those who are vulnerable, have mobility problems, are prone to falls or have a mental health problem.
- Safeguarding responsibilities, including Multi Agency Safeguarding Hub
- Locality Hubs with access to Integrated Care Teams
- 24-hour emergency support for anyone with an urgent unplanned need (Norfolk Swifts) providing support with personal care and minor nursing tasks, assisting people who have fallen and providing support at times of crisis (e.g. a flood or power failure) where no other help is available
- Initiatives to assist the ambulance service (EEAST) in determining whether to convey individuals
- Crisis prevention through respite provision to militate hospital conveyance

Key Milestones

Flexible Dementia Provision

- Scope by September 2017
- Stakeholder engagement September to December 2017
- Proposal by January 2018

Services to Carers

- Procurement evaluation and award June 2017 to September 2017

- New services commence 1 October 2017

Other services to execute crisis response exist, and will be developed/flexed as required to produce a coherent and appropriate crisis response.

3.2. Additional Funding for Social Care

The Chancellor's Budget in March 2017 announced £2bn additional non-recurrent funding for social care, of which Norfolk can expect £18m in 2017/18, followed by £11m in 2018/19 and £6m in 2019/20. This is in addition to the additional funding announced in the 2015 spending review and collectively this funding paid directly to councils is known as improved Better care Fund (iBCF). This additional funding is required to be pooled through the BCF and should be spent on unmet social care need.

Grant conditions also make clear that iBCF must be used to support BCF National Condition 4, which stipulates councils should work with CCGs and NHS providers to implement the High Impact Change Model for managing transfers of care. How we will do this is set out below – Section 3.2.2

The grant conditions stipulate that the funding grant is to be spent on three purposes: -

- Meeting adult social care needs
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- Ensuring that the local social care provider market is supported

This iBCF funding is not subject to the same approval and assurance process as the BCF and can be spent following agreement between the County Council and the Norfolk CCG's.

The additional funding will support management of overall system pressures and will be subject to Norfolk County Council (NCC) agreement through its Adults Social Care (ASC) Committee.

Funding discussions have produced a number of proposed areas of priority for Norfolk, which include:

1. Protection of social care – maintaining social care services
2. Sustain social care – focusing on the market and securing supply and workforce
3. Invest and improve social care – support health functions in discharging their duties including work with CCGs and providers effectively manage transfers of care.

3.3. Consultation and Engagement of Local Providers in Planning

Consultation with NHS providers and other key stakeholders is taking place as part of the process of developing, submitting and refining the Norfolk BCF plan.

All CCGs have individual governance arrangements for engaging with key partners including leading on liaison and engagement with the three acute hospitals. CCGs hold regular Board meetings to discuss the integration of health and social care, at which a number of partners are represented. This may include:

Primary Care, Acute Care, District Councils, Community Health Care, Norfolk County Council, East of England Ambulance Service Trust (EEAST), IC24, and voluntary and independent providers.

Provider consultation and engagement also takes place on a locality level with integrated health and social care locality provider forums held on a quarterly basis. These forums will continue to act as a key method of sharing and shaping BCF plans with providers of services.

Norfolk continues to benefit from shared teams between the main community health providers and NCC social care staff forming a fully integrated operational service across the five CCG areas. This collaboration ensures that effective communication and engagement is achieved across health and social care operational teams.

Key health partners and providers are included as part of the STP Membership and are therefore engaged via the STP Delivery Board. Membership of this group comprises:

- 5 CCGs
- Norfolk County Council
- 3 Acute Providers (NNUH, QEH and JPH)
- 2 Community Providers (East Coast Community Healthcare CIC and Norfolk Community Health and Care Trust)
- 1 Mental Health Trust (Norfolk and Suffolk FT)
- East of England Ambulance Service Trust (EEAST)

Key stakeholders are engaged via the STP Stakeholder Group. Membership of this group includes:

- District Councils
- Norfolk Independent Care
- IC24
- Norfolk and Waveney Local Medical Committee
- Healthwatch Norfolk

3.4. Risks

Risks associated with the delivery of Norfolk BCF Plan are captured within the BCF risk register, at Appendix E.

[NB Appendix E is not included in Health and Wellbeing papers. A risk register is under development and will be completed and consulted upon once the BCF Guidance is published.]

Section 4. National Conditions 2017-19

4.1. Condition 1: Plans are jointly agreed

Norfolk BCF is seen by partners and stakeholders as a key enabler towards greater health and social care integration and indeed as a means of assisting in the delivery of the STP. This submission reflects that the plans proposed for 2017-19 have been jointly agreed across key stakeholders. The BCF governance arrangements are a key element for ensuring that this join up between key organisations continues to develop to support this agenda.

The Plan is agreed by NCC, the Norfolk CCGs and will be considered for sign off by the HWB.

District Councils have had the opportunity to comment on draft proposals, and have been engaged via the development of the Locality DFG Plans and through the STP Stakeholder Group.

4.2. Condition 2: NHS contribution to adult social care is maintained in line with inflation

For 2017/18 and 18/19 the minimum contribution to adult social care is calculated using the assured figures from 2016/17 as a baseline. The NHS contribution to adult social care at a local level must be increased by 1.79% in 2017/18.

Agreement on the protection of social care for 2016/17 was achieved and is enacted through a three year S75 agreement until March 2019. This agreement reflects the recognition of the importance of social care provision and its role in supporting the overall system.

In response to the introduction of the Care Act 2014, Norfolk implemented a number of measures and there continues to be a clear focus on achieving excellence in the local delivery of social care, following implementation of Care Act changes.

The schedule of schemes for the Protection of Social Care contained within the S75 agreement comprise:

- Part funding of Community Care front line operational teams
- Provision of 7 day hospital social work service (direct cost of weekends)
- Provision of hospital social work service (direct cost of weekdays)
- Provision of Council funded Integrated Care Co-ordinators
- Council funding of Reablement Service

There will be continued investment in these schemes.

4.3. Condition 3: NHS commissioned out of hospital services

4.3.1. Delivery of 7 Day Services

- A gap in the provision of staffing for weekends within the hospital social work teams was highlighted (although there had been weekend staffing available at the three acute hospitals on an ad-hoc basis). NCC has agreed to fund a weekend presence at the three acute hospitals and also within the Care Arranging Service.
- There has been investment in weekend social work teams for the three acute hospitals in addition to an Emergency Duty Team service. There are several 7 day services that will be maintained including reablement support, community liaison teams, home care support and intermediate healthcare support.
- Capability in the emergency areas of acute hospitals has been bolstered through investment in community, acute, mental health and social services practitioners working together to support patients to access community services where appropriate. Key to this has been referral pathways to independent, voluntary and community sector provision as well as statutory services (such as Local Housing Authorities) to ensure that patient needs are met holistically. This has helped reduce avoidable hospital admissions and improved patient experience.
- There has also been significant healthcare investment in intermediate care services that operate 7 days a week, including Hospital Care at Home support and Nursing / Residential Care provision allowing patients time to stabilise and recuperate. These services typically include provision for social care input to ensure a seamless transition from health funded to social care / self-funded arrangements, as required.
- Mental health support, available 24 hours a day, 7 days a week, is provided via community crisis resolution teams, home treatment teams and mental health liaison services in acute hospitals.
- Additional Primary Care support within the Acute setting (streaming at the front door, GP in Emergency Department and urgent care car in the community to support home visits) have also been developed. Norfolk First Support operate a seven day service offering intensive assessment and reablement services in a person's own home for up to six weeks following hospital discharge. They also offer a 'Home Safely' service to enable discharge, offering a visit within 24 hours of discharge to ensure a person is managing where the hospital has concerns.

- Norfolk Swift Response (Swifts and Night Owls) offer a 24 hour service providers help, support and reassurance if a person has an urgent, unplanned need at home, but doesn't need emergency services.
- The Emergency Duty Team also offers an out of hours service to respond to emergencies from Child Protection, Mental Health Act assessments and Adult Safeguarding
- Weekend hospital social work presence at the NNUH and QEH acute hospitals is provided on a permanent basis.
- Weekend hospital social work presence at the JPH acute hospital is provided, but ongoing work to secure funding on a permanent basis is required.
- Seven day working in NCC's Care Arranging Service is established, and work is underway with providers to enable placements to be made consistently over weekends.
- Further work is required to ensure that home care and residential care providers are available to prevent avoidable admissions and support people on discharge seven days a week.

4.3.2. Delayed Transfers of Care (DTOC)

Focus on delayed transfers of care provides has provided a real opportunity to join up system initiatives. Each of the three Norfolk acute care systems has an A & E Delivery Board which closely monitors patient flow. Increasingly this work is combined with the management of social care services needed to ensure safe transfers back to the community. These groups also monitor progress in achieving the 10 national clinical standards for seven day services.

Norfolk has undertaken a self-assessment against the High Impact Change Model for managing transfers of care, linking to each of the three acute areas. This has provided the opportunity to take stock of where are currently are and will be developed into an action plan describing what steps need to be taken to achieve maturity/exemplary against the eight changes areas, and a responsible lead to ensure delivery.

Collaboration across NCC, CCG and Acute will ensure joint responsibility and ownership across organisations, thus enabling pathways that are joined up and ensuring consistent improvement of patient flow across the health and social care system.

A strong evidence base on DTOC will drive investment, linked to an Intermediate Care Strategy which will underpin the delivery of intermediate care services and will ensure that resources are focussed where they can have most impact. The delivery of this strategy will be supported via the STP Prevention, Primary and Community Care work stream, thus ensuring it is founded with the STP.

A number of invest to save initiatives are proposed, which include: co-production of a trusted assessor model, expansion of preventative services, including social prescribing and care navigation, development of a supported care model and a homefirst model to promote independence of older people while relieving pressure on the health and social care system.

Countywide plans being developed by the Integrated teams include the development of a resilience network of care providers to ensure that homecare can be provided at short notice for those being discharged and investigation is being undertaken (in conjunction with the Local Government Association) into the cost benefits of integrated domiciliary care. Both initiatives will be developed within the framework of the BCF integrated plan.

Plans for the formulation of a robust and evidenced plan that covers all three acute care subsystems within Norfolk are in place. These plans will build on the rapid response services that Norfolk County Council already provides through Swifts and Nightowls.

4.3.3. Discharge to Assess Schemes

Norfolk is continuing to develop Discharge to Assess models across Norfolk, following initial pilot schemes.

West Norfolk:

- A discharge to assess project for patients with complex needs has been in place since January 2016 and is continuing on the basis of evidenced successful outcomes for patients and value for money (and has informed the development of a similar scheme at the NNUH). The project has introduced pathways to enable patients to be referred for community support dependent on the level of their care or nursing needs. The pathways will be further refined and developed during 2017-19 and is founded on integrated working between Norfolk County Council, WNCCG, Queen Elizabeth Hospital, NELCSU, Care Home and Community Health providers
- Local health and social care partners are developing a 'Home First' approach at QEH to enable patients with therapeutic or reablement needs to be supported at home. It is anticipated that this will help reduce numbers of permanent care home admissions through enabling older people to regain their confidence and capacity to remain independent at home.

Central Norfolk:

- A Discharge to Assess initiative is being introduced at the NNUH based on the QEH pilot and focused on CHC patients.
- The NNUH pathway commenced on 1 March 2017.
- The next phase is to expand the pathway from more complex cases to include individuals who are likely to be awarded Funded Nursing Care.

East Norfolk:

- The core of this approach is the trusted assessor arrangements with both social care and staff at the JPUH referring directly into the Norfolk First Support Reablement Service, which should have the capacity to convey all patients home.
- To improve the outcomes for the individual and reduce the risks of re-admission we are exploring the development of accommodation-based reablement services for this pathway to support the whole system.

As part of the development of an Intermediate Care Strategy for Norfolk, further exploration of Discharge to Access and Trusted Assessor models is planned, including identifying gaps, solutions, benchmarking across other areas and seeking to widen pathways to include social care patients and reduce Delayed Transfers of Care.

4.4. Condition 4: Managing Transfers of Care

Norfolk has undertaken a self-assessment against the High Impact Change Model for managing transfers of care, linking to each of the three acute areas. This has provided the opportunity to take stock of where are currently are and what steps we would need to take to achieve maturity/exemplary against the eight changes areas.

Norfolk seeks to implement the model to support system wide improvements in transfers of care.

We will develop with partners how will work together to jointly fund and implement this model, and monitor the impact of changes.

The Norfolk High Impact Change Model Plan can be found at: Appendix C.

5. Programme Governance

The Health and Wellbeing Board has a duty to promote integration and Board members have agreed that driving integration is one of its three strategic goals in its Joint Health & Wellbeing Strategy. It is responsible for developing and implementing the strategic plan for the Norfolk Better Care Fund Plan and is accountable for the Norfolk Better Care Fund. Norfolk Chief Officers Group provide formal governance and

direction to the Programme, including monitoring finance, delivery and performance. Membership comprises CCG Chief Officers, Chief Finance Officers and the Executive Director of Adult Social Services.

The STP Prevention, Primary and Community Care work stream will provide a role in supporting the delivery of the Programme.

A more detailed description of governance arrangements can be found in Appendix D.

6. Assessment of Risk and Risk Management

1. Overall Risk Management- An overall risk register is in place, which sets out the key risks and mitigations across delivery and financial risks. There has been opportunity for key stakeholders to assess risk locally.

2. Programme Delivery- There are a number of risks to the delivery of the 5 priority areas of work, including market and workforce capacity and demographic pressures. There is a joint commitment to deliver the priority areas of work. The strategic challenges to the BCF are described in the Evidence Base section.

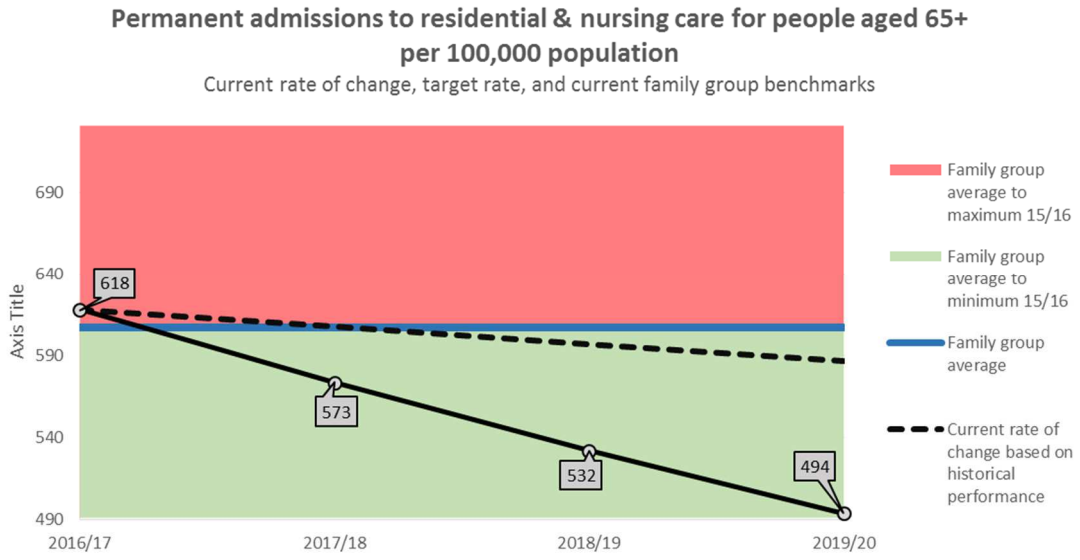
3. Governance- the Programme Governance in place is designed to ensure that a number of key stakeholders meeting to ensure programme delivery and monitor finance and performance. This will utilise an existing group which comprises CCG Chief Officers, CCG Chief Finance Officers and NCC representation.

7. National Metrics

7.1. Permanent Admissions to residential and care homes

Indicator: Permanent admissions to residential & nursing care for people aged 65+ per 100,000 population

Proposed target: The below graph sets out the current (16/17) rate, and proposed draft targets.



Rationale:

Norfolk County Council are currently using a Cost & Demand Model (CDM) to understand the impact of changes in service volumes to costs throughout the adult social care system.

The provisional targets proposed here are taken from a basic 'affordable' scenario for Adult Social Care that reflects a reduction in the number of contacts going on to assessment by 12%, an increase in the number of people receiving reablement services of 10%, and a subsequent reduction in the percentage of people that receive an assessment going on to receive a formal service.

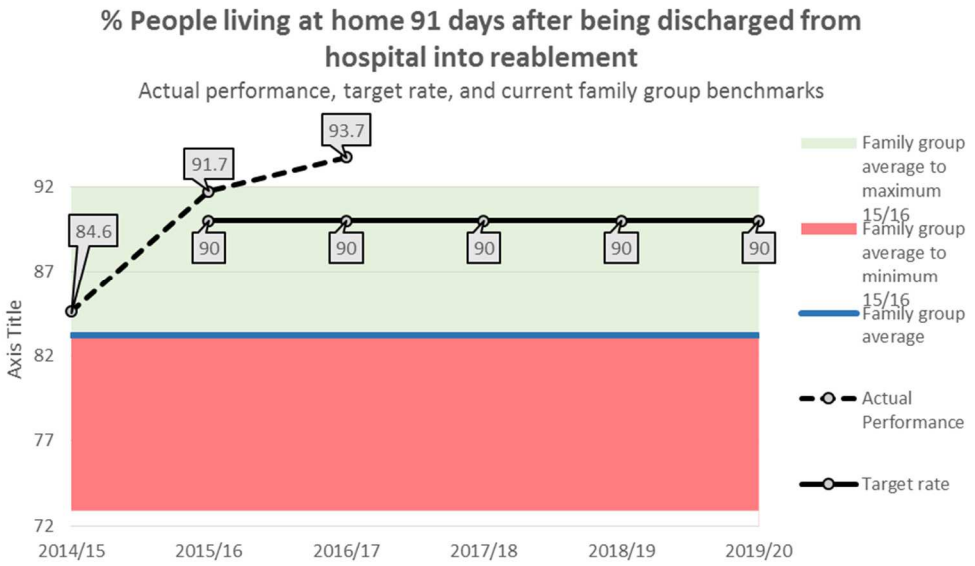
This basic scenario has not been tested, and so the target may change once this testing has taken place.

The reduction – from 618 admissions per 100,000 population to 494 – represents a 20% reduction in the rate in 3 years, although (because the population will change in that time) it only represents a 16% reduction in placements. The target would see Norfolk move to very near to the minimum rate for its family group of statistical neighbours.

7.2 Effectiveness of Reablement

Indicator: % People living at home 91 days after being discharged from hospital into reablement

Proposed target: The below graph sets out the historical and current (16/17) rate, and proposed draft targets.



Rationale: Norfolk's performance in this indicator is currently very good – the highest in the council's family group.

Norfolk's strategy involves increasing the number of people receiving reablement. Local analysis of national data has shown that councils that 'reable' more people tend to see a reduction in performance as council's provide reablement services people with more complex conditions, for whom interventions may be less successful.

Given this, it is proposed that the target remains at 90%, ensuring a strong focus on continued quality whilst providing scope for the council to broaden the extent of its reablement services.

7.3 NEAs

[To be confirmed]

7.4 DTOC

[To be confirmed]

7.5 Local Metric: Dementia Diagnosis

Norfolk has agreed to continue with a local metric of the rate of dementia diagnosis. Our rationale for including this metric is that it is a key measure within the STP.

During 2016/17, Norfolk did not meet its target of 66.7%. However, there are a number of local initiatives in place to improve the rate of dementia diagnosis.

We have agreed that the 2017-19 target for this metric will be 68%.

The evidence base for setting this target is the CCG information submitted within NHS Constitution planning returns, which provides a monthly overview of data.

Contextually, the target within the STP is 70%, to be achieved by 2021, therefore we have agreed that as 68% is the average across the 5 Norfolk CCGs currently, this forms a strong basis for ultimately reaching the STP target.

8. Norfolk's Plan to reduce DTOC for 2017-19:

There are a number of planned actions in place to address and reduce DTOC. These are predominantly focussed on NNUH, and are to include:

- Care arranging services to be available to source care at weekends from January 2017
- Continue the review of social care support to the community units and health purchased care beds. The ideal solution may well require additional support. Ensuring flow to these beds supports the whole system overall.
- Oversight of providers to ensure block arrangements are used to full capacity. Ensure response timescales are met
- Performance colleagues to work in partnership regarding the verification and recording of DTOCs to ensure 100% accuracy and consistency when reporting regionally and nationally.
- Ensure provision of equipment process is a "tight" as possible and all in place for providers.

Planned commissioning activity includes:

- Gain understanding whether the home care market is saturated
- Able to operate at current rates
- Are fully aware of levels of need
- Support positive image of care provision as an attractive role

- Increase support to “informal or unpaid carers”

Actions to reduce DTOCs at the Queen Elizabeth Hospital during 2017/19 include:

- Increased early supported discharge through Rapid Assessment Team comprising health and social care practitioners working in the Emergency Areas of the Hospital. Expansion of discharge to Assess pathways to enable patients to return to the community as soon as they are medically fit (building on the success of an existing scheme which has reduced delays associated with Continuing Healthcare assessments to zero for Norfolk patients). There will be a particular focus on patients whose therapeutic and reablement needs can be met in the community
- Co-location of Discharge Nursing and Social Services professionals to facilitate improved joint working
- Investment in Social Care resource to enable placements at weekends (with block home care and residential care contracts that support this). Further work is required to ensure that the whole system adjusts to utilise this capability.
- Significant increased Investment in intermediate Hospital Care at Home and Care Home provision enabling patients to be discharged to recover in the community
- Priority access to Housing Adaptations services (such as installation of ramps and stair lifts) to enable patients to return home more quickly

Actions to reduce DTOCs at the James Paget Hospital during 2017/19 include:

- Joint pre-admission discharge planning process
- A&E delivery board to review plans linking with NNUH and QEH
- Expand social prescribing wider than General Practice
- Expand home to assess/home first/discharge to assess pathways.

Norfolk’s Plan to reduce DTOC will be supported by and underpinned by the High Impact Change Model Plan.

9. Approval and sign off

Signed on behalf of NHS Great Yarmouth and Waveney Clinical Commissioning Group	
By	Melanie Craig
Position	Chief Officer
Date	
Signature	
Signed on behalf of NHS North Norfolk Clinical Commissioning Group	
By	Antek Lejk
Position	Chief Officer
Date	
Signature	
Signed on behalf of NHS Norwich Clinical Commissioning Group	
By	Jo Smithson
Position	Chief Officer
Date	
Signature	
Signed on behalf of NHS South Norfolk Clinical Commissioning Group	
By	Antek Lejk
Position	Chief Officer
Date	
Signature	
Signed on behalf of NHS West Norfolk Clinical Commissioning Group	
By	John Webster
Position	Chief Officer
Date	
Signature	
Signed on behalf of Norfolk County Council	
By	James Bullion
Position	Executive Director of Adult Social Services
Date	
Signature	
Signed on behalf of Norfolk Health and Wellbeing Board	
By	
Position	
Date	
Signature	

Integration in Norfolk

As partners in health and care, we are committed to working on behalf of Norfolk citizens to deliver integration which meets the definition developed by National Voices:

"I can plan my care with people who work together to understand me and my carers allowing me control and bringing together services to achieve the outcomes important to me."

And which reflects the approach set out by LGA, NHS Confederation, ADASS and NHS Commissioners in Stepping up to the place:

"Services that are organised and delivered to get the best possible health and wellbeing outcomes for citizens of all ages and communities…"

This table sets out our ambitions and 2020 destination. The delivery plans will be set out in our STP, BCF and commissioning plans.

Ambition	→	→	→	**The 2020 destination**	**Impact**
We will provide seamless services to ensure that individuals can access the care they need without organisational boundaries getting in the way	MDTs working with primary care supporting those most at risk	Single point of access Single assessment Care co-ordination	New models of care are operational	**Fully integrated health and care teams in each locality**	Better support to people with LTCs and reduced admissions
We will work in partnership with citizens, carers, voluntary sector and communities to support people to maintain their health and wellbeing in their homes and communities	Joint early help offer with District Councils and voluntary sector in all areas	Social prescribing rolled out across the footprint	Voluntary and community sector are part of our new models of care	**Strong support and prevention in every community**	Improved personal resilience and delayed call on formal services
We will work together with our health and care providers to ensure networks of high quality services which are able to prevent and respond to crisis, including going home from hospital	Home to assess and integrated discharge pathways Roll out Extended Health in Care Homes	Integrated intermediate care, rehabilitation and reablement	Rapid response and 24/7 out of hospital teams	**Effective 24/7 support in a crisis**	Reduced unplanned admissions to hospital and care
We will work with partners in housing to secure accommodation solutions to support health and wellbeing	Accommodation and support strategy including use of DFGs	Housing expertise part of an integrated discharge pathway	Planning and delivery of housing for groups with particular needs	**Improved access to housing which supports wellbeing**	Reduced reliance on care and health services
We will develop shared commissioning intentions across health and social care and will deliver these together where this enables us to better meet citizen outcomes	Published two year commissioning intentions December 2017	Design and implementation of integrated commissioning function	New payment methods	**One efficient commissioning function**	Improved ability to deliver impact across the footprint
We will align, share and pool our resources and budgets where this enables us to better meet citizen outcomes	Better Care Fund pooled budget (BCF) of £65m	Align budgets across health and care for visibility and monitoring	Pool resources for key elements of integrated service	**A clear health and care budget for each area**	Improved ability to deliver seamless services and reduced transaction burden
We will plan our workforce together in order to ensure we have the skills and capacity needed in Norfolk	Shared workforce needs analysis Shared sector skills plan	New roles in place New training in place	New models of skill mix to address sufficiency	**A sufficient, capable and flexible workforce**	High performing services delivering excellent outcomes
We will ensure that our ICT systems facilitate outcomes for citizens	NHS number as shared identifier and shared core citizen data	Shared population level data to support commissioning and service redesign	Implement Liquid Logic to release 'integration' capabilities Patient owned shared record	**One set of data on citizens and population**	Improved prevention, treatment and planning
We will review our governance and ensure that it helps us to achieve our outcomes across our system	Map of local governance	Review to identify opportunities to better enable timely decisions	Implement	**Governance which supports our outcomes**	Greater agility and impact in system change

Scheme ref no.

North Norfolk 1

Scheme name:

Development of Community Care Teams around GP clusters

What is the strategic objective of this scheme?

To implement the formation of community care teams around the North Norfolk 4 GP clusters so that cohorts of 'at risk' people are collectively reviewed and managed via MDT meetings and there is easy access via Integrated Care Co-ordinators (ICCs) to support services in the community

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The community care teams will work closely their primary care colleagues to:

- Use risk profiling tools to identify the following categories 'at risk' people :
  - End of life
  - Complex case management
  - Prevention
  - This will include strong links to the Multi-Disciplinary Discharge hub at the NNUH to support people discharged from hospital
  - Work towards the delivery of 7 day working
  - Facilitate shared access to health and social care records (via ICCs) so that there is a joint assessment to care planning at the regularly occurring MDT meetings

Reduce the number of avoidable emergency hospital admissions

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioner or Provider	Role
Commissioning Manager – Integrated Team	Project management, engagement and communications. Chair the operations groups and provide feedback at board level.
Primary Care Clinical Commissioner	To support alignment of primary care staff to community care teams and implementation of ECLIPSE data analysis tool
NCH&C ops teams	To implement frailty tool across all community nursing team and alignment of the community nursing team resources to GP clusters
NCC ops teams	Alignment of social care resources to community care teams
NSFT ops teams	Alignment of MH resources to community care teams
Integrated Care Board	To sign off recommendations, inform and support the delivery of the programme

QIPP Programme & BCF Boards	To review and monitor impact

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The development of the Integrated Care Co-ordinators posts have been highly praised as GPs, nurses and social care teams value their help and ability to access health and social care records and make non clinical referrals into the community. The expansion of the team from 4 to 8 FTEs (Full-Time Equivalents) means that a comprehensive service is available 5 days per week delivered by a well-managed, well trained and experienced team. The ICC team statistics up to quarter 3 and show there was a 28% increase in ICC activity for 16/17 Q1-Q3 when compared to Q1-Q3 from 2015/16. Other statistics include :

- There is an even spread of referrals across 4 areas
- 3453 patients were supported with 2630 onward referrals
- The ICCs offered 51 different onward referral options
- 43% of onward referrals were to voluntary, district or independent providers

In addition to this:

- The work has been identified as 'best practice' across the eastern region and a presentation was given to the Eastern Region Better Care Fund meeting in February 2016.
- North Norfolk CCG were invited by the Eastern Academic Health Science Network (EAHSN) to deliver a webinar and entitled 'The Integrated Care approach to support older people with Frailty in North Norfolk' in October 2016.
- As a result of the collaborative programme good working relationships have been developed with the operational managers from NCC (Jo Britton), NCH&C (Stuart Morton) such that social workers, assistant practitioners and therapists are all aligned to the 4 GP clusters.
- A new ICC data sharing agreement has been written which clarifies the role of the ICCs as data processors. Once the document has been finalised and signed off by each GP practice the ICCs will formally be part of the GP practice team
- There has been a successful integration of housing supported services in The Market surgery where a Home Improvement Agency Officer joined the MDT meetings and in tandem with the ICCs enabled 15 patients to access housing services
- The implementation of the ECLIPSE data analysis tool is also under way with all GP practices now having the software installed in their practices

Investment requirements

Please enter the amount of funding required for this scheme

£208,674

Impact of scheme upon BCF Metrics

The main outcome for the ICC and GP cluster scheme is that more people are supported at home and this outcome is measured by a reduction in emergency admissions to hospital. The December BCF Dashboard shows that North Norfolk target for reducing non-elective emergency admissions is on track and currently rated as GREEN.

Emergency admissions for long term conditions have reduced by 0.5% when compared to M7 from the previous year. This continued trend of reduced LTC admissions set against a background of increasing demand is significant given the large reductions made last year.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The ICC activity in closely monitored and regular bulletins given via the GP practices and Council of Members meetings such that the role is visible. A library of case studies is being collected and 'a day in the life of an ICC' published in local newsletters and on our website.

An annual audit of the work the ICCs was conducted In January 2017 which summaries the role the ICCs are playing checking that key structures such as time spent in GP practices, MDT meetings, risk profiling and access to patient databases is in place. A key finding of this audit is that for most of the time the ICCs spend as much time supporting carers as they do patients.

An evaluation of the impact of the additional housing support given to 15 patients at The market surgery in underway. The hypothesis under review is that '*The timely delivery of housing support services in conjunction with health and social care services can prevent or delay emergency hospital admissions'.* Interim findings of this review will be taken to the Council of Members meeting in March 2017.

What are the key success factors for implementation of this scheme?

The key success factors for implementing this scheme is as follows :

- Practitioners on the ground are beginning to understand why they need to work together and via lunch times sessions are being involved in identifying opportunities to work together more effectively
- The open access of the ICCs 5 days a week and use of backup phone for anyone to use them really works and there is a clear understanding of their role.
- The GP practices see the value that the ICCs can bring and give them access to patient database systems and surgery space
- Slow and incremental building of this scheme over a number of years with good management and lots of support and stable teams
- GP practices who are committed to working with other agencies as shown by the inclusion of Housing Improvement Agency Officer is also vital to success

The table below summarises the detailed project objectives, outcomes and progress to date.

Objective Number	Objective Description	Outcome Benefit	Progress to date
Objective 1	To align ICC and social care staff around the 4 GP clusters operating at a 40,000 patient grouping level	Future service delivery centred around smaller clusters of GP practices and to improve continuity of care for patients	Social care has aligned their staff and 2 out 4 GP cluster events have been run with health and social care staff over lunch time

Objective 2	To align health and social care staff to create an integrated front door service at Rebecca House	Holistic service delivery of care at point of access	Plan created to bring together relevant NCC and NCH&C together in one room. This was delayed but now progress has resumed
Objective 3	To design and implement a clinical professional practice audit of ICC referrals	The ICC professional practice audit will inform the quality and destination of ICC activity	Have run an audit of ICC role. Professional practice audit under developments
Objective 4	Forensic analysis of Eclipse data analysis tool to focus on management of key chronic conditions	Eclipse will improve ability to find and manage patients with targeted chronic conditions to provide better preventative support at home	ECLIPSE has been installed across all 19 GP practices. Targeting 2 practices (EMIS and SystmOne) to use ECLIPSE to identify specific cohorts of people
Objective 5	To establish a standard MDT format (minimum of 6 per year) across all GP practices. This will include mental health and LD professionals and GSF reviews for people on End of Life pathway	A joint approach to assessment and care planning will ensure that all 'at risk patients' are regularly reviewed and proactively directed to appropriate care for their individual needs	Linking into frailty CEQUINs from NNUH and NCH&C with a view to creating frailty lists for ICCs to manage in a proactive way in GP practices
Objective 7	ICCs to develop pathway with NNUH integrated discharge hub	Improved outcomes for patients discharged from NNUH	New ICC data information sharing agreement written which will be finalised by 30 March 2017
Objective 8	ICCs to support join up of care needs with services available early help hubs (district councils) and community clinics (Promoting Independence)	Improved access for 'at risk' patients to services available from local district councils and services in the community	Completed pilot with Broadland District Council and have successfully linked in housing support at The market surgery. Evaluation of impact
Objective 9	To establish options for working towards 7 day service delivery model across the community care teams and supporting services	Availability of 7 day services in the local community that keep people living in their desired home location	Contract has included funding for extended evening and week-end work if required

Objective 10	To deliver meaningful staff stakeholder, patient/ service user consultation and engagement and communications throughout the lifecycle of the project	Communication and engagement will be a key driver in a shared vision across all stakeholders for the project	Regular updates to CoM on progress , integrated care updates to northern provider forum, care homes network meeting and Older people's forums

Scheme ref no.

North Norfolk 2

Scheme name:

Targeted Support to Promote Independence

What is the strategic objective of this scheme?

This project will seek to support and promote the continued independence of people identified through the multi-disciplinary team (MDT) processes in place across the 4 North Norfolk GP Clusters further underpinning the work of the Integrated Care Programme to reduce avoidable hospital admission. The project will ensure interventions are made available and targeted towards a clearly identified cohort of patients living with long term conditions through:

a)The delivery of condition specific support, information and peer support available locally

B) Improved referral process and joint working within the voluntary sector to better align and make best use of services available.

c) The improved delivery of targeted housing support to older people regardless of tenure including the utilisation of Disabled Facilities Grants.

D) Improve integration and availability of homecare within the locality.

E)Improved communications across the health, housing and social care sectors to support organisations delivering care to proactively engage in the delivery of integrated care and promoting independence.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Objective	Impact
People identified through the MDT process are offered a tailored menu of options to	People are able to manage their conditions without input from health or social care practitioners resulting in a better experience

allow them to manage aspects of their conditions and lifestyles.	of the health system and reduced avoidable admissions to acute or residential settings
The menu of options is in place and readily available to people, practitioners and carers and includes : 1. Condition specific information tailored to the person 2. Peer support and self-help groups in the local community 3. Information about services and alternative therapies 4. Access to targeted wellbeing programmes including supported activity.	People, professionals and carers know what services are available, how to access and pay for them and what they can hope to achieve by using them. Peer support exists in localities where needed. Partnership working with PH and District's supports statutory bodies to meet their objectives without duplication and reduces the likelihood of gaps emerging in the locality.
The causes of unplanned avoidable admissions are reviewed on a monthly basis by cluster to target interventions swiftly.	Targeted interventions can be rolled out quickly and in the right areas to have the biggest impact on reducing avoidable admissions.
Practitioners adopt social prescribing as a mechanism for supporting people to improve their wellbeing.	People are able to volunteer, access community activities and engage with other groups resulting in improved wellbeing.
Voluntary sector and housing services are remodelled to deliver care and support aligned to promoting independence, and understands integrated working.	Every funded voluntary sector service can demonstrate how they are supporting people to achieve outcomes in line with promoting independence.
The offer of Disabled Facilities Grants (DFG) is clear and accessible so adaptations can be delivered in a timely way.	People are supported to stay in their own homes, which are made safe and accessible for longer.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioner or Provider	**Role**
Commissioning Manager – Integrated Team	Project management, engagement and communications. Chair the self-care group and provide feedback at board level.
Voluntary sector providers including housing and homecare	To work with commissioners to realign their services with the GP Clusters
Integrated Care Board	To sign off recommendations, inform and support the delivery of the programme
NCHC & NCC Operational teams	Active participation in MDT process and utilise the self-care menu of options when working with people
QIPP Programme & BCF Boards	To review and monitor impact

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Description Of Benefit	Metric Measurement
Condition specific reduction in avoidable admissions to hospital	Sub-set analysis of avoidable admissions (beginning with UTI as a primary and secondary diagnosis)
Reduction in DTOC	Excess bed days data Number of home from hospital activities reported by BRC and RVS
Increase in volunteer befrienders working with people living in their own homes	Performance data from Voluntary Norfolk (quarterly)
Increase in referrals to wider voluntary sector organisations (as per QIPP 16)	ICC data referral activity recorded at GP cluster level (see QIPP 016)
Increase in the delivery of homecare through the North Norfolk Blocks	Homecare Dashboard (NCC)
Increase in the number of positive outcomes delivered by British Red Cross OPOS	Performance reports from BRC (quarterly from NCC)

Investment requirements

Please enter the amount of funding required for this scheme

£500 for UTI leaflets.

Impact of scheme upon BCF Metrics

The Integrated Care Programme has made significant progress in the reduction of avoidable admissions to acute settings through the delivery of several work streams throughout 2015/16 and a comparison of avoidable admissions from 2014-15 and 2015-16 demonstrate the programme's effectiveness.

BCF Metric	2014/15	2015/16	% Change
Reduction in ALL non-elective admissions (MARS)	17,786	18,124	1.90%
Reduction in ALL non-elective admissions (SUS)	16,125	1,6274	0.92%
Reduction in avoidable emergency admissions to hospital	3,761	3,643	-3.14%
Reduction in LTC admissions to hospital	1,413	1,360	-3.75%
Falls emergency admissions	1,298	1,188	-8.47%
Admission to residential and nursing homes	326	299	-8.28%

Delayed Transfers of Care (delayed days Norfolk)	28,388	27,884	-1.78%
Increased effectiveness of reablement	90	96.1	-6.78%

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Feedback from patients / professionals friends and family
- Quarterly monitoring of number of MDT meetings, number of patients on registers, ICC referrals,
- Quarterly monitoring of emergency admission and falls data
- Review meetings with Council of Members and local Practice Manager forum

What are the key success factors for implementation of this scheme?

Key Milestone	Milestone Achievement Date
Process developed and embedded that builds on the practice dashboards to identify top reasons for avoidable admission by GP cluster	Complete
A self-care pathway is in place that aligns cohorts of patients with the self-care continuum. The self-care menu of options is in place to support each stage of the pathway. Referral routes in to services are established	Pathway drafted by Self-care Advisory Panel by July 2016 Signed off by ICP Board August 2016
A proforma is produced by the SAG (Self-care Advisory Group) that allows clinicians to develop patient specific information about their condition easily. Peer Support best practice is researched and a programme for implementation developed.	SAG convened to develop proforma August 2016 Clinical sign-off of proforma via ICB Sept 2016 Roll-out across GP Practices July 2016
Referral processes for all voluntary sector contracts reviewed and realigned to prioritise getting people home from hospital.	Initial review process developed June 2016 Review conducted with OPOS, Central Support and VHT Sept
DFG Plans in place with each District Council to improve and speed up the application, assessment and delivery of major adaptations NOTE – elements of the DFG programme link with QIPP016 GP Clusters	Plans agreed End May 2016 Implementation from June 2016
Home support services linked and aligned to GP Clusters to enable direct referral for self-funders and improved access to locally available services for social care teams	

Home support block re-commissioned for remaining areas of North Norfolk to deliver an outcome focused service.	Block design aligned to GP Clusters April 2016 (Complete) Market engagement TBC Procurement undertaken TBC New service TBC
Housing support for older people is reviewed and remodelled to deliver a time limited strengths based service increasing capacity and aligning with integrated care.	Initial proposals to NCC SMT July 2016 Development work Summer 2016

Norwich CCG
Better care fund annual report -2016/17

For Norwich CCG it links closely with the CCG's vision for greater health and social care integration and has given us the platform to accelerate progress in delivering our vision locally. We believe that our work so far, along with our plans for the future, place us in good stead to bring about further integration of services in the interests of local people

During 2016/17, we have worked with our partners in Norfolk to develop BCF plans, which have been approved at a national level.

The 2016/17 Norwich schemes will continue to be delivered in 2017-19 and will form part of a Norfolk countywide programme of integration. The 5 overarching themes are:

1. **Locality Integrated Care Programme Infrastructure**

- **New model of care for Norwich** –
- Norwich CCG continues to develop its programme of integration of care services across Norwich, building on the Healthy Norwich and Your Norwich work programmes.
- One Norwich has been established (an alliance of all but one Norwich GP Practice) providing one voice for GP Practices.
- A New Norwich Model Programme Board (NNMPB) (replacing the Your Norwich Programme Board) has been established with membership from CCG, Providers, Voluntary Sector and Healthwatch. The NNMPB will provide senior cross system support and assurance on the delivery of the design and development of the new model of integrated care for Norwich, and that the programme is aligned to the STP challenge and strategic objectives.
- A number of work streams have been established – reporting to the NNMPB – namely Prevention & Wellbeing, Primary Community & social Care, GP Practice at Scale and Mental Health. There are also 'enabling' work streams on ICT/Digital, Estates, Workforce, Governance, Finance Contracting & Performance and Communications & Engagement.
- The primary aims that the new model of care will deliver on are:
    - Preventing illness and promoting wellbeing by targeting lifestyle risk factors (eg alcohol, obesity) to secondary prevention preventing unnecessary escalation to higher acuity care settings.
    - Bringing together health and social care professionals, alongside local support organisations to improve the lives of the people in greater Norwich.
    - Offering care that wraps around the person – to respond to the holistic needs of the patient and carer whether wellbeing, health, social and/or emotional.
    - Flexible model so able to respond to both planned and unplanned needs.
    - People are supported to live with maximum independence, with improved access to primary and community care, supported by the third sector. Keeping people out of hospital and as close to home as possible when safe to do so.
    - To reduce demand at the acute hospital front door and assist discharge to maintain capacity within the acute system.

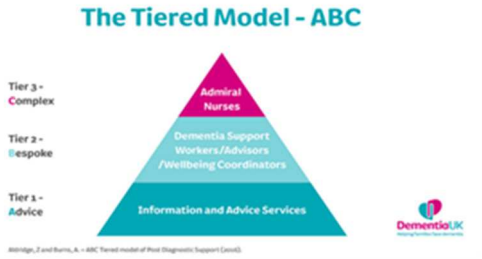
To enable the CCG to deliver this change there is a 4 year plan - at a high level:-
2016/17 – to build collaborative leadership
2017/18 – to develop and design the New Model of Care

2018/19 - to phase implementation of Provider Model and 2019 The New Model becomes operational.

- **Dementia Diagnosis and Post Diagnostic Support** – The ongoing work to increase the dementia diagnosis rate

  The dementia diagnosis rate for Norwich CCG for January 2017 is 62.7% which is on our planned trajectory to reach the national ambition of 67% by October 2017

- NCCG have been delivering the actions detailed in the Dementia Improvement Plan which was submitted to NHSE on the 30/11/2016 which includes:
  - To undertake Dementia harmonisation exercise.
  - To increase Dementia screening and diagnosis in Care Homes.
  - The CCG has been supporting GP Practices to review care home patient records and complete a desktop review to consider harmonization and screening. As part of the Bowthorpe Exemplar project, the lead clinician has developed support and guidance to GPs relating to screening, diagnosis and medication management and this is being included in the CCG's Care Home Locally Commissioned Service.
  - Continue to work with Norfolk & Suffolk Foundation Trust (NSFT) to improve diagnosis conversion rates, coding, data quality, discharge letters from the memory service
  - Encourage all GP Practices to sign up to CQRS to enable Dementia data collection
  - Evaluate the outcomes for the enhanced service delivered as part of the Bowthorpe Exemplar to support increased screening and diagnosis by GPs in Residential Care and Nursing Homes settings. To pilot the approach with a small number of GP Practices with a few to including more robust expectations in the Care Home LCS from April 2017 onwards.
- Admiral Nurse Service – Following the decision to fund the service the CCG is working with South & Norfolk CCGs and Dementia UK to mobilise the service. In Norwich we will be delivering "The Tiered Model – ABC" and will be committing new resource to Tier 3, additional resource to tier 2 and working with existing Information and Advice providers in Tier 1.



- Norwich CCG has made the following pledges to the NORWICH City Dementia Action Alliance led by Age UK:
  - To increase dementia diagnosis in Norwich and increase dementia screening and diagnosis in care homes
  - To develop an information flyer for professionals in primary care, advising what dementia services are available in Norwich. This action is already underway.
  - To ensure 90% of our staff become dementia friends
- The CCG is also supporting the Broadland Dementia Action Alliance which is in the early stages of development

- **Support for Carers** - The Carers Support Service is provided by Norfolk Carers – a partnership with Norfolk Carers Support (NCS) as lead partner, provides information, advice and support to carers across Norfolk.

  The main element of the contract is provision of the advice line to carers, but they also provide 1-to-1 support to carers (including home visits), brokerage of one-off breaks for carers, small grants for carer's groups and produce the Norfolk Carers Handbook.

  The Carers Council (Norwich) which represents carers in Norwich continues to meet approximately every 6 weeks. The Carers Council for Norfolk now has a membership of 500+ across the county, with approximately 100 members in Norwich.

  The Norfolk Carers Handbook continues to be distributed in Norwich (including GP surgeries).

- **Personal Health Budgets (PHB's) -** NHS England have asked that we identify suitable step increments year on year to ensure that Norwich CCG hits it 2020 target of 430 PHB's below is what has been agreed and submitted:

Total CCG ambition				
	Fin. Yr	% Increase	New PHB	Target
Long-term	2020/21	49.31%	142	430
	2019/20	100.00%	144	288
Medium-term	2018/19	100.00%	72	144
	2017/18	176.92%	46	72
Short-term	2016/17	0.00%	5	26
	Baseline		0	26

  The figures are achievable based on current figures submitted in the 2 year operational plan and Norwich CCG is working with South & North CCG's to share the workload and achieve our individual CCG PHB targets.

  The target figures is the number of PHB's Norwich CCG would like to have in place by the end of that financial year and the new PHB number is the amount of new PHB's that need to be implemented in that year.

2. Care Homes

- **Enhanced care in care homes** - In Norwich we have multiple care homes with an increasing trend towards specialist dementia and palliative care units, and a new model of care to deliver enhanced care in care homes is a priority for the CCG. The focus on this model has been accelerated by the opening of Bowthorpe Care Village in April 2016. This scheme is the first Housing with Care project to be delivered under the Building a Better Future strategy.

  NCCG officers are working in partnership with the GP Alliance 'One Norwich' to create a joint action plan where a new model of care will be developed and implemented in accordance with the NHSE framework 'enhanced health in care homes'.

- **Falls Prevention** - A multi-agency falls reference group has been established to review the way falls are managed, monitored and prevented in Norwich.

  Falls prevention is already a consideration in all other CCG projects to ensure opportunities for improvement are identified and acted upon.

  The falls pathway has been redeveloped and rolled out alongside identified best practice at the new Bowthorpe Care Village and that learning will be rolled out across all the other Norwich care homes in 2017/18

3. Housing Adaptations

- **Community Equipment stores** - The project is still providing good rates of return and care homes in Norwich continue to be the current focus.

  Plans to expand the recalls service to cover the whole of Norfolk are ongoing with progress expected in 2017/18. This expansion not impact on the results for Norwich but will reduce costs once implemented.

- **Disabled Facilities Grant (DFG)** - We have worked in recognition of the greater integration across housing and involvement of the BCF partnership Board to consider services the Borough and District councils offer, to develop a joined up health, housing and adaptation system for patients to remain at home

4. Out of Hospital

- **Home ward** – In 2016/17, HomeWard will be extended to deliver an enhanced service specification which has been developed based on the findings of the intermediate care review. This includes:

  - A community gateway for all unplanned health and social care interventions (including multi-provider triage).
  - Clinical co-ordination, tracking and pathway management of all NCCG patients within the intermediate care system.
  - Rapid clinical assessment of patients in the community through the realignment of existing Community Nursing & Therapy resources with HomeWard.
  - Therapy and social care in-reach and pathway planning of NCCG patients in procured and spot-purchased bed provision.
  - Additional Community IV pathways (subject to risk assessment).
  - Enhanced palliative/end of life care pathways.
  - Integrated community mental health services.

  The positive impact of HomeWard (HW) has been clearly evidenced. "Step up" activity remains the core focus of the service (71% of admissions in November 16) with "step down" cases supporting system flow through the acute hospital and community inpatient settings.

  Throughout 2016/17, HomeWard has demonstrated a positive impact on supporting admission avoidance and early supported discharge. This has resulted in Norwich CCG being

significantly under plan for both emergency short and long stay admissions to the acute hospital with a marked reduction in excess bed days compared with 15/16 data. Ambulances dispatches and conveyances are also lower than the previous year.

Headline year to date activity for HomeWard as at February 2017 is as follows –

- 704 admissions to HomeWard
- 700 discharges from HomeWard
- 14,477 visits undertaken
- 47 Care Home MDTs attended (since Nov 16)
- 297 acute admissions avoided
- 122 A&E attendances prevented
- 49 specialist placement bed days avoided
- 58 patients received Community IV Therapy
- 10 fewer community inpatient admissions (compared with 15/16 data)
- 61 fewer community inpatient bed days (compared with 15/16 data)
- 72% "step up" (admission avoidance) admissions and 28% "step down" (supported discharge) cases

At the end of February 2017, Norwich CCG were 1044 cases under plan for short stay unplanned admissions to NNUH and 336 cases under plan for long stay unplanned admissions representing significant financial savings.

HomeWard is an 'invest to save' initiative and savings for the year are now forecast to exceed target by a considerable margin. The service has recently been shortlisted for an HSJ Value in Healthcare Award in the "health service redesign" category and in February 2017, an open letter from a grateful carer in praise of local service provision (including HomeWard) was published in the local press

- **Supported Self Care (education, tools and resources)** – Norwich are developing a partnership approach to patients, families, and communities in Norwich, 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.

  Improved 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

- **Age UK Promoting Independence** - Age UK Norwich has linked up with the Royal Voluntary Service (RVS) to collaborate on this service. RVS will be able to source further appropriate community support following the intensive support (approximately 12 weeks) provided by Age UK Norwich.

  This service aligns with the STP and the Norwich New Model of Care and SMT have requested a plan for growing the service beyond the initial 3 year commissioned period.

- **NEAT (Norwich Escalation Avoidance Team)** - The NEAT project incorporates the additional functionality of HomeWard Phase 2 and focuses on co-locating staff to deliver an integrated, multi-agency, local response that will:

    1. Manage people safely in the community through a period of crisis with an appropriate, coordinated response using the lowest level of intervention.
    2. Facilitate fast-track early supported discharge from an in-patient setting.

    The NEAT model adopts an 'every contact counts' approach which addresses the urgent and unplanned need and incorporates a navigator function to identify the additional support required to promote independence and keep people safe and well at home for as long as possible.

    It is a mechanism for multi-agency referral management, resulting in the coordination and deployment of existing services as effectively as possible to optimise capacity in the system without generating increased activity. Later phases of the project may include Telehealth and telemonitoring.
    Key stakeholders are currently working together to pilot the NEAT model from May 2017.

5. Crisis Response

- **Protecting Social Care** – Continuing support by Social Workers and Occupational Therapists for people with social care needs in community and acute settings. This includes:

    - Protecting access to social care services and care packages which enable people to manage long term health conditions and disabilities.
    - Social work assessment and care planning with integrated health and social care arrangements in community settings.
    - Provision of equipment and specialist sensory support services.
    - Maintaining services to improve mental health outcomes, including helping people with dementia to live at home for longer.
    - Provision of effective early interventions and support to prevent increase in need; reduce the likelihood of hospital admission; reduce health crises; and defer moves to higher care settings. Prevention services include the 24/7 Emergency Duty Team, Swifts unplanned care service, and Night Owls (out of hours unplanned care and rapid response).
    - Contributing to timely hospital discharge and recovery from ill health and injury. Reablement provided through Norfolk First Support.
    - Ensuring support and care provided safely, and that the market for social care provision responds to changing needs.

- **Mental Health rehabilitation & recovery** – 2016/17 saw the provision of a new, integrated rehabilitation and recovery service offering long-term support to people with complex mental health problems (psychotic illnesses and personality disorders) enabling them to stay well in the community and self-manage their illness.
    Existing residential beds and supported living placements will be redesigned and a new community reablement model implemented. Support will address a broad range of need: housing, debt, education and training, life skills, co-morbid mental health issues and self-confidence.

Scheme ref no.
South Norfolk 1
Scheme name:
Community Services Redesign – Supported Care Programme
What is the strategic objective of this scheme?
This scheme demonstrates that South Norfolk and North Norfolk Clinical Commissioning Groups are committed to the Norfolk and Waveney Sustainability and Transformation plan. As part of this focus the aims to keep people at home and help them to maintain their independence as long as possible which also link into the County Councils promoting Independence strategy. This scheme focusses on the evidence and benefits that keeping patients at home or out of the hospital is more cost effective. The aim of the project is to develop and implement an agreed system model for local integrated multidisciplinary community provision closer to home to reduce emergency attendances and admissions and reduce the need for as many intermediate care beds for post-acute rehabilitation. The model will be based upon the current Integrated Care Teams, linked to GP practices and will enhance existing relationships with our primary care providers, hospital discharge teams, in-patient units and specifically the ambulance service. The key components of the integrated model will be: • Community Engagement and Development • Reablement Care • Rapid Response Clinical Assessment and Review • Equipment and Products
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Primary Patient Cohort • Frail older people • People with disabilities and • People with long term conditions. The proposal is for a systems redesign project to make more efficient and effective use of community resources to reduce admissions and increase patient independence. The approach would seek to meet the expectations of the NHS Five Year Forward View, Sustainability and Transformation Plan by taking decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care. The approach would include: review of beds commissioned in the SNCCG locality to establish a system of beds use through which rehabilitation, acute prevention and re-ablement are optimised and patient flow through bed based and other care pathways is managed. One aim would be to free investment through reducing acute care and some level of community bed based care to develop locality based multi-disciplinary discharge and care at home teams which would support people to go home and to remain at home where it was safe to do so.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

- Preventative services:
- Promoting advice, practical help and community support;
- Support to reduce pressures on statutory health and social care provision
- NCC front door services (offering appointments in community clinic settings);
- NCC and CCG funded third sector advice and support providers;
- District Council community signposting and community navigators;
- District Council DFGs, small grants and handypersons;
- Early help hubs;
- Housing support;
- Volunteering for health;
- Carers support;
- Community groups and assets;
- Community help in a crisis:
- Rapid response;
- Acute medical care at home

NCH&C community nursing and therapies

- Primary care;
- NCC social work assessment and care
- planning;
- NCC Swifts and Night Owls;
- Independent nursing and care homes;
- Community mental health teams;
- Dementia Intensive Support;
- Acute providers
- Recovery and living with long term conditions:
- supported discharge when there is no longer a medical need to be in hospital;
- medical care;
- support with complex needs;
- support to self-care;
- befriending;
- practical help at home;

NCH&C nursing and rehabilitation;

- Integrated and coordinated care through GP;
- NCC commissioned home care;
- NCHC intermediate care;
- NCC reablement (Norfolk First Response);
- NCC contracted beds with Norse care;
- Independent Community Equipment;
- NSFT Mental Health services including
- primary care facing dementia support;
- District Council DFGs;

- Norfolk Learning Difficulties Service
- Medicines Management

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

To assist with planning Public Health produced a revised Joint Strategic Needs Assessment - "NHS South Norfolk CCG – Developing an understanding of health and wellbeing, 2016". This describes the demography, health status and impacts of deprivation on the locality population.
The 2015/16 Norfolk BCF evidence base (ref) summarises the evidence in respect of Integrated Care pilots, virtual wards, Multi-disciplinary team working, long term condition specialisms (including support for self-management).
There is growing evidence through the BCF vanguards about the impact of community integrated community based initiatives. The Great Yarmouth and Waveney system undertook a major reorganisation of its bed and community based provision and is evidencing positive outcomes.

Investment requirements

Please enter the amount of funding required for this scheme

The original funding listed against his was £12,500,000 in expected cost and current value of services provided.

Impact of scheme upon BCF Metrics

The scheme should help reduce non-elective admissions, help to reduce DTOC rates and should support independence through re-ablement against the 91 days measure. This sachem should also help develop greater independence and should help impact towards a reduction in residential or nursing home placements.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

What are the key success factors for implementation of this scheme?

The key success factors for implementing this scheme are a 20% reduction in emergency admissions and facilitation of earlier discharge from in-patient settings back into the community alongside promoting independence.

Additionally this scheme has benefit in connecting health and social care with the voluntary sector and wider community including monitoring and maintaining community assets to facilitate some of the aspirations around STP in Norfolk Waveney. Strong community capacity will facilitate those in need accessing the new service in a timely way to reduce admissions. Increased capacity within the Norfolk First support (NFS) service through both day and night. This will allow up to 12 additional patients to be supported in each locality. The overnight support will include unplanned visits, planned toileting assessments and night sits to assess overnight support. Economies of scale are being agreed with the proposed additional palliative care service. Assistive technology will allow patients to be monitored between visits. Clinical oversight from the integrated team including rapid response medical and social assessment of needs and review.

Scheme ref no.
South Norfolk 2
Scheme name:
Reducing Admissions from Care Homes
What is the strategic objective of this scheme?
Each CCG had a Care Home scheme within BCF and so this is collaborative piece of work across the central belt. This scheme is therefore pretty bog n scope and also predicated by thinking around interventions that might support a reduction in admissions from Care Homes and the focus will be on areas as listed below: UTI's, Falls COPD, Dementia, Diabetes, palliative care and other long term conditions The scheme will look to develop a number of tools for Care Homes to use to assist them in their work to help reduce the use of emergency services in particular and admissions as a result particularly out of hours. The scheme will develop a focus on the top 30 homes against admissions across the central belt to further develop targeted actions to support practice to reduce admissions.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Co-ordination of work across the central belt and working in conjunction with North and Norwich. A cohort of the top 30 homes in terms of admissions has been pulled together 10 in each locality with targeted work being done around developing a set of tools for homes to use to help avoid admissions. In particular who to call what for and why, reducing the number of admissions, reducing the number of 999 calls particularly those that don't translate into a conveyance or admission. Further work has been done around training and development of staff around falls, UTI's, falls, COPD, Dementia, Diabetes, palliative care and other long term conditions. Work around these areas and developing a set of tools for homes to use to reduce admissions has been undertaken. The training has already begun to roll out across homes. Work has been targeted around falls prevention and a falls checklist as and end of bed tool has been developed for use and this has been linked into the locality falls group alongside the countywide falls steering group. Work is about to be done around monitoring activity in accident and emergency against the top 30 care homes as identified across North, Norwich and South to collate a sense of level and type of activity.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

- Residential care and nursing care providers; Independent trainers; NCH&C; NCC; Third
- Sector Providers
- GPs; NCH&C
- 111; GPs; NCH&C; central system CCGs
- (Out of Hospital Pre Improvement Board)

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There are significant current pressures on primary and community (health and social) care as a result of the numbers of people in residential and nursing care homes in the South Norfolk CCG area, and the proportion of urgent care admissions from those homes. Emergency admissions from care homes average about 120 per month in the SNCCG area, representing about £240k (£2.9m pa) in acute costs. By definition people in care homes are frail and there are higher levels of admission to urgent care than for people living in their own homes. Admissions related to health attack and stroke are unavoidable but there is a high proportion of admissions as a result of problems such as urinary tract or chest infections that clinical opinion suggests could be managed more effectively in the community than they are now.

The SNCCG locality has around 2,600 beds in 100 care homes. There is a particular density of provision in the Dereham area with smaller concentrations in Attleborough, Long Stratton and Thetford. Care homes pressures that have been identified in South Norfolk include:

- Rising acuity of health needs of residents both in nursing and residential care
- Challenges for homes in maintaining income and viability
- Changes in managers and high turnover of both qualified and unqualified staff
- Demand and recruitment pressures in primary care

The most common reasons for hospital admission from care homes in South Norfolk are falls, infections (primarily respiratory and urinary tract) and acute cardiovascular disease as demonstrated through the following primary diagnoses (top 10):

- Lobar pneumonia (chest infections)
- Urinary Tract Infection
- Pneumonitis due to food and vomit
- Unspecified acute lower respiratory infection
- Hip fracture
- Pneumonia
- Stroke
- Congestive heart failure
- Cellulitis (skin infection)
- Myocardial Infarction (heart attack)

Data analysis of admissions in 2015/16 showed the care homes around the following practices have higher levels of admission to urgent care:

- Dereham practices combined
- Attleborough
- Watton
- Wymondham
- Thetford practices combined
- Long Stratton
- Humbleyard - Cringleford / Hethersett/ Mulbarton
- Wymondham

The times of the day at which relatively higher levels of admissions are made are evenings from 6.00pm to Midnight Thursday to Sunday and weekend afternoons between 12.00 – 6.00pm.

The evidence on realisation of benefits through initiatives focussed on reducing admissions from care homes from other health systems is mixed. Amongst the inputs that have had some impact in other systems in reducing admissions are:

- Education and training for care homes staff to identify and manage conditions before these get worse
- Care planning including effective planning for CPR DNR
- Medication review
- Enhanced support including out of hours contact
- Supported discharge for patients who have been admitted

Investment requirements
Please enter the amount of funding required for this scheme

The investment agreed and required for 17/18 for this scheme is £58,333 with a further forecast for investment of £41,667 for 18/19.

Impact of scheme upon BCF Metrics

- Reduction in emergency admissions to hospital
- Reduction in falls emergency admissions
- Reduction in ambulance calls which do not result in conveyance to hospital
- Standards of care improve in residential and nursing care settings

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

What are the key success factors for implementation of this scheme?

The key success of implementing this scheme are intended to be:

- Reduction in emergency/unplanned acute admissions from Care Home settings
- General reduction in costs and use of services such as 999, 111/OOH by care homes across the central belt.
- A Reduction in development of particular conditions at the care home level including UTIs and falls related injuries
- Reduction in the level of support needed from primary care to care homes
- Better medicine safety and concordance and link up with acute prescribing and impact on community settings.

Scheme ref no.

West Norfolk 1

Scheme name

Primary Care Prevention: Social Prescribing and Care Navigation

What are the strategic objectives of this scheme?

This scheme includes 2 key strands: Social Prescribing, a new initiative in West Norfolk, and Care Navigation, a continuation of a 2016/17 Better Care Fund scheme.

Social Prescribing

There is a diverse range of voluntary sector services in West Norfolk, some of which have established links with GP Practices. However, the approach across the locality is inconsistent, largely based on arrangements that have built up over time. The strategic objectives of this strand will therefore be to:

- Increase capacity of GP Practices by reducing the number of patient appointments focussed on social issues. This will support prevention across the health and social care system by enabling GPs / Practice Nurses to focus on use of their clinical skills to support patients (reducing risk of unnecessary use of acute services)
- Provide an improved, more holistic, service to patients presenting at GP Practices with social issues linked to their health.

Care Navigation

West Norfolk has commissioned a range of Care Navigation services that aim to support patients and their carers to self-manage where possible, and to access the wide range of statutory and voluntary and community services where appropriate. This includes the Living Independently in Later Years (LILY) service, aimed at older people aged 50 and over, which provides a website and network of voluntary organisations helping people to use the website and providing advice and information. In addition, there is a Care Navigator service which provides more intensive support for up to one month to help patients with higher / more complex needs (e.g. an individual with dementia) to utilise services. In both cases, the strategic objectives of this strand will be to:

- Support increased use of Care Navigation Services to help prevent escalation of needs / encouraging self-management and promoting independence
- Ensure support is targeted at those who need the support most
- Reduce pressure on statutory services; freeing up their capacity

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Social Prescribing

A best practice approach to social prescribing will be co-produced with GP Practices, social support organisations (particularly across the voluntary and community sectors), Public Health and with patients and carers. This will include learning from local developments and other areas around the country that have already adopted this approach (e.g. Bromley-by-Bow, Rotherham and Gloucester). Key principles will be that: a) GP Practices must be able to social prescribe quickly with a minimum of

bureaucracy; b) Access to service providers should be as seamless as possible for patients and service providers alike and c) Delivery arrangements will vary according to the specific services / strengths of each Practice area / locality.

The focus will be on supporting patients (of all ages) who regularly seek support from their GP Practice for social issues. It is estimated that 20% of GP appointments are taken up with social issues – the objective will be to minimise this figure.

Consideration will also be given to the potential application of Social Prescribing within the Queen Elizabeth Hospital and Swaffham Community Hospital.

It will be crucial to ensure that there are technical processes in place to make referrals; that feedback and evaluation mechanisms are in place and that pressures on prescribed services are monitored.

Care Navigation

The emphasis of this strand will be on ensuring system wide awareness of existing provision and appropriate and increased use of Care Navigation resources. This will include provision of support to statutory services to free their capacity for other tasks – e.g. support to individuals awaiting formal social care / carers assessment and referrals from health practitioners (such as Community Matrons) to support their patients with social issues.

In addition, Care Navigator support will be offered routinely to individuals awaiting major housing adaptation and frequent users of community alarms, triggered for social reasons – as these are considered to be likely proxies for escalating needs.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

- West Norfolk CCG, King's Lynn and West Norfolk Borough Council and Norfolk County Council (including Public Health) all commission services that could be within scope of social prescribing
- LILY is commissioned by NCC and KLWNBC
- The largest Community Alarm provider in West Norfolk is commissioned by KLWNBC
- Care Navigators are commissioned by WNCCG
- GP Practices would, in effect, commission a wide variety of community services via social prescribing
- QEH and Swaffham Community Hospital could also commission via social prescribing (scope of their involvement TBC)
- A wide variety of predominately voluntary sector services provide services that could be prescribed by health professionals

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Social Prescribing

There are several examples across the country, e.g. Gloucestershire, Rotherham and Bromley-by-Bow, where social prescribing has been adopted. These areas have demonstrated that GP time can be released by referring patients with social needs to relevant services.

Care Navigation

LILY and Care Navigator services in West Norfolk have developed in the less 2 years. The Care Navigator service has received 387 referrals during 2016/17, and has evidenced significant improvements in patient / carer capacity to self-manage and thereby have reduced need of statutory services. This has included approximately 90 referrals from Social Services for individuals awaiting formal social care / carer assessment.

Approximately 25 individuals per month frequently (10 or more times per month) trigger their KLWNBC Community Alarm for social reasons.

There is considered capacity for upto 500 – 600 referrals in total to the Care Navigator service within existing resources.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Social Prescribing

TBC – dependent on current review.

Care Navigation

Care Navigator resources are in place. LILY resources TBC.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below

TBC

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Social Prescribing

This is dependent on the model eventually agreed and implemented. However, it is envisaged that there would be a referral mechanism that would enable the number of referrals; referred to organisation and support types to be calculated. It would also be possible to count changes in GP appointments.

Care Navigation

Information is already captured by activity levels and referrers. With regard to the Care Navigator service, outcome information (e.g. capacity to self-management following support) is also captured. Analysis of referrer will act as a proxy for the level of need being addressed.

What are the key success factors for implementation of this scheme?

- Increased appropriate referrals to existing community services to support patient health and wellbeing
- Reduced pressure on statutory services / freeing up Primary Care capacity to focus on clinical issues and thereby delay / mitigate rising pressures
- Increased patient / carer feedback that they have increased capacity to self-manage and access community services for support

Scheme ref no.

West Norfolk 2

Scheme name

Admission Avoidance through Integrated Rapid Assessment at QEH

What are the strategic objectives of this scheme?

This scheme is a continuation of activity initiated via the 2016/17 Norfolk Better Care Fund. The focus of the scheme is on the development of the Rapid Assessment Team (RAT) at the Queen Elizabeth Hospital which comprises health and social care practitioners providing support within the Emergency areas of the Hospital (particularly the Accident and Emergency and Medical Assessment Units). The primary role of the team is to identify patients whose needs can be met in the community and to make appropriate arrangements for this to take place, and thereby reduce unnecessary admissions to the QEH.

Following significant investment in the team, this scheme will deliver against the following strategic objectives:

- Reductions in admissions to QEH
- Improved 'patient flow' through the QEH, releasing bed capacity
- Increased utilisation of community services to support patient health and wellbeing, including newly commissioned services such as intermediate care beds and weekend social care provision
- Increased capacity to support patients presenting at QEH as a result of a fall
- Increased capability to support patients presenting at QEH with mental health related issues (e.g. delirium) and dementia
- Enhanced capacity to deliver a more comprehensive 7 day service
- Improved patient experience and outcomes, through ensuring access to appropriate support and eliminating risks associated with unnecessary hospital admission (e.g. disorientation for people with dementia, reduced mobility and confidence, risk of contracting infections)

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

RAT comprises practitioner input from Norfolk County Council, QEH and Norfolk Community Health and Care, providing a service 7 days a week (reduced working hours and staffing at weekends).

During 2016/17, it is projected that RAT will support 3216 patients, with most referrals coming via A&E (53%), MAU (23%) and Observation Bays (15%). Of those, 2283 patients are Norfolk based and it is anticipated that 70% will be discharged with support (admission avoided) and 30% are admitted into a hospital bed. It is not possible to verify whether all of the admission avoidance activity was dependent on the role of RAT, but it is considered likely that they had a significant role to play on the basis of a) their access to more detailed patient background information, b) the ability of team members to risk assess, negotiate and diffuse conflict, c) discharges being led by clinical and therapy team members and d) the team's knowledge and experience of community services and the support that they can provide.

The team accepts referrals for medically stable adults over the age of 18 whom have complex social, functional, physical needs which may prevent them from being discharged from the emergency care settings, with the exception of <65 musculoskeletal patients, *without* complex needs, who are required to attend the physiotherapy outpatients department at the QEH. However, older people form the majority of patients supported by the team.

During 2017/19, RAT will be expanded to include mental health practitioner input provided by the Norfolk and Suffolk Foundation Trust (enabling improved support for patients with dementia, for example), increased social work capacity (Including access to the Social Services team at weekends) and increased community health and physiotherapy. This will increase the capacity of the team so that there are 4 members of staff, as a minimum, providing a service from 08:00 – 18:00 Monday to Friday (higher number of staff) and at weekends from 08:00 – 16:00.

In addition, to boosting RAT capacity and capability, the team will be supported to fully utilise community based services to support patients discharged from QEH. This will include arranging education / training packages about newly commissioned services, and refresher information about established services. Examples of this include ensuring access to Home from Hospital voluntary sector services, information and advice services (e.g. for people with dementia), carers support services, intermediate care services, housing adaptation and care navigator services. RAT will also be able to participate in the social prescribing scheme (see WN1).

There will be increased collaboration with Social Services and appropriate use of provision at weekends (for example, greater use of block home care and residential care contracts that are available at weekends but currently are not well utilised to expedite discharge).

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

- West Norfolk CCG are the commissioners of acute care and community based healthcare support
- Norfolk County Council are the providers and commissioners of social care support
- QE Hospital are providers of support to patients with acute needs
- Norfolk Community Health & Care NHS Trust provide community nursing and intermediate services
- General Practices provide primary care services
- Independent sector providing nursing, residential and home care
- Voluntary and Community Sector providing a wide range of services, such as Care Navigation for patients with complex needs and home from hospital support

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

RAT has been operational for 10 years and has consistently supported large numbers of patients (increasing year on year) from QEH to be discharged to community services.

The number of attendances at QEH do not fluctuate significantly across the week, justifying additional capacity at weekends.

The team have advised that they increasingly encounter patients with low level mental health needs, including dementia. This is being addressed through greater integration with mental health provision and recruitment of staff with mental health practitioner skills.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
The following has been approved: £173K – 2 Band 4 practitioners (NCHC / QEH) and 1 Band 6 Mental Health Practitioner (NSFT) and £40K – 1 Assistant Practitioner (NCC) There has been considerable investment in community based services that receive referrals from RAT (e.g. intermediate care provision).
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below
• 30 Additional Admissions Avoided per Month in Year 1 = 360 X £1500 Average Admission Cost = £540K Gross Saving (£327K net) • 45 Additional Admissions Avoided per Month in Year 2 (through improved staff experience / access to commissioned services) = 540 X £1500 = £810K Gross Saving (£597K net). This is considered an aspirational / stretch target; 30 admissions avoided per month is considered a realistic minimum expectation
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Information will be collected by the RAT service and reported to WNCCG Business Intelligence and the Project Manager. The service already collects comprehensive information regarding activity, admission / discharge outcomes and referrals to other services. Feedback will also be collected from key partners, such as service providers referred to by RAT.
What are the key success factors for implementation of this scheme?
• Increased operational hours with a minimum of 4 staff across 7 days • Increased activity; leading to increased admission avoidance • Increased capability to support patients presenting with mental health issues, including dementia • Referrals to full portfolio of commissioned services, including utilisation of social prescribing to ensure holistic support approach

Scheme ref no.
West Norfolk 3
Scheme name
Discharge to Assess for Patients with Complex Care Needs
What are the strategic objectives of this scheme?

This scheme builds upon a pilot scheme that was initiated in January 2016 to better support patients with complex needs, including those potentially eligible for Continuing Healthcare. The principle objective is to develop the model of care and support that was piloted so that it is embedded as 'business as usual' and is fully integrated within the local health and social care system. Inclusion within the Better Care Fund is expected to provide a framework for delivery of a scheme which can only succeed through genuinely integrated working across health and social care.

The focus of this scheme will be on patients admitted to the Queen Elizabeth Hospital with complex needs. The scheme will ensure that patients are:

- Identified as having complex needs
- Discharged to a community setting as soon as acute needs have been addressed
- Supported with their care and/or nursing needs and can recuperate to their optimal state
- Assessed in the community after a period of recuperation; for Continuing Healthcare, Funded Nursing Care, Social Services support, as appropriate
- Enabled to access any ongoing support that is required following their recuperation

In achieving the above, it is anticipated that:

- Continuing Healthcare Assessments will not be conducted at the QEH for Norfolk patients. This will contribute to reducing Delayed Transfers of Care and improving patient 'flow' through the QEH
- Patient outcomes and experience will improve through speedier discharge (reducing the risk of complications arising from lengthy stays in Hospital, such as risk of contracting infections and loss of mobility / independence)
- Patients will benefit from support to recover in the community, potentially leading to greater independence
- More accurate assessments will be conducted when patients have optimised; also improving care planning arrangements
- Cost savings will be achieved across the system, through more effective and efficient care arrangements; these savings can potentially be shared between health and social care

The scheme is focussed on support for patients admitted to QEH, but consideration will also be given to potential improvements that can be made within the community.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The pilot included use of a '5 Questions Care Test' to identify whether patients with complex needs had substantial and complex nursing needs (Positive Discharge to Assess pathway) or care needs (Negative Discharge to Assess pathway). Positive DTA patients were referred for 28 days of community based NHS funded support, to enable patients to recuperate sufficiently for Continuing Healthcare assessments to be conducted. Negative DTA patients were referred for support by Social Services, with Continuing Healthcare assessments being conducted where required.

The pilot focussed on older patients (typically aged 75 and above) and was considered to be successful; resulting in a Memorandum of Understanding between WNCCG and NCC for the scheme to continue, subject to further refinement and development. These developments, which are the subject of this scheme to be delivered through the Better Care Fund, are:

- Improved communication with patients and families about the process
- Joint working between health and social care colleagues, particularly regarding 'negative DTA' cases, to ensure that care plan arrangements are appropriate
- Review of resourcing of community based assessments
- Improvements to transitional arrangements; particularly in relation to NHS funded Care Home placements and transition to NCC funded care for patients who are judged to be ineligible for Continuing Healthcare
- Data collection about the quality and financial implications (particularly for NCC) arising from the process. Consideration to be given to financial gain sharing depending on the results of the data collected
- Development of pooled budget arrangements between health and social care to streamline and harmonise care planning arrangements

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

- West Norfolk CCG are the commissioners of acute care and community based healthcare support
- Norfolk County Council are the providers and commissioners of social care support
- QE Hospital are providers of support to patients with acute needs
- Norfolk Community Health & Care NHS Trust provide community nursing services
- General Practices provide primary care services
- Independent Nursing Homes provide nursing care

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

An evaluation of the pilot scheme was completed in December 2016. Key findings included:

- The new pathway is cost effective and improved outcomes for families and patients
- Health economic analysis indicated £562K savings achieved over a 7 month period
- Zero delayed transfers of care from the QEH due to CHC funding decisions as well as reductions in excess bed days thus relieving operational hospital pressures
- 81% reduction in CHC checklists (from 178 to 34)
- Social Care costs attributable to the new pathway were not accurately calculated, however, there were no significant changes to overall social care activity at QEH
- Reduced complexity of CHC packages required due to earlier discharge and optimal recovery
- Qualitative findings included: the views of staff were mixed, with hospital nurses being the most enthusiastic about the new pathway and social workers the least. Care homes felt they had been kept informed and involved but had not felt they had much influence on the process. It had not been possible to receive sufficient patient / family feedback to form a view from their perspective, but no complaints had been received

Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Most resources are already in place as the focus of the scheme is on reconfiguration of existing provision. However, there may be a case to increase Social Work capacity to undertake community based assessments; the cost of this is expected to be c.£30K or £60K (depending on whether a part or full time role is required).
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below
• £307K net savings projected in 2017/18 from reduced CHC expenditure. This to be achieved through investment in Positive DTA pathway to support patient recuperation • Reduced CHC packages (linked to above) • Nil / low delayed transfers of care attributable to CHC assessments at QEH for Norfolk patients
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Information will be collected by the Discharge Nursing Team, for Positive DTA patients, and by NCC for Negative DTA patients. This information will include number of patients, discharge placement and the outcomes of community based assessment (i.e. eligibility decisions regarding CHC, FNC, Social Care). This will enable system analysis of patient outcomes, costs and savings. There will be monthly project group meetings including health and social care representation to share learning and ensure that integrated care arrangements are in place.
What are the key success factors for implementation of this scheme?
• Delayed Transfers of Care attributable to CHC assessments • Improved value for money; resulting in gain sharing between health and social care where merited • Timely community based assessments (usually approximately 14 days of discharge) • Timely implementation of care arrangements following assessments (usually within 28 days of discharge) • Improved patient outcomes; including greater proportion of older people still at home 91 days after discharge

Scheme ref no
West Norfolk 4
Scheme name
Norfolk First Support (NFS) First - Optimisation of referrals to Reablement Service by QE discharge team(s)
What are the strategic objectives of this scheme?

To effect change to the current pathway to NFS for QE patients with the aim of improving the volumes, efficiency and effectiveness of referrals by:

- Mapping the current pathway to identify opportunities for improvement
- Engaging all partners in the case for change
- Implementing change
- Ongoing monitoring and engagement in continuing improvement to pathway (contributing to the work of the A and E delivery board and West CCG Best Value Programme)
- Develop a mechanism to inform/engage with wider system to improve post discharge support and ongoing therapy

Leading to:

1. A substantial increase in the number of patients being referred directly to NFS (corresponding decline in home support and residential packages)
2. Reduction in referral days delay to NFS and hospital stays
3. A new efficient, effective handover to NFS from therapy services leading to improved governance and patient/client outcomes
4. Increased capacity for hospital social work teams to focus on complex social work cases
5. Reduction in the requirement for post hospital support by community social work teams
6. Recommendations for future commissioning of services currently commissioned to support hospital discharge (The British Red Cross, Age UK etc.)

*the learning from this initiative will also feed into the planned whole system review of therapy currently undertaken within the QE (expected outcome being to move to a home based therapy model)

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Increase the use of home based Reablement via NFS by improving/building upon the current pathway, leading to NFS referrals being made much earlier within discharge planning so increasing the volume of patients/clients ultimately reabled and enabling earlier discharges home for patients.
An increased tolerance to NFS entirely managing the ongoing, low level, risk of patients previously `held' by hospital social work teams.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

West Norfolk CCG including member practices
Norfolk County Council
QE Hospital
Norfolk Community Health & Care NHS Trust

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Normal reablement positives in here plus the findings from the recent data dive undertaken by NFS (west)
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Current resources
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?
Reduction in formal packages of care (residential and home based) Delayed transfer of care Positive service user feedback (Experience metrics) Reduction in social work holding lists (hospital and community teams)

East Norfolk

Appendix B- Locality Schemes
Norfolk Better Care Fund 2017-19

No	Locality	Scheme	Project (If different from Scheme)	Principal Outcomes	Expected Project Benefits	Planned Implementation Date	Measures of success
1	GY	Locality Integrated Care Programme Infrastructure	Vol and community sector development	Delivery for the Voluntary and Community Infrastructure support, pooling funding from GY&W CCG, Norfolk County Council and Great Yarmouth Borough Council to extend Voluntary Norfolk's remit under the 'Neighbourhoods that Work' scheme to provide support to this valuable sector.	A strong and diverse voluntary community sector providing support to the community. - Enhanced community cohesion - Local VCS organisations more equipped to take on the running of services - Local communities empowered to develop activities and services to meet local need - More opportunities for the local VCS to work collaboratively amongst themselves and with partners from the statutory and private sectors - Reduction in reliance on and demand for health and social care services by having a strong and vibrant VCS which helps support people living in the community	Service went live in Dec 16	Reduction in demand on primary care/ Increase in the number of people who are able to self care
3	GY	Locality Integrated Care Programme Infrastructure	Integrated Care Co-ordinator	Develop the ICC role to operated across the GY&W area to provide co-ordination of complex care packages (from health and social care). An area of key focus will be EOL/ Pallative Care	Increased patient statisfaction	TBC - draft paper for Gateway decision being developed	TBC
3	GY	Locality Integrated Care Programme Infrastructure	IRR	Stage 1- Process mapping a journey for a patient on this pathway to identify areas of delay and/ or where improvements in this pathway could be made. Stage 2- Integrated Care Co-ordinator (ICC) could be used to co-ordinate care delivery and make improvements to this pathway.	• Shared vision and operational processes between professionals so that care is better co-ordinated to support the individual achieving their single set of goals • Better communication between services to coordinate timings of visits, and share resources • Continuity within a patient's journey at key transition points. • Making every contact count for improved independence and wellbeing.	TBC	Increased patient satisfaction, Reduction in A&E readmissions
	GY	Locality Integrated Care Programme Infrastructure	Dementia Support Pathway	Reviewing dementia pre and post-diagnosis pathways for Great Yarmouth and Waveney to continue work on a mapping exercises linking with the RightCare dementia programme	Patients ongoing diagnosis of dementia- a variety of options to support the needs of the patient and their carers	TBC	A&E attendances Ambulance call outs Dementia diagnosis
	GY	Care Homes	Care Home development	Great Yarmouth and Waveney took part in a Strategic Care Market review to provide a robust evidence based to inform future commissioning approaches and decisions. Building on the evidence base to support Care Homes to deliver best practice support for people in care homes. This will use the Enhanced Framework for Health in Care Homes to influence and drive areas for development.	Improve the care and support provided to patients within care homes Reduces hospital admissions Work to ensure timely discharge from hospital Improve medicines optimisations within care homes - reducing prescribing costs Improved work with primary care	Jun-Aug-17	A&E attendances Ambulance call outs
	GY	Housing Adaptations	DFG adaptations	We have worked in recognition of the greater integration across housing and involvement of the BCF partnership Board to consider services the Borough and District councils offer, to develop a joined up health, housing and adaptation system for patients to remain at home	Supports residents to live in their own homes independently.	Ongoing	A&E attendances Ambulance call outs
	GY	Housing Adaptations	Healthy homes	Undertake works to vulnerable people's homes that deliver a clear benefit to their health and wellbeing Reduce demand for services in health and social care Ensure qualifying works are professionally complete in a minimal amount of time Work on receipt of referrals from medical professionals	Reduce the number of hospital bed days lost because of delayed discharge Reduce hospital admissions and re-admissions Preventative measures to reduce risks around the home and improve health and social care outcomes	Nov-16	A&E attendances Ambulance call outs/ Reduce DTOC
	GY	Housing Adaptations	I'm going home' project	A short term package primarily aimed to assist early hospital discharge or to prevent hospital admission through A&E.	Reduce the number of hospital bed days lost because of delayed discharge Increased patient confidence in going home Cost benefits of enabling someone to go home sooner Providing reassurance to the client by offering 24/7 monitoring Maintain client independence in their own home Family members can be rest assured that their loved one has access to a 24/7 local call centre	Nov-16	A&E attendances Ambulance call outs/ Reduce DTOC
4	GY	Out of Hospital	Medical Loans	• Provision of short-term loan of medical equipment for any referrals either directly/indirectly • Provide support to people in the community to increase/maintain their independence • Respond to needs highlighted in and around safety and mobility at home issues e.g. falls prevention • Act on requests from health and social care professionals working in the Great Yarmouth and Waveney footprint to provide loan of appropriate equipment to meet patient needs • Respond in crisis situations where equipment is needed urgently • Delivery and collection of specified medical equipment on three days per week – alternating on a weekly basis between week 1 Monday, Wednesday and Friday and Week 2 Monday, Wednesday and Saturday.	Enhancing quality of life for people with long-term conditions Helping people to recover from episodes of ill-health or following injury	Ongoing	Reduce DTOC
5	GY	Out of Hospital	Home from Hospital	The service supports anyone who is experiencing a crisis following a hospital discharge, who is over the age of 18 years old and who live in Suffolk & Norfolk. The service is for those whose re-ablement, recovery or rehabilitation would benefit from practical and emotional support; or for those that do not have family or friends to provide the practical support needed following a hospital discharge. The service can also help prevent unnecessary hospital admissions by providing extra short term support at home	As above	Ongoing	Reduce DTOC
9	GY	Out of Hospital	NMSS	NMSS will improve medication adherence and reduce hospital admissions.	A study calculated savings to the local health economy (considering only secondary care and prescribing costs) of £307 per patient. Taking into account the cost of the service at £323k, this results in an annual net saving of approx. £0.5m	Ongoing	A&E attendances Ambulance call outs
	GY	Out of Hospital	Out of Hospital team	Referrals must be for patients for whom it is considered input from the OHT will be of benefit. Referrals could, for example, include: Patients experiencing an acute exacerbation of their Long Term Condition Patients experiencing acute symptoms due to chest infection or urinary tract infection Patients whose mobilisation has suddenly reduced or is rapidly deteriorating Patients for whom the current care package is no longer robust enough and urgent review and amendment is required to prevent a breakdown of carer support Patients requiring a supported hospital discharge to their usual place of residence Patients presenting at Accident and Emergency who do not require an emergency admission but do require additional short term support to enable them to return home Patients who require a short term placement in a bed with care	Benefits analysis has been completed on the impact of the Out of Hospital team	Ongoing	A&E attendances Ambulance call outs
2	GY	Out of Hospital	Social Prescribing	• Better social and clinical outcomes for people with LTC's and their carers • More cost efficient and effective use of NHS and social care resources • A wider, more diverse and responsive local provider base • Established and connected VCS support to GP's to support service users with Long term conditions but who do not require clinical input to manage their condition • Improved resilience to maintain the individual's independence by empowering them at an early stage and empowering them to have more control over their lives.	• Improved health and quality of life • Increased patient satisfaction • Fewer primary care consultations • Reduction in the number of hospital admissions, social care interventions, police, housing and mental health assessments • Financial savings through demand reduction; hospital assessments and admissions, visits to GP's, social care assessments and care packages, housing evictions, ASB cases and S851 police welfare cases • A decrease in the use of wider hospital resources including statutory resources to support people at home	Aug-16	Reduction in GP appointments Reduction in A&E attendances Reduction in Prescriptions
	GY	Out of Hospital	Equipment	Link to NRS contract and expected benefits			
	GY	Out of Hospital	Dom Care & CHC (including EOL)	It requires councils to promote individual wellbeing, to prevent the need for care and support, and where care and support is required to reduce or delay the need for it. The Home Support model has been developed to ensure that care and support delivered, is in line with the Care Act 2014.	Ensuring adequate capacity to deliver care and that staff are trained and competent in delivering the new model of Home Support. Links with the voluntary and community sectore to ensure a holistic package of care is delivered	Apr-16	Reduced DTOC
	GY	Out of Hospital	Discharge to access	TO BE ADDED	TO BE ADDED	TBC	Reduced DTOC
	GY	Crisis response	SWIFTs and Night Owl	24/7 Crisis response to support people who required emergency care and support. Need to develop this service alongside the Out of Hospital team.	A potential yearly saving of approx. £340k due to a reduction in ambulance attendances and A&E admissions. (awaiting theses figures to be verified) An additional figure of approx. £1m which could be saved if those A&E admissions resulted in a hospital admission. (awaiting theses figures to be verified)	Ongoing	A&E attendances Ambulance call outs
	GY	Crisis response	Community Alarms	Review of community alarm responses to identify if the appopriate response is being given. Early identification of people who would benefit from proactive support.	TO BE ADDED	TBC	TBC
	GY	TBC	Shrublands development	Development of potential housing/ accommodation scheme for Older People, LD and PD. This would contribute to the overall development of this site with the Vol and Comm sector, Children Centre and Primary Care	TO BE ADDED	TBC	TBC

Appendix C

High Impact Change Model Plan

Activity -by month	Owner	04/2017	05/2017	06/2017	07/2017	08/2017	09/2017	10/2017	11/2017	12/2017	01/2018	02/2018	03/2018
Planning													
Early Discharge Planning													
Systems to Monitor Patient Flow													
Multi Disciplinary/ Multi Agency Discharge Teams													
Home First/Discharge to Assess													
Expansion of pathways								Q3 2017/18					
Seven Day Services													
Social care provision available across all three Norfolk acutes								Q3 2017/18					
Trusted Assessors													
Development of model								Q3 2017/18					
Focus on Choice													
Enhancing Health in Care Homes													
Development of a robust care homes dashboard				06/2017									
Workforce development			05/2017 - 09/2017										
Develop and introduce a falls prevention tool for care homes				06/2017 - 11/2017									
Improve the pathway between hospital and care homes				06/2017 - 12/2017									
Introduce a communication tool to support decision to support decision making by care home staff				06/2017 - 03/2018									
Target support at care homes making most use of 999							09/2017 - 03/2018						

Work Planned	
Deadlines / Events	
Milestones	

Programme Governance

- Norfolk Chief Officers Group provide formal governance and direction to the Programme, including monitoring finance, delivery and performance. Membership comprises CCG Chief Officers, Chief Finance Officers and the Executive Director for Adult Social Services.

- The Health and Wellbeing Board has a duty to promote integration and is accountable for the Norfolk Better Care Fund.

- A HWB sub group will continue to provide scrutiny of quarterly data collection forms and other any business, as required.

- The STP Prevention, Primary and Community Care workstream will provide a role in supporting the delivery of the Programme.

Appendix F	Significantly Worse Than England	Not Significantly Different	Significantly Better Than England
Trend Getting Better	Pupil Absence First time entrants to youth justice system Smoking Status at time of delivery	School Readiness Smoking prevalence in adults Smoking prevalence in routine and manual MMR immunisation NEET	Fuel poverty Breastfeeding initiation Teenage conceptions Other childhood immunisations Communicable disease mortality Preventable sight loss (AMD) Self reported well being (Anxiety) Complaints about noise
Trend not changing significantly OR not improving as fast as England	Adults with MH in stable and appropriate accommodation Suicide Rate (although recent increase) KSI Social Isolation Smoking prevalence in young people Excess weight in adults First time offenders Statutory homeless Emergency hospital admissions for self-harm Diet in young people Deaths from drug misuse Gap in employment between LTC and the rest Gap in employment between LD and the rest Gap in employment between MH and the rest Children where there is cause for concern	Adults LD in stable and appropriate accommodation Sickness absence Population exposed to high noise levels Utilisation of outdoor space for exercise Low birthweight Breastfeeding @ 6 to 8 weeks Emotional wellbeing of looked after children Self-reported wellbeing Hip Fracture in 65 and over Excess winter deaths SII Excess weight in children (5 yr olds) Social isolation Physical activity / inactivity Infant mortality Preventable sight loss	Excess weight in children (10 yr olds) Cancer diagnosed at an early stage New-born hearing checks Bowel cancer screening Health checks received Injuries due to falls Respiratory disease mortality CVD mortality Cancer mortality Mortality from causes considered preventable Life expectancy at birth Life expectancy at 65 Emergency re-admissions Quality of life for older people Five year olds free from dental decay Self reported well being () Percentage of people in employment Adult healthy diet
Trend Getting Worse	Violent Crime (some indicators) Re-Offending Levels Hospital injuries to children Recorded diabetes Alcohol admissions Flu vaccination HIV late diagnosis Successful completion (non opitate and alcohol) Chlamydia detection rate	Mortality rate in adults with SMI Successful completion (opiate)	Domestic Abuse Breast cancer screening Cervical cancer screening Liver disease mortality Respiratory disease mortality (females) Gap in life expectancy between England and Norfolk
No Data			

BCF 2017-19

Policy Framework and Norfolk response

1. The Integration and BCF Policy Framework provides guidance to develop integration. As the only mandatory policy to facilitate integration it brings together health and social care funding with an injection of social care money announced in the Spring Budget 2017, which is subject to separate grant conditions.

2. The Policy Framework for the Fund covers two financial years to align with the NHS operational plan timetables and to give areas the opportunity to plan more strategically. For 2017-19 there are four national conditions, rather than the previous eight. These are:

    1. Plans to be jointly agreed
    2. NHS contribution to adult social care is maintained in line with inflation
    3. Agreement to invest in NHS commissioned out of hospital services, which may include 7 day services and adult social care
    4. Managing transfers of care (a new condition to ensure people's care transfers smoothly between services and settings)

3. Beyond this, areas have flexibility in how the Fund is spent over health, care and housing schemes or services but need to agree how this spending will improve performance in the following four mandatory metrics:

    1. Delayed transfers of care
    2. Non-elective admissions (general and acute)
    3. Admissions to residential and care homes
    4. Effectiveness of reablement

4. Norfolk has agreed to include a local metric on increasing the rate of dementia diagnosis.

5. Partners have developed:
    a) An agreed narrative including details of how national conditions will be addressed (Appendix 1)
    b) Mechanisms to confirm indicative funding contributions from each partner organisation, subject to final guidance and assurance
    c) An indicative spending plan which sets out funding for each of the BCF schemes
    d) A plan detailing how health and social care integration will be achieved by 2020
    e) Quarterly plan figures to meet the national metrics
    f) Engagement with stakeholders in formation of the plan
    g) Progress a new nationally produced 'High Impact of Change' Model template

6. Disabled Facilities Grant (DFG) funding has again been included in the Fund so that the provision of adaptations and associated funding can be incorporated in the strategic consideration and planning of investment. The statutory duty on local housing authorities to provide aids and adaptations under the DFG, to those who qualify, will remain and funding will be transferred accordingly as for the current year. However, it will be important also to consider how adaptation delivery systems can help meet wider objectives around integration. Much work has been undertaken to form stronger and more influential partnerships with housing to promote DFGs and other areas where closer joint working and integration could reap benefits for citizens.

7. Stronger partnerships here are pursuing innovative ways to ensure that the increase in funding for DFGs is reflected in a broader set of activities that support the key priorities of

the BCF rather than simply generating a higher volume of adaptations.

The vision, ambition and integration plan

8. In Norfolk, our BCF Plan for 2017-19 is aligned with the vision and guiding principles already established within *"in good health"* - the Norfolk and Waveney STP. The *in good health* principles comprise:

    a) Preventing illness and promoting wellbeing
    b) Care closer to home
    c) Integrated working across physical, social and mental health
    d) Sustainable acute sector
    e) Cost effective services

9. Delivery of the BCF Plan is supported by PPCC workstream of the '*in good health*' programme.

10. In Norfolk our BCF is built upon five priority areas of work. These agreed areas comprise:

    a) Locality Integrated Care Programme Infrastructure – building on the operational integration already in place and improving pathways across all parts of health and social care
    b) Care Homes – including incorporating key elements of the Vanguard Enhanced Health Care in Care homes (EHCH) framework
    c) The Home Environment– such as energy efficiency measures and including maximising flexibilities provided in DFG regulations, the Regulatory Reform Order and a new Grant Regulation Letter
    d) Out of Hospital – including an intermediate care strategy covering integrated reablement, discharge to assess and homecare
    e) Crisis Response – including rapid response and integrated services to support admission avoidance

11. It is proposed that monitoring of key milestones forms part of future reports to HWB.

Integration plan

12. There is a national requirement for a locally developed plan for full integration of health and social care by 2020 to be published by 2017 and the draft BCF Guidance stipulates that this must be a component of 17/19 BCF Plans. Norfolk is reviewing its integration plan in conjunction with council members and CCGs. The review will consider operational and commissioning arrangements with a view to aligning them to emerging STP themes. Key goals for 2020 are envisaged as follows:

    1. Fully integrated health and care teams in each locality
    2. Strong support and prevention in every community
    3. Effective 24/7 support in a crisis
    4. One efficient commissioning team
    5. A clear health and care budget for each area
    6. A sufficient, capable and flexible workforce
    7. One set of data on citizens and population

Note – This is being shared with HWB for information only

Adult Social Care Committee

Report title:	**Additional Social Care Funding**
Date of meeting:	**10 July 2017**
Responsible Chief Officer:	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

Adult Social Services faces huge challenges in delivering a sustainable model of care and support in the context of growing financial and demographic pressures. The Chancellor's Budget in March 2017 announced £2bn additional non recurrent funding for social care, of which Norfolk will receive £18m in 17/18, followed by £11m in 2018/19 and £6m in 2019/20. The additional funding reflects the pressures and demands on adult social care nationally and will support the service to re-shape and transform for the future.

This funding is in addition to recurrent funding received through the Better Care Fund (BCF). The funding will be paid as a direct grant to councils by the Department of Communities and Local Government (DCLG) and as a condition of the grant, councils are required to pool the funding into their BCF. The BCF is governed by the Health and Wellbeing Board and signed off by NHS England and DCLG through national and local assurance.

Funding proposals for the additional social care funding are not subject to NHS England assurance and require ASC Committee approval.

Executive summary

This report outlines how Adult Social Services will use the additional one-off funding announced as part of the budget in March 2017.

The grant, which followed significant lobbying from councils, amounts to some £35m over three years, and effectively acts as a 'bridge' to the Improved Better Care Fund. It is a timely and positive contribution towards helping Adult Social Services achieve its vision and objectives. It will help manage existing and new pressures in the health and social care system, as well as bringing on stream new preventative activities which reduce and delay the need for formal care and support the safe discharge of people from hospital. Plans for this expenditure combine protecting and sustaining social care services, which are key to achieving our PI ambition, with ambitious and innovative plans for investment that aim to fundamentally shift demand patterns.

It explains how the grant will be directed towards and benefit the following key areas:

a) Protecting social care – Funding required to manage shortfall in recurrent pressures and protect social care services. Protection of social care will ensure that vital service

provision such as homecare is maintained and people are supported to maintain their independence and stay out of hospital

b) Sustain social care – Supporting capacity of social work strengthens the prevention offer, ensures people receive support that meets their needs and is fundamental to people being able to leave formal care settings as soon as they are medically fit. It will also be utilised to mitigate pressures on the costs of care and secure the supply of home care and residential care which is affordable and of good quality for Norfolk people

c) Invest and improve social care – investing in prevention, including earlier intervention in the community, additional care at home, and specialist care for those people who can leave hospital but are not ready to go home

Taken together, this approach is fully in line with, and strengthens, plans to achieve over £50m in savings and efficiencies by 2020.

Recommendations:

a) Agree to support the proposals for use of the additional monies as set out in Appendix A, and recommend to Policy and Resources Committee for sign-off.

1. Background

1.1 The Chancellor's Budget in March 2017 announced £2bn additional non recurrent funding for social care, of which Norfolk will receive £18m in 17/18, followed by £11m in 2018/19 and £6m in 2019/20. The funding will be paid as a direct grant to councils by the DCLG. As a condition of the grant, councils will be required to pool the funding into their BCF. This fund is governed by the Health and Wellbeing Board and signed off by NHS England and DCLG through national and local assurance.

1.2 Additional investment and funding proposals require approval and endorsement of the ASC Committee in addition to agreement by Clinical Commissioning Groups (CCGs).

2. Grant Conditions from the Additional social care funding

2.1 Councils are required to meet the grant conditions which have been set out in the grant determination letter sent to all councils. The new, one off additional social care grant will be paid directly to local authorities from the DCLG and will be included in the BCF. Guidance sets out the purposes of the funding which is to be spent on adult social care and used for the purposes of:

1. **Meeting social care needs**
2. **Reducing pressures on the NHS supporting people to be discharged from hospital when they are ready**
3. **Ensuing that the local social care provider market is stabilised**

2.2 The Government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities are therefore able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans have been locally agreed.

2.3 The additional funding supports the shared agendas of health, Acutes and social care. Funding is short term and operates as a 'bridge' to recurrent funding within the Improved BCF (IBCF) therefore it is important that initiatives undertaken seek to genuinely manage and divert demand with the system. Robust evaluation and monitoring of all interventions will be undertaken to identify where in the system efficiencies are made - this will support sustainability in the long term.

3. Promoting Independence – Adult Social Services vision and priorities

3.1 Adult Social Services has developed a vision for the future – to support people to be independent, resilient and well. The strategy to achieve that vision – Promoting Independence – is shaped by the Care Act with its call to action across public services to prevent, reduce and delay the demand for social care.

3.2 It aims to shift spending away from the more costly intensive spending such as residential care, towards earlier intervention and prevention, reducing demand for services over a number of years.

3.3 The strategy has these main elements:

3.3.1 **Prevention and early help** – Empowering and enabling people to live independently for as long as possible through giving people good quality information and advice which supports their wellbeing and stops people become isolated and lonely. It will help people stay connected with others in their communities, tapping into help and support already around them – from friends, families, local voluntary and community groups. For our younger adults with disabilities, we want them to have access to work, housing and social activities which contribute to a good quality of life and wellbeing.

3.3.2 **Staying independent for longer** – for people who are most likely to develop particular needs, we will aim to intervene earlier. Our social care teams will look at what extra input could help people's quality of life and independence – this might be some smart technology, some adaptations to their homes to prevent falls, or access via telephone or on-line to specialist tailored advice. When people do need a service from us, we want those services to help people gain or re-gain skills so they can live their lives as independently as possible.

3.3.3 **Living with complex needs** – for some people, there will be a need for longer term support. This might mean the security of knowing help is on tap for people with conditions like dementia, and that carers can have support. We will look at how we can minimise the effect of disability so people can retain independence and control after say a stroke or period of mental illness.

3.4 Together with implementing this change programme, these are the service priorities:

a) Strengthen social work so that it prevents, reduces and delays need - great social work, in all its forms, is at the heart of delivering our vision, and is at the heart of our statutory role as outlined in the Care Act

b) Be strong partners for integrated working to support a good life in communities – working with partners, sharing information, joining up services will help us avoid duplication and plan health and social care so it is organised around how individuals want to live their lives, not around organisational structures

c) Increased focus on quality and safeguarding – during a period of change, the need to be relentless on quality and safeguarding becomes even more important

d) Strong financial and performance accountability – the council has prioritised spending on adult social care and made some tough decisions to ensure that we are on a sound financial footing. There must be a continuous focus on efficiency, driving out waste and unnecessary cost, and ensuring every pound invested represents the best possible value

4. Improved Better Care Fund and NCC Budget Planning

4.1 The additional funding is one-off and is being provided as a bridge to the recurrent improved Better Care Fund. Both funding sources will be received directly from DCLG. The table below shows the profile of the one-off additional funding and the improved Better Care Fund. The improved better care fund has been shown within the medium term financial plan agreed by County Council. The funding for 2017-18 was built into funding sources.

4.2

£Ms	New funding iBCF as per 2017 Spring Budget (one-off)	iBCF as per 2015 Spending Review (recurrent)	Total	Additional/Reduction in funding year on year
2017/18	18.561	1.885	20.446	20.446
2018/19	11.901	15.828	27.729	7.283
2019/20	5.903	28.372	34.275	6.546
2020/21		28.372	28.372	(5.903)

5. Norfolk Priority Proposals

5.1 Priority areas for Norfolk are summarised thus:

a) Protection of social care – maintaining social care services
b) Sustain social care – focus on the market and securing supply and workforce
c) Invest and improve social care – support health functions in discharging their duties including work with CCGs and providers to meet National Condition 4

5.2 While the additional funding will need to be pooled within the BCF and principles agreed as part of the overall plan, investment of this element of the fund will be agreed by NCC Adult Social care Committee. Detailed description of the proposals is contained within Appendix 1.

5.3 These priority areas complement and support the key PI themes and are focused on supporting the shared objectives of health and social care partners, combining an enhanced prevention offer, with direct support to NHS systems to support discharge from hospitals.

5.4 Grant conditions note that NCC, together with health partners, will need to meet National Condition 4 of the BCF (Managing Transfers of Care) and key to managing transfers of care is the implementation of the High Impact Change Model (HICM). This offers a practical approach to supporting health and social care systems to manage patient flow and discharge and can also be used to self assess how health and social care systems are working now.

5.5 The national condition applies to both councils and CCGs, and both are expected to agree how the model's implementation will be funded. The model requires active management and funding of discharge pathways by CCGs, Acutes and social care; the impact on delayed discharge figures will be contingent on this. Strong partnership and co-operation will be needed to ensure a joined up a consistent approach.

5.6 S151 Officers will need to confirm that funding provided through the improved BCF is spent in additional to existing plans for spending in 17/18.

5.7 DCLG will monitor the impact of the grant on local care services and delayed hospital transfer (DTOC) figures through a comprehensive narrative required quarterly. The focus of the return is on care provision that supports effective discharge and flow through the system as a whole in addition to monitoring capacity and resilience of the market overall.

5.8 The impact of the additional spend will need to be swiftly felt in 17/18 and high level agreement of principles will facilitate detailed proposals to be developed and implemented. For clarity, and in order to support CCGs to manage and plan flow, funding has nominally been allocated across the three acute systems (Appendix 1). This indicates how resources will be allocated to support the health system although in practice there will need to be flexibility to direct resources where problems with delayed transfers and social care capacity are most intense.

5.9 **Protection of social care**

5.9.1 This area covers medium term risk to the social care budget and the consequent impact on services arising from:

a) The end of the three year protection of social care Section 75 in 2019/20 (BCF)
b) Enabling some future protection of social care through mitigating the need for additional reductions arising from the identified budget shortfall for future years. 2017-18 budget

5.9.2 Sustaining the care market is key to the sustainability of the system overall as additional cost pressures would otherwise need to be met through reductions in social care provision.

5.10 **Sustain Social Care**

5.10.1 Social care is under pressure to continue to meet the care and support needs of the population and as part of this task NCC is required to ensure the market for social care is managed to be sustainable and effective.

5.10.2 Much of NCC spending is in market based services such as homecare and care homes and the additional short term funding will be used to help support increases in costs, sustain services and ensure that capacity within social work teams is sufficient to meet demand. These areas are crucial in ensuring that the health service is able to manage its demand effectively and supports the close partnership between health and social care necessary to ensure overall system sustainability.

5.10.3 In practice much of this spend will have a recurrent cost pressure, which will need to be a first call on the improved better care fund in future years

5.10.4 Key areas for the Norfolk system are:

a) Working with homecare and care home markets to ensure sustainable care provision and managing potential market failures which presents risk to individuals but also the system overall. Funding here will support integrity of the care market.
b) Responding to additional contractual cost pressures arising from national living wage (NLW). NLW while supporting recruitment into the care sector places a direct pressure on providers. NCC needs to support the sector in managing these pressures and ensuring that provision is sustainable.
c) Care pressures – direct support to secure increased capacity in the home support market in areas where there is unmet need, which can reduce options for individuals and delay discharges from hospital. The principle which supports managing needs within the community rather than in formal care settings increases demands on the market based offer and resources will be focused on strengthening this
d) Managing capacity within social work teams to enable timely assessment and assist people at discharge and to prevent admissions. Strengthening social work is one of the key strands of prevention of admissions to both hospitals and care homes. Additional capacity here will also support the development of a more dynamic response to hospital teams with resources directed at areas of pressure. Further detail on cost and capacity is contained in Appendix 2. The expectation is that this investment would help achieve additional savings and would need to be self-financing by 2019-20

6. Invest and Improve

6.1 Additional one-off funding offers the opportunity to implement demand management initiatives that will support ensuring people are safely and quickly discharged from hospital when they are medically fit to do so. These initiatives will ensure that Condition 4 – 'managing transfers of care are met' and the principles of the HICM, including a Discharge to Assess model, are explored and implemented.

6.2 Initiatives will require full collaboration of the Acutes and CCGs in order to ensure that system flow is consistently improved across the health and social care landscape. Joining up of pathways in and out of hospital is essential for any new initiatives to have real and sustained impact.

6.3 Analysis of delayed transfers of care (Dtoc) for each of the Acutes and Norfolk and Suffolk Foundation Trust (NSFT) hospitals will support identification of the most effective intervention for each part of the system.

6.4 Priorities, which will need to be on an invest to save basis include:

a) Expansion of prevention schemes and community/care navigation schemes including social prescribing (SP). Evidence shows that SP can have a significant impact on reducing demand on hospitals and work with District Councils and Public Health will explore how these initiatives can be linked to work closely with the provision of disabled facility grants and information and advice sources. In order to impact change across Norfolk it is anticipated that external finance will need to be secured and funding opportunities are being explored
b) The HICM will require Acutes and CCGs to commit to work collaboratively in order to apply best practice to facilitate hospital discharges. Co-production of a trusted assessor model with providers will ensure that each Acute is able to discharge people safely and efficiently back to care homes. Further work with Acute and health partners to establish a consistent and robust approach to shared assessments is underway

c) Bed based reablement and active assessment beds– the 'homefirst' model describes a system that helps promote independence for older people and at the same time relieves pressure on health services. Bed based reablement facilities will be scoped to serve appropriate discharge from Acutes; these facilities would work in conjunction with active assessment beds and CCG 'supported care' initiatives and, combined, will support the process of swift and safe discharges
d) Wrap around home care – supporting the development of 'supported care models' it is proposed to develop an enhanced level of homecare that will wrap around people on discharge to ensure needs are met expertly and the 'homefirst' model is resourced effectively
e) Additional provision is being scoped to support discharges from mental health hospitals and support to carers. Funding is proposed to enhance existing initiatives on the basis of invest to save

7. Financial Implications

7.1 The additional social care funding has been factored into the medium term financial plan and supports the protection of social care over the next three years, this in turn supports the health system to manage pressures.

7.2 Many of the initiatives under the Invest and Improve priority are on an invest to save basis. A full assessment of their impact on the whole Health and Social Care system will need to be made before considering:

a) Whether the scheme is to continue as per the initial investment.
b) Whether the scheme needs to evolve
c) Whether the scheme needs to stop
d) If a) and b) how and where the system intends to sustainably fund on a longer term basis.

8. Issues, Risk and Innovation

8.1 The risks in the adults' risk register are all pertinent to the delivery of the improved performance required from the additional social care funding. The funding is specifically focused on addressing key areas of pressure within the system and the combination of protection of social care and innovation in terms of investment in new mechanisms will need to be demonstrated in the performance of the system as whole, both in terms of delayed transfers of care, but also in enhanced capacity and sustainability within the care market.

8.2 Close monitoring of performance is already undertaken and this will support the flexing of resources to ensure that maximum impact is felt from the additional funding. Sustained improvements in performance will require the close collaboration and joint working of Acutes, CCGs, NSFT and ASC.

9. Summary

9.1 The government has made clear that part of the one-off additional social care grant is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities are therefore able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans for spending the grant have been locally agreed with CCGs involved in agreeing the Better Care Fund plan."

9.2 The additional social care grant is short term and there is a strong focus on the proposed commitments in 17/18. However, where necessarily expenditure would give rise to an ongoing commitment, this is stated as recurrent in Appendix 1. In practice these commitments will be a first call on the recurrent iBCF in future years. All short term investments will need to demonstrate how demand for services is shifted and pathways improved as a result. This is key to ensuring that improvements in flow and customer experience are maintained as funding subsequently reduces.

9.3 The proposed investment of additional social care funding will support the health and social care system in Norfolk, managing existing and new pressures and implementing the HICM as required by the DCLG grant conditions. The use of the funding reflects the priorities identified within the Promoting Independence strategy and builds on the overarching priorities of the service; strengthening social work, being good partners for integration and improving the quality of services. By working with our health partners the additional spend will have a positive impact on delayed transfers of care and increase capacity to support people in their homes. The impact of the additional spend will also strengthen the plans to achieve over £50m in savings and efficiencies by 2020.

Officer Contact

If you have any questions about matters contained in this paper or want to see copies of any assessments, e.g. equality impact assessment, please get in touch with:

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

Table 1 – Summary of proposed areas

Planning priority	Grant Condition	Description	2017/18 £m	2018/19 £m	2019/20 £m	Impact
Protect	Meeting Social Care Needs	Funding required to manage shortfall in recurrent pressures and protect social care services	1.9	11.9	22.2	Over the three year period this funding will ensure that vital service provision such as homecare is maintained and people are supported to maintain their independence and stay out of hospital
Sustain	Reduce pressure on the NHS and stabilise Social Care provider market	Support the care market and develop resilience against the impact of specific recurrent market pressures	9.3	11.0	11.0	Recent legislation on NMW and the cost of care presents additional pressures to the care sector that require supporting if provision to remain sustainable. Market failure presents a risk to individuals but also the system overall funding here will support integrity of the care market
	Meeting Social Care Needs	Managing recurrent capacity with DOLs when alternative funding finishes	0.0	0.2	0.2	
	Reduce pressure on the NHS and meet social care need	Managing capacity – strengthen social work to assist people at discharge and to prevent admissions	2.6	2.5	0.0	Social work is core to ensuring people's needs are met quickly and effectively. Supporting capacity of social work will strengthen the prevention offer, ensure people receive support that meets their needs and is fundamental to ensuring that people are able to leave formal care settings as soon as they are medically fit. Resources here will

Planning priority	Grant Condition	Description	2017/18 £m	2018/19 £m	2019/20 £m	Impact
						enable services to be flexed according to pressure within the system. Investing in social work will reduce pressures on the NHS and supports the PI agenda. The invest to save element here will be realised through better management of needs and management of flow through the system. **Note**: of the £2.6m in 2017/18, £1m will need to be carried forward into 2018/19 to reflect recruitment timescales, therefore £3.5m will be spent in 2018/19. For 2019/20 it is the intention for the investment to remain at 2018/19 levels (£3.5m) but the additional capacity should be self-financing through savings delivered in the Purchase of Care budget.
Invest and Improve	Reduce pressure on the NHS	Expansion of prevention schemes – social prescribing and community/care navigation schemes – Invest to save	0.7	0.7	0.0	Social prescribing has been evidenced to divert demand from formal care services, especially hospitals. Combined with an offer that builds on community resilience and capacity this initiative is designed to support demand management initiatives and enhance community ability to respond to need
		Respond to care pressures – micro commissioning invest to save pilot	0.1	0.0	-0.1	Homecare is a key service in ensuring people can stay out of hospital and be discharged quickly when they are medically fit. Micro commissioning initiatives have been shown to have a positive impact on homecare capacity in similar rural areas. Increased capacity in the system is designed to be sustainable

Planning priority	Grant Condition	Description	2017/18 £m	2018/19 £m	2019/20 £m	Impact
						without additional funding after the first two years
		Managing transfers of care – Trusted assessor	0.2	0.2	0.2	Managing transfers of care and implementing the HICM requires a number of joint initiatives between social care and health partners. Key elements of the pathway are trusted assessor and discharge to assess. The implementation of these will be supported by an enhanced, wrap around, home care offer and additional capacity in reablement beds – these initiatives will support the reduction of delayed transfers of care and provide a better quality of care for people in this pathway Many of these initiatives are to be run as pilots to evaluate outcomes and put in place sustainable funding based on the part of the system where benefits accrue. There may be a requirement to c/fwd an element of the 2017/18 funding depending on the progress and timing of implementing each pilot.
		Managing transfers of care – through invest to save programme for example discharge to assess; home support wrap around service; accommodation based reablement and active assessment beds	5.1	0.5	0.2	
		Enhanced community offer for carers - 3 year invest to save pilot	0.1	0.1	0.1	Carers are key to supporting people to stay safe and independent. Additional funding here will work alongside newly commissioned carers service to ensure that carers are fully supported to have a good quality of life
		Enhanced flexible dementia offer - 3 year invest to save pilot	0.2	0.2	0.2	Providing support that enables people with dementia to stay in their own homes is a priority for both health and social care. This

Planning priority	Grant Condition	Description	2017/18	2018/19	2019/20	Impact
			£m	£m	£m	
						funding will enhance the existing offer and allow innovations in service to be implemented and tested for success. This service will support people with dementia to be discharged safely from formal care settings.
		Reduce DTOC mental health services	0.2	0.2	0.2	Providing sufficient support when people with mental health problems leave formal care services is crucial in ensuring people can settle and establish their independence. We are working with mental health colleagues to formulate the most effective mechanisms that will support discharge from hospitals and formal care settings.
Total			**20.4**	**27.5**	**34.2**	
Funded by:	iBCF as per 2017 Spring Budget		-18.6	-11.9	-5.9	
	iBCF as per 2015 Spending Review		-1.9	-15.8	-28.4	
	Total		**-20.4**	**-27.7**	**-34.3**	
Balance			0.0	-0.2	-0.1	

Table 2 Additional Social Care Funding – Investment, Protection and Sustaining Social Care – by Acute system (population basis)

System	2017/18	2018/19	2019/20
Eastern (GY&W CCG)	2.3	3.1	3.8
Central (North, South and Norwich CCGs)	14.1	19.0	23.7
West (West CCG)	4.0	5.4	6.7
	20.4	**27.5**	**34.2**

Report title:	**Joint Health and Wellbeing Strategy for Norfolk 2014-2017 Final Evaluation Report**
Date of meeting:	**12 July 2017**
Sponsor:	**Dr Louise Smith, Director of Public Health**

Reason for the Report

It has been three years since the Board agreed the Joint Health and Wellbeing Strategy 2014-17. The Board is asked to receive, discuss and agree this evaluation report of the highlights, achievements and impact of this strategy as it comes to an end and to endorse the lessons learnt that will inform the newly developing strategy for Norfolk.

Report summary

This final evaluation report for the Health and Wellbeing Strategy 2014-17 outlines how the Board selected the priorities to focus on and what the Board set out to achieve in this first 3 year strategy. Examples have been included to illustrate some of the activity undertaken by partners and the outcomes and impact are listed through indicators in the Norfolk Health and Wellbeing Profile 2017 (Appendix 1). Lessons learnt will be taken forward into the development of the new Health and Wellbeing Strategy for Norfolk.

Action/decisions needed:

The Health & Wellbeing Board is asked to:

- Receive the final evaluation report
- Endorse the lessons learnt

1. Background

1.1 The Board agreed the Norfolk Health and Wellbeing Strategy in July 2014. Regular update reports have advised the Board of progress with a technical report demonstrating impact on outcome measures being received at each July Board meeting. This enabled the HWB to ensure the strategy was on track and to agree any further actions required by partners.

1.2 This final evaluation report summarises some of what has happened over the three year life of the strategy and identifies lessons learnt to take forward in the development of the new Health and Wellbeing Strategy for Norfolk. The following documents are attached:

- Norfolk Health and Wellbeing Profile 2017 – a summary progress over the last three years (Appendix 1)
- Final Evaluation Report (Appendix 2)
- Progress against 40 activity themes (Appendix 3)

2. Summary

2.1 Overall people in Norfolk are healthier and are living longer. Looking more closely at our priority areas:

- We are seeing signs of improvement in school readiness however, children's social and emotional wellbeing continues to be a concern with the numbers of children living in poverty increasing in recent years.
- Childhood obesity is also starting to show some signs of improvement whereas obesity, in adults, is increasing in line with national trends.
- Diagnosis rates for dementia have improved year on year, identifying the numbers of cases we expect to have in Norfolk. However, dementia will continue to become more common as our population ages and we are already seeing more dementia related deaths in Norfolk reflecting the national trend.
- The biggest inequalities gaps are in our mental health outcomes. The numbers of people being diagnosed with mental health conditions are increasing at a greater rate in Norfolk than the national trends. Self-harm emergency admissions and deaths by suicide are higher than the national average.
- We are also seeing increases in measures of community safety, including violence, accidents, and suicides.

2.2 Where we have seen improvements, these have been in activities that link to core priorities for key parts of the system within the membership of the Board. An example of this is school readiness where there has been cross departmental working with Public Health, Children Services, and Education.

2.3 It must be acknowledged that the complex nature and inter relationship of issues plays a significant part in the extent to which impact can be made on outcomes.

Lessons learnt that we can take forward to a new strategy for Norfolk

2.4 **What has worked well locally?**

- There is some evidence that the strategy was instrumental in streamlining how partners worked together to achieve better outcomes, particularly around dementia. However this did not apply to all the priorities and there was a variable response in reflecting these priorities in other HWB partners' strategies across the county.

- Critical appraisal of progress made over the last three years has shown that some progress has been made, as demonstrated in looking at the full data set of health and wellbeing metrics e.g. School readiness at age 5 and early deaths from circulatory disease (heart disease and stroke). This now becomes a 'touchstone' for the future.

2.5 **What has worked less well locally?**

- The 3 initial strategic priorities, although based on findings from the JSNA, were still largely selected on a life course model (early years, obesity in middle years and dementia, generally in later life), rather than focussing on the biggest issues for the county.

- There is a question as to whether the indicators used to demonstrate progress would have improved over the last three years anyway and, with some data lag, we cannot yet fully understand what the impact has been.
- As strategy coordinator resource had been dedicated from the NCC Public Health budget to support the Board Priority Champions, this led to the effect of strategy implementation and delivery not being fully owned by the wider health and wellbeing system
- Despite the agreed priorities and goals of the strategy, there is little evidence that the day to day work of Board partners changed to any significant extent to make a greater system wide impact.

2.6 We know from research evidence from the past few years that an effective Health and Wellbeing Strategy should include a number of key features.

2.7 Key features of this **national good practice** and how this applies to Norfolk:

- Having a **'Place Focus'**, addressing place issues – i.e. resilience, skills and employment or children rather than condition specific issues such as obesity or dementia. Taking forward the strategic themes of prevention, integration and inequalities will ensure the new strategy continues this focus to greatest effect. Supporting this will be the implementation of the LGA's guidance, 'Health in All Policies'.

- **Genuine systems leadership** – this is essential to a successful delivery of any partnership strategy. Chairs and Vice chairs of the Board are from local government and Health with membership also including voluntary and community sector and other county wide partners with the Chief Officer to the Board as the Director of Public Health. This all means that the Board is set up to deliver a successful strategy. Norfolk has a strong history of partnership working and this will continue into the newly developing health and wellbeing strategy.

- The Board as both a hub, bringing leaders together and a fulcrum, where things happen. The Board has ensured that the **time between meetings has been used effectively**. The Strategy Implementation Group together with the Board Priority Champions has monitored the Strategy making sure it is on track, on behalf of the Board. Updates on progress have been pulled together to provide the Board with information and the annual technical report demonstrating the impact on outcome measures and the selected indicators. This has been of mixed success and there have been difficulties in securing broader leadership for and identifying resources for special projects in some of the priority areas, as these may have been seen as delegated to a separate sub group. Consideration should be made to whether there is a more effective way to do this in the future.

- Collaborative 'plumbing' **– how we work together** in a challenging geography with variation in needs over a period of austerity and change. The Board has been able to regularly assess whether the Health and Wellbeing Strategy was on track which led to the fourth priority of Mental Health being selected. The Mental Health Strategic Framework agreed by the Board in July 2016 will be taken forward as a key and continuing important issue in the new strategy – perhaps a year of mental health?

2.8 It is a proposed for the HWB's next strategy to hold an umbrella across the whole health and wellbeing system - to jointly produce a strategy that reflects everyone's priorities, not create a separate, additional list distinct from core strategic plans.

2.9 It is anticipated that the health and wellbeing system will continue to experience rapid change in the coming years and the next strategy will need to evolve to move with the pace.

2.10 The development and agreement of the Board's next Joint Health and Wellbeing Strategy will benefit from the involvement of key NHS providers, who now join the Board, and who will help in identifying how to implement priorities going forward.

Officer Contact

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

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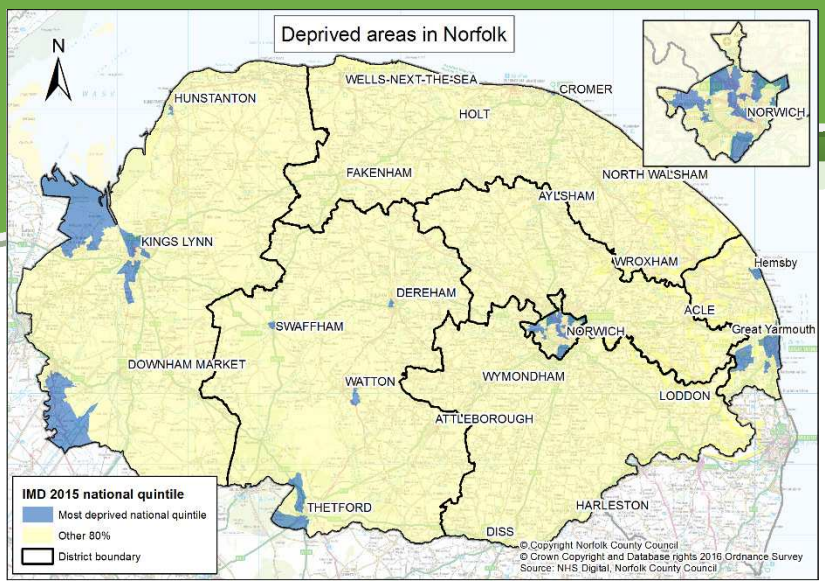
IN TRAN communication for all

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

Norfolk Health and Wellbeing Profile 2017 Appendix 1



This profile gives a broad picture of the key Health and Wellbeing issues for Norfolk and shows how these compare to England. It is a snapshot in time using the latest available data. For more information go to Norfolk Insight **www.norfolkinsight.org.uk**

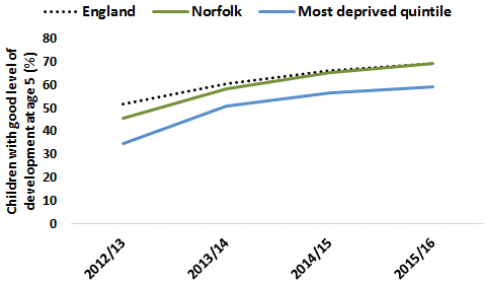
If you have any queries about this profile or its data, please email insight@norfolk.gov.uk.

Population 885,000

2015 mid-year estimate | Source: Office for National Statistics

Social and emotional wellbeing of preschool children

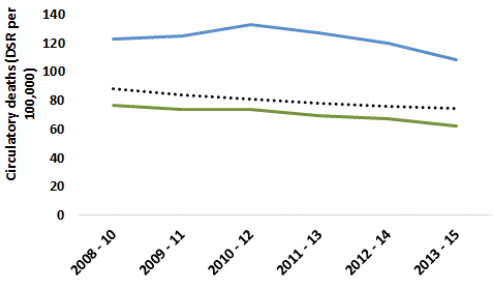
69% of five year olds have a good level of development



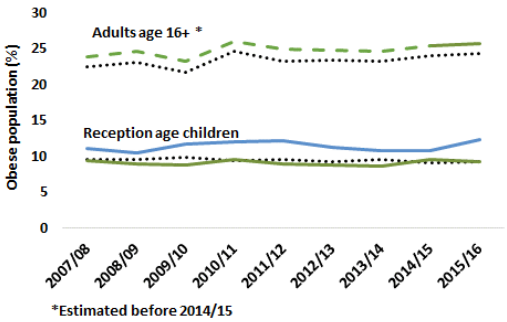
School readiness in Norfolk has previously been poor, but this has improved and is now similar to England.

Preventing obesity

541 people die early each year of circulatory conditions including heart disease and stroke



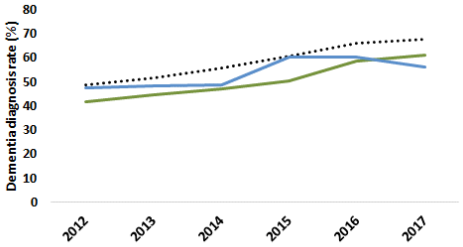
Deaths from cardiovascular diseases have reduced over time …



…but obesity is increasing in adults with more than a quarter in Norfolk now obese.

Dementia

8,517 of 13,927 (61%) estimated dementia cases are diagnosed



Dementia diagnosis has improved and as a result more people are able to access the care and support they need. There are now more dementia related deaths in Norfolk which reflects the national trend.

Health & Wellbeing summary

The summary set of indicators show that there has been improvement in some outcomes but for others there is some way to go.

While many of the key measures show **children** in Norfolk do as well and better than children in England as a whole, there is still much to do. The percentage of children in reception year with excess weight is significantly worse than England but has improved for children in year 6. Emergency admissions for children in Norfolk are also significantly worse than England particularly for injury and poisonings.

Improvements have already been seen during the strategy period and school readiness is now in line with the England average. 69.3% of children achieved a good level of development at the end of reception in 2015/16, an increase of 643 compared to the previous year.

More than a quarter of Norfolk **adults** are **obese**. This is higher than the national average and is contributing to a 'new norm' in the public perception of weight. This is likely to be contributing to the increased numbers with diabetes and other cardiovascular conditions not listed in the profile such as high blood pressure.

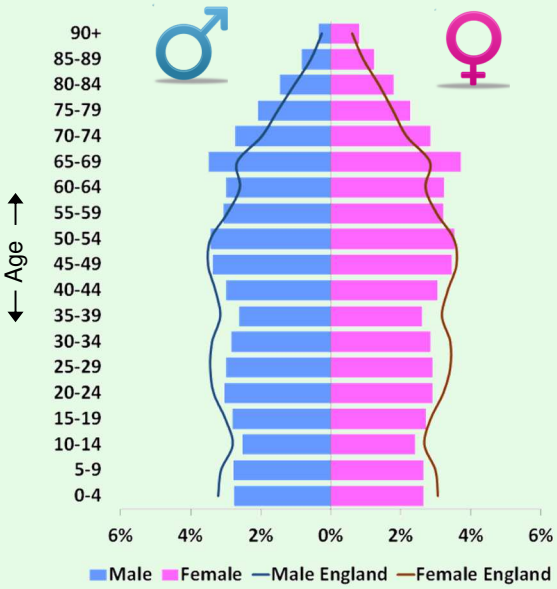
Deaths from cardiovascular diseases have reduced by an average of 20 deaths per year in Norfolk. With improved treatments and reduced smoking prevalence, people are living longer with cardiovascular conditions. However, if the prevalence of obesity continues to increase it is likely that in the future there will be increased numbers of deaths from cardiovascular diseases.

There are 8,517 people with a recorded **dementia** diagnosis which indicates 61% of the expected prevalence for Norfolk. Dementia diagnosis has increased compared with 50% of expected in 2014, which means that nearly 900 extra people have been identified in Norfolk and are now able to receive appropriate care and support.

Some **Mental Health** outcomes in Norfolk are poorer when compared to England. For example, suicide rates are significantly higher with an average of 97 deaths in Norfolk each year, emergency admissions for self harm are significantly higher and it is estimated that there are 81,600 people in Norfolk with common mental health illness.

Population – 2015

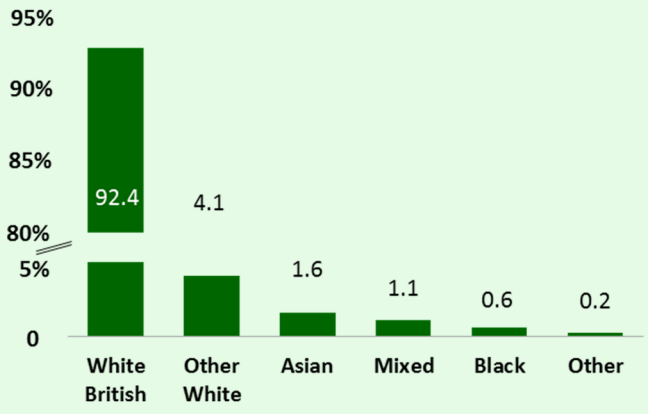
Percentage of resident population by five year age groups 2015 compared with England



Age Structure

The estimates for mid-2015 show that Norfolk's population has an older age profile than England. 24% of Norfolk's population are aged 65 and over compared to 18% in England as a whole. For more demographic information see http://www.norfolkinsight.org.uk/jsna/population

Percentage of resident population by ethnic group



Health & Wellbeing summary

The chart below shows how the health of people in Norfolk compares with the rest of England. Norfolk's result for each indicator is shown as a circle. The rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in Norfolk is shown as a grey bar. A red circle means that Norfolk is significantly worse than England for that indicator; however, a green circle may still indicate an important health problem.

- **Significantly worse than England average**
- **Not significantly different from England average**
- **Significantly better than England average**
- **No significance calculated**

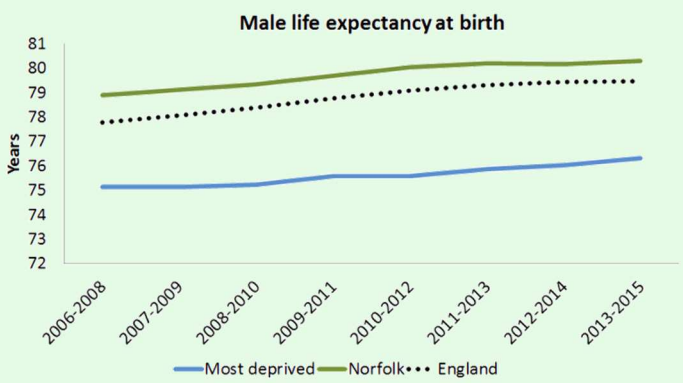
		Profile for Norfolk	Local number per year	County Value	England Average	Norfolk Worst	Norfolk Range	Norfolk Best	Trend Start	Trend	Trend Finish	Change over three years
Our community	1	Life expectancy at birth for males	4,608	80.2	79.5	73.9		84.3	79.2		80.2	↑
	2	Life expectancy at birth for females	4,851	83.6	83.1	79.2		88.8	83.1		83.6	-
	3	Income Deprivation 2015	117,349	13.3	14.6	37.1		5.4	13.2		13.3	↑
	4	General Health - bad or very bad	48,233	5.6	5.5	8.9		2.5				-
	5	Teenage conceptions	295	21.3	20.8	97.2		14.2	33.3		21.3	↓
	6	Provision of 50 hours or more unpaid care per week	23,207	2.7	2.4	4.5		0.8				-
	7	Anti-social behaviour incidents	20,910	23.6	n/a	168.9		7.6	49.3		23.6	↓
	8	Domestic Abuse	15,760	21.4	n/a	81.4		7.7				-
	9	Violence against the person	16,414	18.5	n/a	78.9		5.8	11.0		18.5	↑
Early years	10	Child Poverty	25,510	17.9	20.1	40.7		6.3	19.1		17.9	↑
	11	School Readiness	6,585	69.3	69.3	44.8		83.5	45.6		69.3	↑
	12	Admissions for injuries in under 5s	733	153.0	136.0	250.4		47.7	144.3		153.0	↑
	13	Emergency admissions in under 5s	8,374	174.8	150.3	312.5		98.9	144.6		174.8	↑
	14	A&E attendances in under 5s	16,307	340.4	587.9	713.9		222.0	304.6		340.4	↑
	15	Breastfeeding	4,441	50.1	43.2	37.1		52.4	43.0		50.1	-
	16	Obese Children (Reception Year)	847	9.3	9.3	15.8		4.7	9.6		9.3	↑
	17	Children with excess weight (Reception Year)	2,100	23.1	22.1	32.2		14.6	23.0		23.1	↑
	18	Obese children (Year 6)	1,427	18.0	19.8	26.3		6.5	18.5		18.0	-
	19	Children with excess weight (Year 6)	2,541	32.1	34.2	44.4		12.6	33.2		32.1	-
Obesity	20	Early deaths from circulatory conditions	541	62.3	74.6	149.7		21.8	76.4		62.2	↓
	21	Obese adults	197,729	25.7	24.4	31.7		10.7	25.1		25.7	↑
	22	Healthy eating adults	194,439	26.9	26.4	18.6		34.9	57.4		59.8	-
	23	People diagnosed with diabetes	49,749	6.7	6.5	9.9		2.3	5.7		6.7	↑
Dementia	24	Deaths from dementia and alzheimer's disease	1,073	99.4	102.2	294.0		21.4	60.1		99.4	↑
	25	Estimated diagnosis rate for people with dementia	8,517	61.2	67.6	36.2		129.9	41.7		61.2	↑
Mental health	26	Self harm emergency admissions	1,898	225.0	196.5	877.1		76.5	189.4		225.0	↑
	27	Suicide	97	12.4	10.1	48.0		3.5	9.2		12.4	↑
	28	Social isolation*	n/a	47.5	45.4	n/a		n/a	37.9		47.5	↓

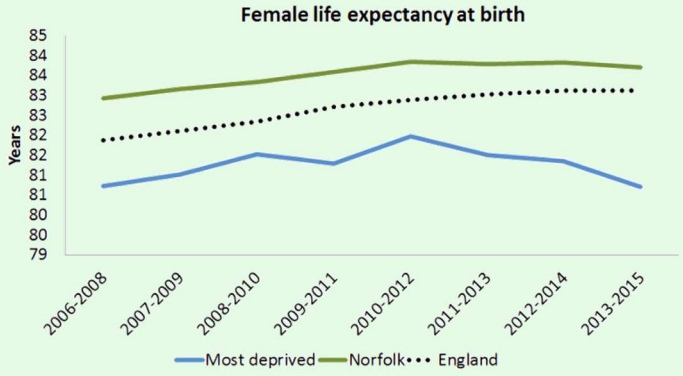
* Norfolk range has been replaced by the range for local authorities in the East of England

Follow this link for indicator notes: https://tinyurl.com/y8w94evt

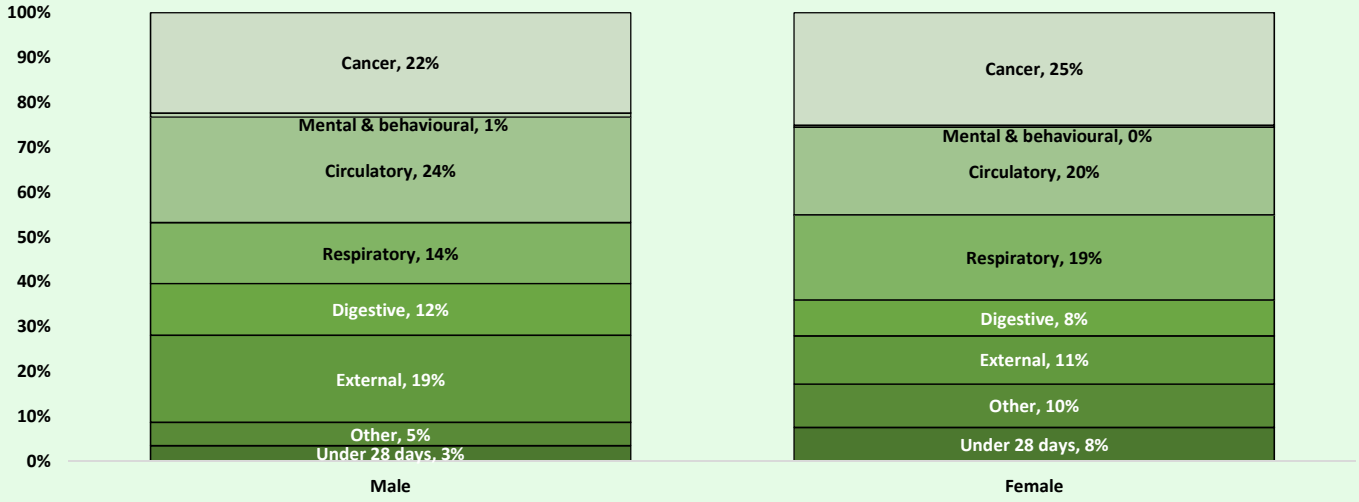
Inequalities

For males, although life expectancy is increasing steadily both for Norfolk as a whole and for those in the most deprived areas, the gap has remained about the same. However, for females in the most deprived areas in Norfolk life expectancy is decreasing and the gap between the most deprived and the rest of Norfolk has increased. This is similar to England but is more pronounced in Norfolk. For both males and females deaths from circulatory conditions and cancer contribute most to the difference in life expectancy between most deprived and the rest of Norfolk.





Reasons for life expectancy gap between most deprived quintile and least deprived quintile in Norfolk 2013-15



More information

Key information links

There is more information available to inform you on Health and Wellbeing issues in your area.

Public Health England publish a range of nationally produced profiles including:

- Local Authority Health Profiles
- General Practice Profiles
- Child Health Profiles
- Injury Profiles
- Community Mental Health Profiles

fingertips.phe.org.uk

Norfolk County Council also produce information on related issues, which include:

- 2011 Census information and analysis www.norfolkinsight.org.uk/census
- JSNA profiles and information www.norfolkinsight.org.uk/jsna
- Health and Wellbeing Strategy and information www.norfolk.gov.uk/hwbstrategy

Appendix 2

Joint Health and Wellbeing Strategy for Norfolk 2014-2017

Final Evaluation Report

What the Board set out to achieve

In the development of the first 3 year Joint Health and Wellbeing Strategy for Norfolk, the Board selected priorities based on recommendations in the Norfolk Joint Strategic Needs Assessment. The Board decided it wanted to focus on issues where the maximum impact can only be achieved by working together and by using practical action to bring about sustainable change.

Priorities chosen, also based on a life stage approach, were:

- Promoting the social and emotional wellbeing of pre-school children
- Preventing obesity (both primary and secondary prevention)
- Making Norfolk a better place for people with dementia and their carers

Activity in each of the priorities had to meet the cross-cutting longer term goals or themes of:

- **Prevention** – providing help and support at an earlier stage before problems become acute
- **Reducing inequalities** in health and wellbeing by narrowing the gap in life expectancy between the most and least deprived in Norfolk

And the best way of addressing these goals was through:

- **Integration** – partners working together to provide effective, joined up services

<u>Promoting the social and emotional wellbeing of pre-school children</u>

The first years of a child's life are a key influence on their future health, school performance and ultimate employability. Poor social and emotional skills increase the likelihood of anti-social behaviour and mental health problems, substance misuse, teenage pregnancy, poor educational attainment and involvement in criminal activity.

Norfolk was performing significantly worse than the national average for many of the indicators relating to young people. Several outcome measures also indicated a national deterioration and Norfolk was following this trend, including:

- School readiness at age 5
- Admissions for injuries in under 5s
- Emergency admissions in under 5s
- Breastfeeding initiation and at 6 weeks
- Obesity and overweight in children (4-5 and 10-11 year olds)

All of these factors were relatively worse in Norfolk's most deprived areas.

Preventing obesity (both primary and secondary prevention)

Adult obesity rates in Norfolk were similar to the national average. Excess weight in children aged 4-5 and 10-11 was also similar to the national rates but higher than the East of England average.

Evidence shows that obesity is a common risk factor for diabetes, other metabolic diseases, heart disease, stroke, liver disease, many cancers, injuries, arthritis, and depression – causing death and disability, and posing a huge burden to health and social care services.

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

The prevalence of dementia is rising nationally. Dementia is principally a disease of older people and Norfolk has a higher proportion of people over 65 than the England average.

It was estimated that nearly two thirds of people with dementia in Norfolk had not had a formal diagnosis of their condition and that over the next ten years the number of people with dementia in Norfolk would increase by about 5,000.

The Board agreed **40 high level activity areas** to best focus work programmes across partner organisations. These were evidence based, drawn from national health and social care policy and recognised existing key local strategic plans underway in Norfolk.

The Board also made a commitment to **mental health** as a golden thread running through the original strategy and brought this forward as a 4th priority in 2016.

What has been achieved over the life of the Health and Wellbeing Strategy?

The Board has received regular updates giving both qualitative examples of actions underway and an annual technical report, The Norfolk Health and Wellbeing Profile, to demonstrate impact on selected measures and to make sure the strategy was on track.

Highlights from these update reports include:

Prevention

The Healthy Child Programme started in October 2015. Maternal mental health, breastfeeding, attachment and child healthy weight management are being addressed.

Smoking cessation interventions including 'Take 7 Steps Out', aiming to reduce children's exposure to second hand smoke and encourage parents to have smoke free homes.

NCC Road Casualty Reduction Team continues to lead on new cycling infrastructure projects promoting active travel and encouraging walk/cycle to school/work schemes

Norfolk CCGs have come together to develop the commissioning intentions to support unpaid carers. Carer UK Norfolk and incentives through Community Development and Innovation Plans are encouraging innovation in ways to care for carers.

Reducing inequalities

The Dementia Friendly Norfolk website, designed in co-production with carers, has been a successful source of information and signposting to services since 2015.

The 'Joy of Food' cooking skills programme has completed around 400 courses over the life of the strategy targeting vulnerable people across Norfolk and more recently Suffolk. A recent partnership with Norfolk Community Learning Services has introduced literacy and numeracy skills into the intervention, which is delivered by volunteers.

'Healthy Norwich' has been tackling inequalities through social prescribing and holiday hunger interventions addressing priorities in promoting heathy weight and lifestyles, smoking cessation and prevention and affordable warmth.

Integration

The CAMHS Strategy 2015-17 has delivered universal, targeted and specialist provision by joint strategic planning and commissioning. Outcome focused actions have included a rolling programme of competency based training, improving pathways to and from CAMH services including monitoring waiting times and initial assessments, PIMHS issues being addressed through the Point 1 service, developing communications for better understanding to help address mental health stigma, Promoting Alternative Thinking Strategies (PATHS) in schools and routine outcome monitoring across contracted services.

The Dementia Strategy Implementation Board (DSIB) has led task and finish groups to produce a dementia information pack and reducing risks linked to medication leaflet, has developed Life Story Work tools and a Dementia Friendly Employers resource pack as part of a full work programme.

The DSIB is exploring how best to be involved with the newly forming Dementia Academy (in partnership with UEA and NSFT). Focus for the Dementia Academy will initially be working on training issues and methods of education as they prepare to launch and this will enable Dementia to continue to be a high profile priority for Norfolk.

Mental Health Strategic Framework

A multiagency workshop, facilitated by The Centre for Mental Health, developed a mental health strategic framework, which was agreed by the Board in April 2016.

4 strategic aims were identified:

- **To reduce stigma** – i.e. increasing public awareness, reduction in discrimination, reduction in crisis management and ways for people to seek help earlier.
- **Make mental health everyone's business** – i.e. professionals confident in their responses to potentially suicidal individuals, agencies better able to support employees to stay in work and earlier interventions to avoid crisis.
- **Improve access to self-help resources and early help** – i.e. promote consistent messages on early help and prevention, better local digital offer, ways for contact with agencies to be earlier than crisis point, resources that are visible
- **Commission better pathways into and through services** – i.e. work with existing partnerships to improve pathways, align services and integrate responses where appropriate.

Examples of the work that has been undertaken over the last year includes:

'In Good Company' – Combatting loneliness has been a successful campaign across Norfolk with pledges being made. This is still ongoing and there is an ambition to have a quality mark to recognise businesses, communities, voluntary and statutory organisations that run services or events for lonely people, or which support their work.

Suicide Prevention campaigning – two targeted multi-agency networks have been set up, one for Farming and one for Men's wellbeing. Both are planning on sustained, consistent campaigns for high risk groups. These networks are voluntary sector led and will be embedded in the communities they serve.

Norfolk libraries in partnership with CCGs have rolled out 'Mind ed in schools' – an intervention where school nurses are signposting schools, other stakeholders and parents to MindEd resources.

The Mental Health Crisis Care Concordat is implementing a local action plan through the Mental Health Strategic Network.

Actions through to 2020 have been identified and an implementation plan is in place.

Assessing how much progress has been made across the full Health and Wellbeing strategy can be seen in the other appendices.

Norfolk Health and Wellbeing Strategy

Strategy Progress Final Report July 2017

Red = Barriers to progress – action from the board required
Amber = Some progress achieved– more to be done
Green = Progress is being made

	Strategic Intention	Performance
	Social and emotional wellbeing of preschool children	
C1	Improve the promotion of and opportunities for breastfeeding, healthier diets, physical activity and tooth brushing in 0-5s	**Green**
C2	Promote the support for parents and particularly fathers in vulnerable groups such as young fathers, war veterans and offenders	**Green**
C3	Develop arrangements for integrated commissioning of universal and targeted services for children aged under 5	**Green**
C4	Ensure the social and emotional wellbeing of under 5s is assessed - JSNA	**Green**
C5	Support & encourage development of parental & child literacy	**Green**
C6	Ensure that maternal mental health is assessed and any issues identified are addressed at an early stage	**Green**
C7	Promote early intervention with potential perpetrators and victims of domestic abuse and coordinate identification of abuse and referral training	**Green**
C8	Develop a single programme which addresses empowerment and self-esteem in relation to domestic abuse, relationships and risk taking behaviour in teenagers	**Green**
C9	Improve contact between substance misusing parents and treatment services	**Amber**
C10	Promote projects addressing child safety in the home	**Amber**
	Preventing obesity	
O1	Develop a comprehensive countywide obesity strategy	**Green**
O2	Put in place an individual to co-ordinate activity on obesity	**Complete**
O3	Undertake engagement activity to better understand perceptions of obesity in high prevalence areas and what messages and services will be effective	**Green**
O4	Agree a local “obesity branding” - partners to have a shared vision	**Green**
O5	Ensure those working with local communities are aware of the importance of preventing and managing obesity, and that they advocate for action	**Green**
O6	Work with local businesses & partners to increase access to healthy food choices	**Green**
O7	Make the most of the planning system to create a healthier built environment	**Green**
O8	Work with registered social landlords to implement Design Council and the National Housing Federation	**Green**

	Strategic Intention	Performance
	recommendations - to provide opportunities for people to be more active and enjoy the space outside	
O9	Engage with communities and promote behaviour change	**Green**
O10	Provide ongoing training and awareness raising to combat prejudice and discrimination against obese people in the workplace	**Amber**
	Making Norfolk a better place for people with dementia and their carers	
D1	Ensure that a JSNA informs strategic planning	**Complete**
D2	Ensure that the needs of hard to reach groups are recognised and addressed in all localities…. Work with Norfolk Community Transport and bus companies to ensure access for all	**Amber**
D3	…encourage joint working and sharing of expertise so that services are person-centred services and duplication reduced.	**Green**
D4	Make sure that new services are robustly evaluated	**Green**
D5	Improve the awareness and understanding of memory loss	**Green**
D6	Promote and support communities, councils, agencies and businesses to be dementia friendly	**Green**
D7	Ensure the public, independent and voluntary sector workforce, including housing, who support older people and people with dementia are required to have appropriate levels of dementia training.	**Green**
D8	Include people with dementia and their carers in service planning (coproduction).	**Green**
D9	Improve the rate of timely diagnosis of dementia.	**Green**
D10	Ensure continuity of care to deliver patient-centred care, especially for those who have other co-existing health problems.	**Green**
D11	Ensure a range of professional services is available 24/7 for all people with dementia & their carers, and tailored to their stage of dementia and their age	**Green**
D12	Ensure all acute hospitals have a dementia strategy, a dementia lead, a holistic view of the person with dementia and other co-existing long term conditions and a coordinated approach to treatment by different specialists.	**Green**
D13	Develop and implement an individualised and planned approach to end of life care for people with dementia and their carers so that they have an integrated health and social care plan in place to meet their needs and preferences	**Amber**
D14	Ensure high quality information, advice and advocacy on maintaining ***general*** wellbeing and independence are provided in different ways for older people including those with dementia and their carers.	**Green**
D15	Establish and maintain sustainable, low level, preventative services.	**Green**
D16	Recognise and address loneliness and social isolation in people with dementia.	**Green**
D17	Ensure independent and voluntary home care agencies provide high quality care for their clients who have dementia.	**Green**
D18	Identify, assess and meet the ongoing health and wellbeing needs of carers of people with dementia, and treat them as	**Green**

	Strategic Intention	Performance
	valued and equal partners. Ensure that they have access to a choice of affordable, flexible breaks and respite including emergency respite, to peer support (including web-based forums), to training on providing personal care and managing dementia-related behaviours, and to therapy and counselling.	
D19	Ensure commissioners of sheltered housing, housing with care, care homes and nursing homes incorporate best practice design for people with dementia.	**Green**
D20	Ensure residential care and nursing homes provide high quality care for their residents. This should include signposting to an independent advocate, co-ordination across organisations, provision of activities, promotion of dementia friendly design, and a culture and leadership focused on providing high quality care and on treating people with dignity and respect.	**Green**

Report title:	**Pharmaceutical Needs Assessment**
Date of meeting:	**12 July 2017**
Sponsor:	**Dr Louise Smith, Director of Public Health**

Reason for the Report

This report asks the Health and Wellbeing Board (HWB) to agree the planned approach for the production of the Pharmaceutical Needs Assessment (PNA).

Report summary

The HWB has a statutory responsibility* to publish a revised Pharmaceutical Needs Assessment for Norfolk by April 2018. The process must follow a set framework and conform to legal standards.

A multi-agency approach to delivery, overseen by a steering group, is recommended including pharmacy, public health and Healthwatch input. Roles and responsibilities and indicative timescales are provided.

The Director of Public Health is leading the delivery of the PNA on behalf of the HWB and has agreed to provide the resources required to complete the planned revision for 2017/18.

Action/decisions needed:

The Health & Wellbeing Board is asked to:

- Sign off the planned approach to publish a new Pharmaceutical Needs Assessment by April 2018, in line with the HWB statutory responsibilities.

- Endorse the resources required to complete the PNA including spend from the public health grant and requests that CCGs agree this work is a priority for the NEL Commissioning Support Unit (CSU).

1. Background

1.1 Every Health and Wellbeing Board in England has a statutory responsibility to publish a statement of the needs for pharmaceutical services for the population in its area, referred to as the Pharmaceutical Needs Assessment (PNA). This is the main reference document upon which commissioning of pharmaceutical services decisions are made, including the granting of NHS contracts by NHS England.

1.2 The current Norfolk PNA was published in March 2015. It concluded that the number and distribution of pharmaceutical service provision in Norfolk was adequate. The current Norfolk PNA can be found at the following link:

https://www.norfolk.gov.uk/what-we-do-and-how-we-work/policy-performance-and-partnerships/partnerships/health-partnerships/health-and-wellbeing-board/needs-assessments

* Schedule 1, NHS Pharmaceutical Regulations 2013

1.3 It is a requirement to publish a revised assessment when significant changes to the need for pharmaceutical services are identified, or every 3 years whichever is sooner. In line with regulations, a revised Norfolk PNA must be published by April 2018.

2. Proposed approach to deliver the new PNA

2.1 The Director of Public Health has taken the responsibility to lead the production of the new PNA for the HWB. The process will follow the set legal framework, including a set minimum content and a 60 day consultation period.

2.2 After considering the options, it is proposed that a multi-agency approach is taken to the development of the PNA, overseen by a steering group consisting of representatives from Healthwatch Norfolk, Norfolk Local Pharmacy Committee, Norfolk Local Medical Committee, NHS England, Norfolk and Waveney Clinical Commissioning Groups and Norfolk County Council, supported by expert pharmacist input provided by North East London Clinical Commissioning Support Unit (which provides pharmacy support to Norfolk).

2.3 Table 1 sets out a plan for the roles, skills and resources needed to complete the PNA. There are costs associated with the expert pharmacy input from NEL Commissioning Support Unit (CSU) and for Healthwatch Norfolk to co-ordinate and lead the consultation process. Additional support will be provided by the County Council's Public Health team. The total cost will be circa £45,000, with additional Public Health expertise provided in-house by Norfolk County Council. The majority of the costs relate to letting a contract with NEL CSU to provide pharmacist input.

2.4 This is in line with national guidance on costs of PNA production. The Director of Public Health has agreed to meet the costs of developing the PNA in 2017/18.

Table1: Roles and resources needed to complete Norfolk PNA

Component	Detail	Potential Lead provider/partner
Project Management Liaison with NCC Public Health Team & Communications + Engagement Team Consultation Patient & public involvement (PPI)	Convene, host & Chair Steering Group Meetings Admin support Progress & reporting to NCC & HWB Consultation host 5 Consultation workshops & PPI Consultation analysis	Healthwatch Norfolk
Public Health Expertise: Epidemiology, Needs Assessment, Health Economics PH Intelligence	Epidemiology & population health, health economics & needs assessment specialist expertise Direction of review, data analysis	Public Health Consultant, Public Health, Norfolk County Council
Data Analysis Expertise	Review, refresh and analysis of pertinent data sets including: • Expertise in using geographic information	Public Health Information Team, Norfolk County Council

Component	Detail	Potential Lead provider/partner
	system (GIS) mapping, forecasting & the PH England 'Fingertips' suite of tools • Writing Standard Query language (SQL) to query databases • Experience of data visualisation e.g. using Power BI (a business analytics tool) • Application of geodemographic segmentation	
Clinical Pharmacy & Prescribing Expertise	Provision of clinical, pharmaceutical knowledge and expertise In-depth, expert knowledge of the PNA framework and regulations Writing, editing & version control of the PNA document	NEL CSU – Pharmacy team
PNA Steering Group membership & stakeholders	NHS England Pharmacy Contracts Manager Local Pharmaceutical Network Lead Norfolk Local Pharmaceutical Committee Lead Norfolk Local Medical Committee Lead Patient & Public Representative	Individual representatives to be confirmed

2.5 Immediate action is needed to progress the PNA to meet the set deadlines. A project plan will be agreed with Healthwatch Norfolk. Indicative timings are as follows:

Timescale	Action
Immediate	Agree contracting arrangements with Healthwatch Norfolk and NEL CSU, formation of steering group
June 2017 – July 2017	Updated information to be gathered by the steering group
July 2017	Report to HWB
Aug 2017 – Sept 2017	60 day consultation of public and stakeholders
Oct 2017 – Dec 2017	Report writing
Jan/Feb 2018	Draft PNA presented to HWB
April 2018	PNA published

Officer Contact

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Report title:	**Suicide Prevention Conference**
Date of meeting:	**12 July 2017**
Sponsor:	**Dr Louise Smith, Director of Public Health, Norfolk**

Reason for the Report

Suicide is an important public health issue and a priority for Norfolk given our relatively high local rate (12.4 per 100,000 people compared to the England average of 10.2 per 100,000).

No one agency is responsible for suicide prevention – it is a whole system issue involving collective commitment and responsibility. The Norfolk suicide prevention strategy and action plan 2016-21 commits partners to the ambition of reducing suicides by 10%.

The work is led by the Norfolk Suicide Prevention multi-agency partnership including Norfolk & Suffolk Foundation Trust, The Coroner's office, Clinical Commissioning Groups, Norfolk and Suffolk Constabulary, Office of the Police and Crime Commissioner, Criminal Justice Board, Fire Service, Samaritans, and a range of other organisations.

The Health and Wellbeing Board has a direct interest in the work carried out by partners to reduce suicide and this work contributes to the Board's strategic themes of prevention and reducing inequalities.

Report summary

Building on the detailed report to the HWB at its April meeting, this report outlines the work underway by partners to hold a Norfolk Suicide Prevention Learning event in September 2017. It asks the HWB to support the development and delivery of the learning event.

Action needed:

The Health & Wellbeing Board is asked to:

- Agree to support the development and delivery of this learning event, to encourage participation and subsequent engagement.

1. Background

1.1 Suicide is an important public health issue and a priority for Norfolk given our relatively high local rate (12.4 per 100,000 people compared to the England average of 10.2 per 100,000). At its meeting on 26 April 2017, the Board received a report which outlined the work being carried out by partners to reduce the number of suicides in Norfolk. (Page 16 of the April Agenda papers).

1.2 The HWB endorsed the county-wide Suicide Prevention Strategy and action plan 2016-2021, which had been developed using a multi-agency approach and in consultation with a range of agencies and service users. The Board also received

the Norfolk and Suffolk Foundation Trust (NSFT) Suicide Prevention Strategy 2017-2022, which had been recently agreed by NSFT Board.

1.3 The HWB recognised that no one agency was responsible for suicide prevention – it involved collective commitment and responsibility. Responding to suicide required a system-wide approach; local authorities, health services, police, fire and rescue, mental health services and voluntary and community groups all having a role to play in reducing suicide in Norfolk. The Norfolk suicide prevention strategy and action plan 2016-20 commits partners to the ambition of reducing suicides by 10%.

2. Sharing learning about suicide prevention

3.1 A local Norfolk Suicide Prevention multi-agency partnership was established to lead the implementation of the county-wide strategy in order to meet the government ambition to reduce the number of deaths from suicide by 10% by 2021. Led by Public Health, the group includes representation from the Norfolk & Suffolk Foundation Trust, The Coroner's office, Clinical Commissioning Groups, Norfolk and Suffolk Constabulary, Office of the Police and Crime Commissioner, Criminal Justice Board, Fire Service, Samaritans, the County Council's Children's services and a range of other organisations.

3.2 The Norfolk Safeguarding Adults Board has also identified suicide prevention as a priority, and is working closely with the local multi-agency suicide prevention partnership to promote learning and workforce development across agencies in Norfolk

3.3 A **Suicide Prevention Conference** is being planned in Norwich for **Tuesday 12 September,** as part of adult safeguarding week. This will be aimed at equipping those working with vulnerable adults and children in Norfolk with the skills, knowledge and confidence to support those affected by suicide, with a focus on prevention.

3.4 A variety of **resources will be showcased**, including locally developed tools and guidance, and a diverse range of knowledge, skills and experience shared so we can all work better together to support all those affected by suicide in Norfolk.

3.5 The Health and Wellbeing Board is invited to support participation in the development and delivery of the learning event and subsequent engagement.

Officer Contact

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

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