Norfolk Health & Wellbeing Board

Date: **Wednesday 4 November 2015**

Time: **9:30am to 1pm**

Venue: **Edwards Room, County Hall**

Membership	Substitute	Representing
William Armstrong	Alex Stewart	Chair, Healthwatch Norfolk
Cllr Yvonne Bendle	Cllr Alison Thomas	South Norfolk District Council
Stephen Bett	Jenny McKibben	Norfolk's Police and Crime Commissioner
Harold Bodmer	Catherine Underwood	Executive Director of Adult Social Services
Dr Hilary Byrne	Jim Hayburn	South Norfolk Clinical Commissioning Group
Cllr Penny Carpenter	Cllr Marlene Fairhead	Great Yarmouth Borough Council
Cllr Annie Claussen-Reynolds		North Norfolk District Council
Pip Coker	Dan Mobbs	Voluntary Sector Representative
T/ACC Nick Dean		Norfolk Constabulary
Ruth Derrett		NHS England, East Sub Region Team
Dr Anoop Dhesi	Mark Taylor	North Norfolk Clinical Commissioning Group
Richard Draper	Dan Mobbs	Voluntary Sector Representative
Andy Evans	John Stammers	Great Yarmouth & Waveney Clinical Commissioning Group
Cllr Gail Harris	Phil Shreeve	Norwich City Council
Joyce Hopwood	Dan Mobbs	Voluntary Sector Representative
Cllr James Joyce		Chairman, Children's Services Committee, Norfolk County Council
Dr Ian Mack	Sue Crossman	West Norfolk Clinical Commissioning Group
Cllr Elizabeth Nockolds		Borough Council of King's Lynn and West Norfolk
Cllr Andrew Proctor	Cllr Roger Foulger	Broadland District Council
Michael Rosen		Executive Director of Children's Services
Dr Louise Smith		Director of Public Health
Dr Wendy Thomson		Managing Director, Norfolk County Council
Cllr Trevor Carter		Breckland District Council
Cllr Brian Watkins		Norfolk County Council
Cllr Sue Whitaker	Cllr Elizabeth Morgan	Chair, Adult Social Care Committee, Norfolk County Council
Tracy Williams	Jo Smithson	Norwich Clinical Commissioning Group

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

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

1	**Apologies**	Clerk	
2	**Minutes**	Chair	(Page **3**)
3	**Members to Declare any Interests**	Chair	
4	**Any urgent business**	Chair	
Items for discussion/action			
5	**H&WB Review – Chairman's report on outcome of first phase**	Chair	(Page **8**)
6	**Norfolk Better Care Fund Plan – Progress Update 2015/16 and Planning 2016/17**	Harold Bodmer/CCGs	(Page **18**)
7	**CCGs Commissioning intentions - 2016/17**	CCGs	(Page **31**)
8	**Joint Health & Wellbeing Strategy – progress update report**	Dr Louise Smith	(Page **83**)
9	**Developing a Mental Health Strategy for Norfolk**	Dr Louise Smith	(Page **90**)
Break – at the Chairman's discretion			
10	**Healthwatch Norfolk overview (presentation)**	William Armstrong	
11	**Norfolk Child Poverty Strategy Task & Finish Group Report**	Michael Rosen/ Tim Eyres	(Page **94**)
12	**Children's Services Improvement & Performance**	Michael Rosen/ Don Evans	(Page **101**)
13	**Norfolk Integrated Offender Health & Social Care Group – Annual Report**	Jenny McKibben/ Dr Gavin Thompson	(Page **121**)
14	**Transforming Care Programme – Services for Adults with a Learning Disability**	Harold Bodmer/ Derek Holesworth	(Page **125**)
	Minutes of other meetings		
15	**Norfolk Health & Overview Scrutiny Committee minutes of the meeting held on 16 July 2015**	Chair	(Page **138**)

Norfolk County Council

Health and Wellbeing Board
Minutes of the meeting held on Wednesday 15 July 2015 at 9.30am
in Edwards Room, County Hall, Norwich

Present:

William Armstrong	Healthwatch Norfolk
Cllr Yvonne Bendle	South Norfolk Council
Dr Hilary Byrne	South Norfolk Clinical Commissioning Group
Cllr Penny Carpenter	Great Yarmouth Borough Council
Pip Coker	Voluntary Sector Representative
T/ACC Nick Dean	Norfolk Constabulary
Richard Draper	Voluntary Sector Representative
Cllr Gail Harris	Norwich City Council
Joyce Hopwood	Voluntary Sector Representative
Cllr James Joyce	Chair, Children's Services Committee, NCC
Sheila Lock	Interim Executive Director, Children's Services, NCC
Dr Ian Mack	West Norfolk Clinical Commissioning Group
Lucy Macleod	Interim Director of Public Health
Jenny McKibben	Deputy Police and Crime Commissioner
Cllr Elizabeth Nockolds	Borough Council of King's Lynn and West Norfolk
Dr Chris Price	Norwich Clinical Commissioning Group
Cllr Andrew Proctor	Broadland District Council
Dr John Stammers	Great Yarmouth & Waveney Clinical Commissioning Group
Dr Wendy Thomson	Managing Director, Norfolk County Council
Catherine Underwood	Director Integrated Commissioning, Adult Social Services
Cllr Brian Watkins	Norfolk County Council
Cllr Sue Whitaker	Chair, Adult Social Care Committee, NCC

Also present:

- Debbie Bartlett, Head of Business Intelligence and Performance Service and Corporate Planning and Partnerships Service
- Anne Gibson, Executive Director of Resources

1 Apologies

1.1 Apologies were received from Annie Claussen-Reynolds and Ruth Derrett, NHS England, East Sub Region Team.

2. Election of Chair

2.1 Cllr Brian Watkins was duly elected for the ensuing year.
At this point, the Chair thanked Cllr Dan Roper as former Chair, for his hard work and contribution whilst he had been involved with the Health and Wellbeing Board.

3. Election of Vice Chairs

3.1 Dr Ian Mack and Cllr Yvonne Bendle were duly elected for the ensuing year.

4. Declarations of Interests.

4.1 There were no interests declared.

5. Minutes

5.1 The minutes of the Health and Wellbeing Board (HWB) held on the 29th April 2015 were agreed as a correct record and signed by the Chair.

6. DPH Annual report - presentation

6.1 The Board received the annual report from the DPH in the form of a presentation which focused on mental health and the position in Norfolk. The DPH stressed that she was raising whole-system concerns, not specific services.

6.2 There was agreement for partners to develop a fourth priority regarding mental health, rather than relying on the 'golden thread' approach, which was seen by some as not working as effectively as it might.

6.3 Partners welcomed the opportunity to have discussions looking at a whole system approach to mental health, including that of children and young people. It was important to have a process of engagement with young people and to hear their innovative ideas.

6.4 It was suggested that the Board's role could be in putting the appropriate support in place and taking ownership of an integrated, system wide, approach. Work was being carried out on areas such as debt, poverty, domestic violence, but all in separation.

6.5 Early work was being undertaken to protect children and young people from developing mental health problems, and there had been a close tight focus by CCG's and NHS England, but there was concern expressed that the Board's work had moved away from the preventative agenda. The voluntary sector could bring valuable insight into what was going on in communities to assist the Board in its aim.

6.6 The Board AGREED to appoint a mental health champion to help take this priority area forward.

6.7 The Board **RESOLVED to;**

- Note the report.

7. Joint Health and Wellbeing Strategy 2014-17 Annual Report 2014/15

7.1 The Board received the report from the DPH, on behalf of the H&WB Strategy Implementation Group. The report provided information on progress with implementation of the Joint Health and Wellbeing Strategy including its achievements to date.

7.2 It was recognised that a lot of work had been carried out with regards to dementia before the Strategy had been implemented and that service users had been fully engaged. There were considerable variances in the deaths associated with dementia. There was a general assumption that only older people suffer from dementia therefore it was necessary to increase the awareness that younger adults could always suffer from it.

7.3 Mental health was threaded through the three priorities and it would be necessary for the relevant streams of work around mental health, which were currently incorporated in the existing priorities, to be brought together as part of the developing priority area of mental

health. There needed to be a firm definition of this new priority area.

7.4 In the discussion that followed, there was a view that the relationship between the Board and the new Health & Wellbeing Sub Group of the Children & Young People's Strategic Partnership should be strengthened so that it could report into the H&WB. The Chairman confirmed that he would take this view on board in the review of the H&WB.

7.5 The Board **RESOLVED** to;

- Note the report and considered views on the delivery of the Strategy to date and any change on emphasis or reporting required in the forthcoming year

8. Joint Strategic Needs Assessment (JSNA) Annual Summary Report 2014/15.

8.1 The Board received a brief update on the Joint Strategic Needs Assessment (JSNA) since its review and refresh reported in July 2014.

8.2 The Board **RESOLVED** to;

- Note the report and considered views on the progress in developing the JSNA and its future direction.

9. Locally-led Health Improvement

9.1 The Board received a report which brought together updates on the impact being made across Norfolk through locally-led health improvement activity. The report included an update by each of the district, city and borough Councils, who had been working with the DPH, public health team, and local partners to commission activities that would result in a demonstrable improvement in one or more of the Board's strategic priorities and goals.

9.2 The Board heard that it had been challenging working with short term funding but that where success was being demonstrated then local areas were considering integrating into mainstream activity to help keep projects on track to deliver future benefits.

9.3 The Board also received three presentations from local areas about their health improvement activity and, amongst other things, these demonstrated the importance to communities of reducing social isolation.

9.4 The Board **RESOLVED** to;

- Consider the contribution being made on the Board's strategic priorities and goals.

10. Re-Imagining Norfolk

10.1 The Board received the report which set out the County Council's completely new strategic direction – Re-Imagining Norfolk – which would radically change the role of the authority and the way it delivered its services. It outlined the Council's vision and priorities for Norfolk through working effectively across the whole public service on a local basis.

10.2 The Board welcomed the report and the opportunity taken by NCC's Managing Director to share its major change strategy with the Board. Members discussed the importance of the wider context in which all partners were working – one of funding reductions and major change. There was also the devolution agenda and it was noted that discussions were beginning to take place and would develop during the summer and autumn.

10.3 The Board **RESOLVED** to;

- Note the report
- Agreed that developing work on NCC's priorities and the outcomes sought be brought to the next Board meeting.

11. Integration and the Norfolk Better Care Fund Plan

11.1 The Board received the report which provided information about the progress with integration in Norfolk and with delivering the Better Care Fund Plan. This included case studies which illustrated some of the impact being made from a number of initiatives and an outline of overall trends in performance in relation to non-elective admissions to hospital. It also provided the H&WB with the information submitted to NHS England for the first BCF quarterly report, following final sign off by the Board's BCF sub-group.

11.2 Members discussed both the challenges and the lessons which were being learnt, including the fact that one size does not fit all, and there was a need to change historic ways of treating people and work on changing attitudes.

11.3 In relation to the trend data in relation to non-elective admissions in Great Yarmouth & Waveney, the small decrease in admissions was testament to the efforts being carried out by all those involved.

11.4 The Board **RESOLVED** to;

- Note the key issues arising from the information provided in the report, including the examples of good practice identified in the case studies.
- Note the submission to NHS England for the period 1 January to 31 March 2015, and the recent re-confirmation of the target reduction in admissions as agreed in the Norfolk BCF plan.

12. Children's Services Improvement and Performance

12.1 The Board received the report which provided an update on operational performance within Children's Services including support for school improvement and social care and safeguarding. It also updated on partnership arrangements and the recent adoption of eight sub-groups by the Children & Young People's Strategic Partnership.

12.2 It was reported that the numbers of Looked after Children had decreased from 2300 in 2013 to 1058 at the time of the report. All children are known individually and have a support package in place. Signs of Safety had been helpful in reducing these numbers.

12.3 The Board discussed the nature of future reporting on children and young people and it was suggested that in future we could move to exception reporting, and a possible shift to looking at particular issues at a more granular level, including looking at information by locality.

12.4 The Board **RESOLVED** to;

- Note the report.

13. Healthwatch Norfolk verbal update

13.1 William Armstrong, Chairman, Healthwatch Norfolk (HWN) reported that their Annual report had recently been published and this was available at the link

http://www.healthwatchnorfolk.co.uk/about/docs

13.2 It was also reported that Healthwatch had moved to premises in Wymondham which were more suitable for their needs, and the Chairman, HWN, encouraged any partners to get in touch if there was any topic that colleagues at HWN could review or be involved with.

14. NHS Five Year Forward View: New Models of Care

14.1 In the absence of a representative from NHS England, the Board received a brief update report on NHS England's Five Year Forward View (FYFV). The Board had received a full briefing at its meeting in April 2015 and this follow-up report outlined progress with the 29 vanguard projects, which were focused in new models of care.

14.2 It was noted that, although some good bids had been put in, there were no vanguard projects in the East of England. It was also suggested that this pressing need for transformation in health and social care needed higher consideration on the Board's agenda and it should be considered in context with Norfolk County Council's Re-Imagining Norfolk.

14.3 The Board **RESOLVED** to;

- Note the progress towards the new models of care as outlined within the Five Year Forward View.

15. Road Casualty Reduction Partnership

15.1 The Board **AGREED** to appoint Cllr Penny Carpenter to the partnership.

16. Norfolk Health Overview and Scrutiny Committee Meetings

16.1 The Board received and **NOTED** the minutes of the Norfolk Health Overview and Scrutiny Committee from the meetings held on 26 February 2015, 16 April 2015 and 28 May 2015.

The next meeting would take place on **Wednesday 21 October 2015** at 9.30am. The venue would be confirmed.

The meeting closed at 1pm

Chairman

Report to Norfolk Health and Wellbeing Board
4 November 2015
Item 5

Health & Wellbeing Board Review – Outcome of Phase 1

Cover Sheet

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

The Health & Wellbeing Board (H&WB) was established on 25 March 2013 and has been fully operational with statutory responsibilities for two and a half years. The Board has agreed that it would be beneficial for a review of its current working arrangements to be carried out and the Chairman has led this first phase of the Review culminating in this report.

The Board has a number of **statutory responsibilities**, including a duty to:

- Prepare a Joint Strategic Needs Assessment (including a Pharmaceutical Needs Assessment) and a Joint Health and Wellbeing Strategy
- Encourage integrated working between commissioners of health and social care services
- Provide an opinion as to whether the CCG commissioning plan has taken proper account of the Health and Wellbeing Strategy and what contribution has been made to the achievement of it
- Assess how well the CCG has discharged its duties to have regard to the JSNA and JH&WBS

Key questions

- What are your views on the general themes arising from the work in this first stage?
- What are the most important areas for improvement and/or for change?
- Are the proposals for action appropriate and do they offer the best way forward?

Actions/Decisions needed

The Board needs to:

- Consider and comment on the report and agree a way forward

Report to Norfolk Health and Wellbeing Board
4 November 2015
Item 5

Health & Wellbeing Board Review – Outcome of Phase 1

Report of the Chairman of the Health & Wellbeing Board

Summary
Norfolk Health & Wellbeing Board has been established and operational with statutory responsibilities for two and a half years and earlier this year the Board agreed that a review of its current working arrangements should be carried out. The new Chairman has conducted this first phase of the Review, which has involved interviews with all Board members. This paper sets out the outcome of this first phase of the Review and contains proposals for improvement and next steps.

Action
The Board needs to:
- Consider and comment on the report and agree a way forward

1. Background

1.1 Health & wellbeing boards are intended to be **a forum for collaborative local leadership** in an area and as such they have the following main functions:

- **Assessing the needs** of their local population through the joint strategic needs assessment process and a pharmaceutical needs assessment

- **Producing a** local health and wellbeing **strategy** - the overarching framework within which commissioning plans are developed for health services, social care, public health, and other services which the board agrees are relevant

- **Promoting and driving** greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate.

- **Providing an opinion** as to whether CCG's commissioning plans have taken proper account of the Board's Health and Wellbeing Strategy and are contributing towards achieving it

1.2 The Norfolk Health & Wellbeing Board (H&WB) was established on 25 March 2013 and has been fully operational for two and a half years with these statutory responsibilities. Earlier this year, the H&WB agreed that it would be beneficial for a review of its current working arrangements to be carried out to help ensure that the Board was focused on the rights things, working effectively, and adding value.

1.3 On his election in July 2015, the new Chairman proposed to carry out a series of one to one interviews with all Board members to hear views on the H&WB's journey so far and discuss ideas and suggestions for how Board members might best meet its future challenges. The outcome of this first phase of the H&WB Review is reported here together with proposals for improvement and next steps for action.

2. Review of the H&WB – Key themes from Phase 1

2.1 The Chairman invited all members of the Board to meet with him and the following key areas were discussed:

- **Getting the basics right** – membership of the Board, its size, functions, roles and responsibilities
- **The way we work –** formal meetings, informal meetings/workshops, frequency, format, agendas, sub-groups etc
- **Links/engagement with others –** eg the relationship with the safeguarding boards, health scrutiny, the public and service users, etc
- **Making a difference** – joint working, over and above single agency working, shared priorities, driving integrated working,
- **Preparing for the future** – critical issues going forward, influencing system-wide commissioning, the H&WB as systems leader – now and in the future

2.2 This first phase involving a series of one to one interviews with all H&WB members has enabled the Chairman to capture valuable qualitative information on which to base recommendations and next steps. Key themes arising from this phase for the Board to consider are outlined below.

Size of the Board

2.3 The H&WB is large - it was established by the Count Council with its current membership to enable a rich discussion and debate in a diverse and complex area such as Norfolk, as well as to provide good 'reach' into communities. However, the Board is seen by some as potentially too big to operate as an effective decision-making group. This is a difficulty experienced across the country where there is complexity in the system eg with two-tier local authorities, multiple Clinical Commissioning Groups (CCGs), etc.

2.4 There were some suggestions that we **could consider looking to reduce the size of the Board**, for example, with the CCGs nominating one or two representatives, the District Councils (DCs) nominating one or two representatives and reviewing the number of VCS places. However, if we were to consider this approach, the view is that radical reduction would be needed in order to impact on overall effectiveness.

2.5 Others consider that if the H&WB's most powerful role is one of influence, then it needs a range of key people around the table in order to take part in discussion and debate, arrive at a shared understanding and agreement about priorities and, based on that understanding, take key messages back to individual organisations/others. In this case, **a large Board is seen as a positive bonus** but needs to be combined with **effective delegation to sub groups**, with recommendations coming back to the main board. This is seen as allowing for meaningful and productive discussions, as an effective way of arriving at decision making, and helping reduce the full Board agenda.

Membership - involvement of providers

2.6 There are strong views that providers are needed on the H&WB in some way and that this will be critically important for the Board going forward. A key concern, for example, is that if we are to achieve a transformation of services and a reduction in acute hospital spend need across Norfolk, then the H&WB needs to be the place for those discussions. This would only work with the acute trusts around the table to be a part of the discussions and the strategy, and to be held to account.

2.7 However, a range of different views have emerged as to **how** best to involve providers, given the practicalities involved. At one end of the scale providers are considered vital - "we need providers around the table and we need them to be able to contribute to decision-making", or "we need providers to do some shared problem-solving" and also "there needs to be more challenge and bringing in providers would help with that". Some members suggest that it could be through including providers at the Board table itself, or as a sub group which was set up to enable sufficient influence. Another view was that we should simply invite providers when needed, for example, for a particular agenda item of for a specific, themed workshop. In all cases it would need to be representation at a senior enough level to influence/take decisions.

2.8 There was also the question of **which providers** to involve and for many it was clear that it needed to be the 3 acute hospital trusts (or a representative), Norfolk & Suffolk Foundation Trust - Mental Health (N&SFT) and Norfolk Community Health & Care NHS Trust (NCH&C). For others, however, it would be more difficult to draw the line as it would need to involve multiple agencies and, for example, could involve providers based outside of Norfolk. There was also the question of the independent sector (eg Norfolk Independent Care) which is responsible for care homes, residential homes, and Norfolk domiciliary care. For some members, it would be difficult not to involve them.

2.9 Finally, there was also a view that we already have some provider involvement through the **Central System Leadership Group** which was established at the end of 2014 and reports into the H&WB. This Leadership Group involves the Chief Executives of the 3 CCGs in the 'Central' area (North Norfolk, Norwich and South Norfolk) plus the Chief Executives of the Norfolk & Norwich University Hospital Trust (NNUHT), Norfolk Community Health & Care NHS Trust (NCH&C), and a standing invitation to the East of England Ambulance Trust. This group has been working on building knowledge and trust and preparing for systems leadership. It is currently undertaking some broader development work involving system leaders in the other two CCG areas (Great Yarmouth & Waveney and West Norfolk) and was seen as a potential alternative to direct involvement on the Board. The local system leadership partnerships which were well established in Great Yarmouth & Waveney and also in West Norfolk were cited as working well.

Functions, roles and responsibilities

2.10 Whilst some members had a clear view about the role and purpose of the H&WB, a number of members identified a lack of clarity about the exact function of the Board and, to a certain extent, of the roles and responsibilities of Board members. The national and local scenario planning at the very earliest stages of establishing the Norfolk Board had been helpful but it remained difficult to see in practice exactly what H&WB's were there to do. An example of this was a request for greater clarity around who is responsible for making decisions on specific matters and who is bound by those decisions.

2.11 Norfolk is not alone in this and it reflects the position in other H&WBs around the country where they have struggled to define exactly what their role is and to identify how they can add value in their local area. This is seen as partly a result of the lack of direct authority given to H&WBs and that much of their power relies on their ability to influence. It is also due to the wide-ranging nature of 'health and wellbeing' leading to difficulties for members in engaging in and contributing towards what is inevitably broad agenda.

2.12 Views about how to improve on this include practical suggestions, such as:

- **Agreeing a mission statement** – 'this is why we are here and how we will make a difference', to remind us of our role.

- Agreeing **how ambitious we want to be** which would help give the board a stronger **sense of direction**
- **Improving members' understanding of** the Board's **Strategy, priorities** and the **outcomes** that we are striving towards. For example, providing induction material for new members and encouraging learning opportunities for existing members who are not directly involved in the Strategy Group.
- **Improving on-line information** - making it easier for **all members** to know what's going on and, importantly, what is being achieved
- Establishing **a set of objectives and indicators** to tell us clearly the progress we are making towards achieving those outcomes eg this might include, for example, make sure the system works as a whole
- **Introducing more constructive challenge** into way the Board works, for example, individual members challenging how the money is spent, what is being commissioned, how it is contributing towards our agreed priorities and what is actually being delivered
- **Holding each other to account** – making sure that there are **clear actions for all** partner organisations and then holding ourselves, individually and collectively, to account for them.

Agendas

2.13 There are strong views that Board's agendas are too long and that there is little time to get into substantive discussion – although the reasons for why this is are also well understood. There are a range of views as to how best reduce agendas, including:

- **Focusing on action –** breaking the agenda up and separating out items for information/to note. Concentrating only on those items for discussion/a decision/a steer/views. However, a number of members see the H&WB as serving a **useful role in information sharing and learning from what other areas are doing** and so if we were to restrict the agenda in this way we would need to find a way of achieving this
- **Shorter papers** – requesting no more than 2 x sides of A4 for reports and for all other material to be made available via a link.
- **Review other formats** – reviewing the use of presentations, which can be time-consuming and not add significantly to written reports
- **Alternating items** – eg looking at obesity one meeting, dementia another, etc
- **Focusing on the differences** - eg when reviewing CCGs plans the focus should be on the differences, rather than the common ground
- **Sub Groups** – organising the work into sub groups in order to reduce the overall agenda for the full Board.

Meetings format and frequency

2.14 Most Board members consider that 4 meetings a year was about right for the formal Board meetings, as it is currently cast. If we were to look to reduce the board size and move to a smaller, executive decision-making group then it might need to meet more regularly. There was also the view that if we were to consider meeting more frequently then these should alternate between formal meetings and workshops

2.15 There was a strong view that with the full Board meeting quarterly then the key issue was how we get the business done in between meetings. It was recognised that there were capacity issues here, both in terms of ability for members to be fully engaged and involved, and the necessary support/infrastructure needed to help drive the work forward. The Board had tried a number of different approaches to this over the years but current suggestions for getting the business done between formal meetings include:

- **Effective delegation to sub groups** with recommendations to main board – allowing for a meaningful & productive discussion and a decision (and reducing the full board agenda)
- Building in **some longer, working sessions** to explore a subject in more detail and do some **work on something that needs fixing/solving** or for awareness-raising/sharing good practice
- Using **shorter workshop style/informal sessions** either before or after a shorter (eg 2 hour) formal business meeting, in order to make best use of peoples' time
- These sessions could be **focused on improving understanding and engagement** – for example all H&WB members could be asked to declare a particular interest for one of our 3 priorities and then be involved in a workshop on a specific aspect
- Convening a **bigger gathering once or twice a year** to set the overall agenda and review progress, and then use a different format for getting the business done

Links with safeguarding boards

2.16 The relationship between the H&WB and the two safeguarding boards (for adults and for children) is relatively new and under development. The work of these Boards was seen as vitally important and links with them were clearly needed, but there was a degree of caution about adding significantly to the H&WB agendas.

2.17 There was a clear view that the newly established Norfolk Adults Safeguarding Bard (NASB) should formally report to the County Council's Adult Social Care Committee as that Committee was statutorily responsible for setting up the NASB. Similarly, the Children's Safeguarding Board had a direct relationship with the Children & Young People's Strategic Partnership. However, **it was recognised that the H&WB needed to be sighted on the work of the two safeguarding boards** and perhaps be ready to respond/act if a wider view or action was needed, for example, on a longstanding problem that a safeguarding board cannot resolve.

2.18 There were mixed views about whether there should be an agreed set of information made available to the H&WB, for example, on whether there was an increase in activity around safeguarding referrals. Some considered that the H&WB already had "information overload" and that we might want to be wary of adding to this without a very clear reason.

Relationship with Norfolk Health Overview & Scrutiny Committee (NHOSC)

2.19 Some members felt that there was a lack of clarity about the differing roles of the H&WB and health scrutiny and that there was potential for overlap. It was suggested that it would be helpful to look again at the relationship between H&WB and NHOSC and the way the two worked together, including looking at how this worked in other areas.

Engagement with service users, the public

2.20 It was recognised that it was not likely that the public were aware of the H&WB, but the need to do this was also questioned - there was a view that what was important was making sure the services we have meet the needs of the people we need them to reach, not the general public. Another view was the possible role of the H&WB in the provision of general information and advice around health and wellbeing.

Making a difference

2.21 There were mixed views about the extent to which the H&WB was making a difference through joint working - over and above single agency working – and driving integrated working. Some Board members - particularly those directly involved in the Strategy Implementation Group - cited the **progress being made around the priorities** and what was being achieved, for example, with the priority 'Making Norfolk a Dementia Friendly

place'. Some felt that the Board was making progress but could do more – building on what is being achieved and learning the lessons from it. Others felt that the Board hadn't yet had the impact it should have on commissioning in Norfolk.

2.22 Some members commented that there had been **insufficient focus so far on health inequalities** (one of the H&WB's overarching goals) and some felt that the 'golden thread' **approach to mental health had not worked well** and that the H&WB does not have sufficient 'grip' on it. It is generally considered that the **model used for developing and implementing the Board's 3 priorities has worked well** – ie establishing a H&WB Champion and putting in place a dedicated PH Co-ordinator to 'drive' the work forward – and that this would be needed for other emerging priorities, such as Mental Health. There was a clear message that the previous model (from the first H&WB Strategy) of having a larger number of priorities had not worked as there had been no way of being able to drive the work forward between each meeting and capacity was stretched across too many areas.

2.23 A key issue now was **how we would measure impact.** It was recognised that the H&WB Strategy Group had been working on this and on **a way of holding to account for the 3 priorities**. There was also a view that we would need to keep evidence and priorities under review. One suggestion to **make a difference around mental health** was for a Mental Health Sub Group to be set up to drive this priority workstream. Another suggestion was that a Mental Health Strategy for Norfolk was currently under development and it could be agreed by the Board and used by the Sub Group to inform action planning.

Preparing for the future

2.24 The following themes arose from discussions with the Chairman about the H&WB and its role in **influencing system-wide commissioning**:

- There was a real **opportunity** for the Board to become '*the* place' where commissioning priorities are set and that for this to fully develop providers will need to be involved. In order to be effective, the Board needed to clearly position itself so that those making commissioning decisions were concerned about the H&WB and its views.

- The most significant task the Board has undertaken in this area was agreeing the **Better Care Fund** but, due to the timescales involved, the H&WB didn't get involved at the ground floor in shaping it and we missed an opportunity to think about 'what do all of us want from this. **What is our level of ambition here?**

- The H&WB, after a long debate, had set itself **3 priority areas to test system-wide commissioning** within those areas and, although we are making progress, we haven't yet drawn out the key themes from this model and established whether it has worked - we are not clear yet about the delivery

- One of the Board's key responsibilities was to hold the CCGs to account for the contribution being made towards achieving our Health & Wellbeing Strategy – but there is **little challenge** when we see those plans, or we see them after they have been set.

- If the H&WB was looking at **one set of commissioning plans** (ie CCGs) but not social care then this was not well grounded – we need to look at things in the round. **What is our ambition here?**

2.25 The following themes arose from discussions with the Chairman about the H&WB and its role **as systems leader – now and in the future:**

- There were strong views that the H&WB was **not fulfilling the role of systems leader at this stage but there was a willingness to work to get there**. It was recognised that the Board had great potential – with a number of senior/influential people are coming together with the will to do good – and that there was a need to harness this. Members acknowledged that they would need to step up in a different way in order to put the H&WB centre stage as system leader.
- **Structural change might help** with this and this including resolving the way in which we **involve providers**
- Thinking about **workshops** differently – for example, consider using them **to engage the wider constituency**
- It was for **individuals on the Board to take action** – we need to be doing work together **outside of the formal Board meetings**
- **More constructive challenge was needed** with the H&WB acting as **'critical friend -** we need to know that commissioning is doing what we need it to so we need to ask the questions and offer help/co-operation
- **A Peer Review might be helpful** – a way of comparing ourselves to others, in terms of systems leadership.

2.26 Critical areas or issues for the H&WB going forward were identified as follows:

- **Re-structuring** to make the H&WB more effective
- **Systems leadership** – developing this for the Norfolk H&WB and defining clearly what we mean by it
- We have the makings of a very effective H&WB – we need to **focus on our levels of cohesion and our ambition** – including, for example, our aspiration for driving integration for the benefit of the Norfolk population
- **Constructive challenge** - which will require the providers input/knowledge
- We need to **focus on outcomes** – and whether we are getting the outcomes we want
- A **focus on co-ordination in between Board meetings** – the importance of strong communications/liaison by Board members, in particular the district councils
- **Our focus, in terms of strategic priorities,** should be on a system-wide, 'holistic' approach to mental health; inequalities; and integrated commissioning
- **Opportunities for the whole Board** to work together eg to **problem solve**
- **Self-awareness and learning from others** – it would be interesting to see how the H&WB functions in similar areas and/or those with high levels of ambition
- **Possible educative role for the H&WB** - eg to focus on "getting the right messages out there" and working on improvement in advice provision

3. The way forward

3.1 This first phase of the H&WB review has provided the Chairman with a rich source of information which about the H&WB's journey so far as well as individual members' views on how the Board could build on this to improve its effectiveness and prepare itself to face future challenges. This report from the Chairman provides an opportunity for the Board to reflect on the themes arising from the review so far and agree how best to move forward.

Proposals for moving forward

3.2 It is clear that there are a number of changes which can be put into place fairly simply, for example, around reducing agendas for meetings, the format of agendas, meetings format, etc, and it is proposed that these will be implemented by the Chairman straight away.

3.3 **Proposal 1 -** However, there are a number of areas which will need more detailed development and would benefit from the Board working on them as a whole, outside of a formal Board meeting. In order to move forward swiftly it is proposed:

a. To set up a **whole Board development session** for members to work together on taking forward other key changes (eg sub groups/structural changes, etc). This will be held as soon as is possible – date to be announced as soon as available.

b. That the development session has the following **outcomes**:

- The Board will have a clear focus on its development towards effective system leadership and innovation, and on stepping up to the challenge of an enhanced role
- Board members will have a shared understanding of the different ways of working that will be needed in order for it to be fully effective in the future
- There is clarity about how to move towards this and the changes needed
- There is a timeline for bringing these changes into place and clarity about Board members' role in this

3.4 **Proposal 2** - It is important to learn from other Health & Wellbeing Boards and so, to inform the Board's on-going development, it is proposed that:

a. A good practice review and learning from other/similar H&WBs is carried out to see how other areas are approaching their role and responsibilities

b. In preparation for the whole Board development session (para 3.3 above), all Board members identify from their own wider networks (regional or national) a colleague whom they can contact to find out what happens in that area – ie in relation to a key issue of concern or interest arising from the H&WB review

c. That Board members continue to identify our own good practice and look for ways of sharing it

3.5 **Key questions for discussion**:

- What are your views on the general themes arising from the work in this first stage?
- What are the most important areas for improvement and/or for change?
- Are the proposals for action appropriate and do they offer the best way forward?

4. Action

4.1 The Health and Wellbeing Board is asked to:

- Consider and comment on the report and agree a way forward

Officer Contact

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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.

Norfolk Better Care Fund Plan - Progress Update 2015/16 and Planning 2016/17

Cover Sheet

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

The Health and Wellbeing Board has a duty to promote integration. It is the body responsible for developing and implementing the strategic plan for the Norfolk Better Care Fund Plan and is accountable, overall, for the Norfolk Better Care Fund.

Key questions for discussion

Q.1 Where do Board members consider we are in Norfolk in terms of integration?

Q.2 What could we do, individually and collectively, to move forward?

Q.3 What are our priorities in moving forward with our integration agenda – what do we want to see next?

Actions/Decisions needed

The Board is asked to consider the information outlined in this paper and to:

1. Agree the direction of travel for developing plans for Norfolk's 2016/17 BCF Programme.

2. Provide any additional considerations on shaping and developing plans to deliver against the Better Care Fund Programme requirements for 2016/17.

Better Care Fund Progress Update 2015/16 and Planning 2016/17

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

Summary
Norfolk's BCF programme is a key mechanism for the delivery of integration in Norfolk. It is an ambitious programme addressing the suite of national indicators including targeting a reduction in non-elective admissions of 3.5%.

The national initiative went live from April 2015 and this paper outlines Norfolk's positive progress, including the recent BCF quarterly submission, and provides highlights in each CCG area on the progress, achievements and challenges to date.

We have received confirmation that the BCF will continue for 16/17 (although details of this will be provided after the comprehensive spending review of 25th November) and have been asked to start reviewing progress and impact to date and to scope plans for next year. The paper sets out the requirement for Norfolk to start planning and developing BCF plans for 2016/17 building on the 15/16 BCF programme.

Action
The Health and Wellbeing Board is asked to consider the information outlined in this paper and to:

- Agree the direction of travel for developing plans for Norfolk's 2016/17 BCF Programme.
- Provide any additional considerations on shaping and developing plans to deliver against the Better Care Fund Programme requirements for 2016/17.

1. Introduction

1.1 This paper provides Norfolk's Health and Wellbeing Board (H&WBB) with an update on the progress, achievements and challenges to date in the delivery of Norfolk's Better Care Fund (BCF) from both a local and regional perspective.

1.2 It also provides a proposed direction of travel for developing plans for the Board to consider for Norfolk's 2016 – 2017 BCF plan, which is currently anticipated to require formal approval by the Board in February 2016.

2. Background

2.1 The Better Care Fund (BCF) requires Local Authorities with responsibility for Adult Social Services and Clinical Commissioning Groups (CCGs) to create a pooled

commissioning fund (from existing funding) for the provision of integrated health and community care services.

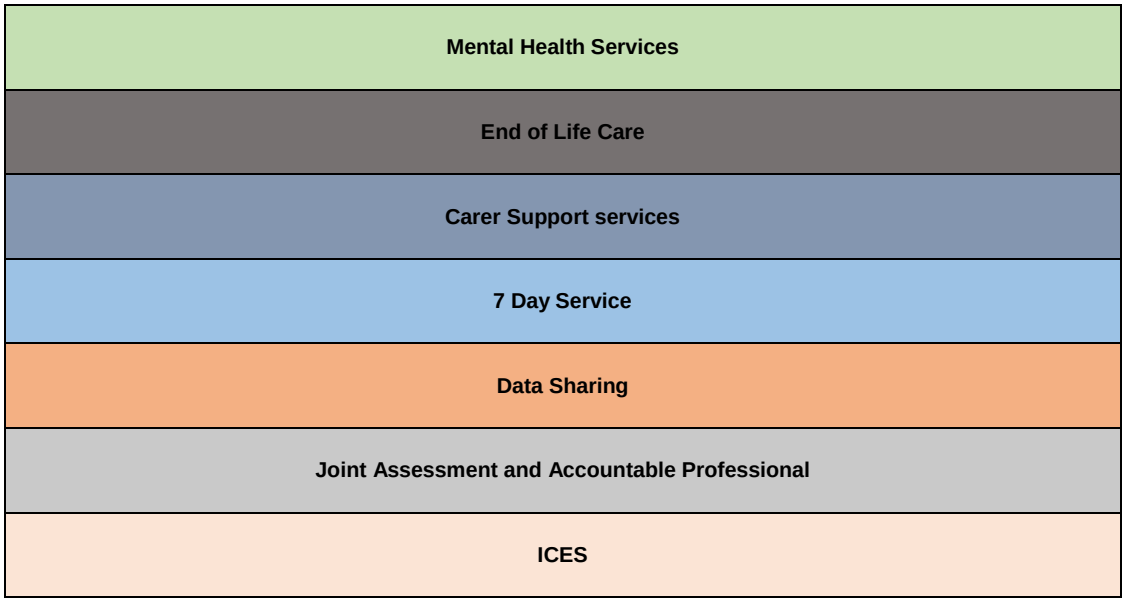
2.2 Norfolk's BCF plan is supported by pooled funds of over £63m. The core principles set out in Norfolk's plan are that:

- **People will be able to access effective and co-ordinated care which is delivered at home or in their local community:** This will see services delivered closer to home and where they need to be provided in a specialist acute setting, time spent there will be minimised through the support of a co-ordinated network of community based services.
- **Services will be shaped around the individual:** Healthcare and support will be built around what individuals need and what works for them. Services will be founded on a personalised approach which will be better at delivering the outcomes people seek because they are tailored to individual need.
- **People will be supported to manage their own care and wellbeing:** People will be empowered to manage their needs and health conditions so that they maintain their own wellbeing as far as possible to enhance quality of life and to reduce the call on formal services.
- **Primary care we be the heart of care co-ordination:** Primary care will be the core of our services. People will be able to connect with health and care services in their community and can be confident that their primary care services are well connected with a much wider range of help and support.
- **Planning will develop at a local level:** In Norfolk, we think that it makes sense for detailed planning and development of 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. This sits within the countywide planning framework under the Health and Wellbeing Board.

2.3 The BCF plan reflects a range of schemes designed to meet the requirements in each CCG area. **Table 1** outlines the consistent BCF themes across Norfolk:

Table 1

Integrated and Coordinated Multi Agency Teams
Risk Stratification
Reablement and Rehabilitation
Self-care and Self-management
Housing Support
Assistive Technology
Falls Prevention
Urgent Care Programme
Dementia Care



3. Regional feedback on Quarter 4 Report (submitted May 2015) and context for Norfolk:

3.1 In July the Midlands and East of England regional BCF team produced a report entitled 'Progress in delivering local BCF plans' based on the feedback submitted by all Health and Wellbeing Boards in their quarterly reports.

3.2 At May submission, Norfolk was in a minority of areas still finalising the pooled fund agreements and yet to transfer the Disabled Facilities Grant to District Councils. These matters were resolved by the subsequent August report.

3.3 A mixed picture was presented on achievement of national conditions with seven day services (7DS), joint assessment and use of NHS number as primary identifier taking longer to deliver. Norfolk has the NHS number as primary identifier in place, but is still progressing work on the other two areas. This is not out of step with other areas with:

- 21% with 7DS in place
- 27% joint assessment condition deemed met.

3.4 Reduction in delayed transfers of care (DTOC's) significantly underperformed against plan. Norfolk however has met its target in this area.

3.5 In terms of payment for performance, out of 151 Health and Wellbeing Boards nationally 59 received payments of which only 36 were fully achieving their targets and payments. Payment for performance is dependent on meeting the target for reducing unplanned admissions alone. Norfolk did not receive payment for performance.

4. Norfolk's Quarterly Progress Report

4.1 Reporting on progress in Norfolk is required on a quarterly basis and the most recent report, signed off by the BCF subgroup of the HWBB, was submitted on 28th August 2015. The full summary of this can be seen in **Appendix 1**, but the following provides the high level summary:

4.2 Norfolk's Better Care Fund schemes continue to develop and progress well against plans with all s75 agreements agreed, signed and in place.

4.3 The 5 local BCF partnership boards provide the local governance of programmes and the pooled funds. The countywide BCF programme group supports management of the overall programme with the opportunity to share perspectives and learning.

4.4 There remain significant challenges in delivering against the ambitious and stretching BCF target reduction of 3.5% for non-elective admissions due to the increasing demand which is experienced across the country and locally. Non-elective admissions for the year to date as at August 2015 stand at 62,908 compared to 60,788 for the same period in 2014. This represents a 3.49% increase over the period.

4.5 These figures and those provided in the Section 5 'Locality Updates' are based on 'monthly activity return' (MAR) data as required for the Better Care Fund by NHS England. However it should be noted that CCG's use 'secondary uses service' (SUS) data for tracking admissions which report against more refined populations and are seen as more accurate for planning and tracking purposes.

4.6 If we were on track to achieve the 3.5% reduction target by the end of 2015, then we should have seen a decrease from 60,788 to 59,102 as at August 2015. This would be a reduction of 2.7%. It is recognised that there are many other factors which come to bear on non-elective admissions and this may have a negative impact on our ability to achieve our end of year target. The Better Care Fund programme is one element of considerable activity across the health and care system to manage these demands.

4.7 Despite the challenges with regard to non-elective admissions the impact on the other suite of metrics (as of August 2015) is showing a clearer positive trend:

- delayed transfers of care from hospital,
- permanent admissions of older people (aged 65+) to residential and nursing care homes,
- the proportion of older people (aged 65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services are all currently within target.

The patient/service user metric: support from local services or organisations to help manage long-term health condition(s), is within 2% of target which signals positive progress.

4.8 It is anticipated for the remainder of 2015/16, as schemes continue to move from development into delivery phases, due to the strong plans, integrated care arrangements and partnership working that impact in all areas will continue to improve.

5. Locality Updates

5.1 In the five CCG areas there have been considerable achievements in terms of the development and delivery of schemes. These have focused on the local demographic pressures and ambitions to drive health and social care integration. The following outlines some of the key achievements in each of the areas and notes the current performance in relation to non-elective admissions:

Progress & Achievements

Norwich:

- Home Ward pilot running incorporating a rapid response service and both clinical and social care provision at home via multi-disciplinary teams (avoiding hospital admissions and enabling early discharge).
- Providers and clinicians contributing effectively to all initiatives.
- GP risk stratification system rolled out across GP practices focusing on areas for targeted interventions.
- Most care homes aligned to a specific GP practice, improving continuity of health care and reducing GP workload.
- Admiral nurse consultant working with GP practices to increase diagnosis of dementia and promote best practice.
- Pilot scheme underway with up to 12 weeks of intensive community support provided via Age UK.

5.2 Non-elective admissions for the year to date as at August 2015 stand at 14,332 compared to 13,689 for the same period in 2014. This represents a 4.7% increase over the period.

5.3 If we were on track to achieve the 3.5% reduction target by the end of 2015, then we should have seen a reduction from 13,689 to 13,340. This would be a reduction of 2.5%.

South Norfolk

- The development of a consistent approach to multidisciplinary teamwork and plans is on track to mainstream this with GP practices
- Integrated Care Coordinator posts have been expanded and contribute to enhanced case management and co-ordination of frail patients.
- Supporting independence and wellbeing by establishing the Age UK led advice and support pilot in GP practices. The volunteering service was remodelled to give a stronger health focus. There has also been joining up with district councils and some work with other CCGs around falls prevention and Warm and Well.
- There is a coproduced vision for supporting people with dementia and an SNCCG locality dementia pathways model.
- Urgent Care Centre is established with 7 day social work service mainstreamed at NNUH. Provider led discharge models are in place and supported discharge, including the Henderson Ward model. (This also relates to Norwich and North Norfolk.)

5.4 Non-elective admissions for the year to date as at August 2015 stand at 14,751 compared to 14,640 for the same period in 2014. This represents a 0.76% increase over the period.

5.5 If we were on track to achieve the 3.5% reduction target by the end of 2015, then we should have seen a reduction from 14,640 to 14,185. This would be a reduction of 3.1%.

North Norfolk

- Risk profiling in place and assurance processes embedded to ensure all practices have risk profiled the right preventative “at risk” population
- MDTs being used for high risk/need patients (target 2%) and to allocate accountable professional. Key worker recorded on Integrated Care Coordinator spreadsheet returns

- Robust care coordination in place with 7FTE Integrated Care Coordinators in place
- Targeted data analysis provided as a communication brief to GP surgeries to focus MDT meetings on hot spots of admissions to focus efforts on.
- Independence, self-care and self-management menu of services moving from development to delivery phase focused on the four locality clusters.
- An integrated falls management Rapid Access Care Service has been in place with a new agreement (based on the evidence of impact) to expand service to an all-encompassing crisis response service

5.6 Non-elective admissions for the year to date as at August 2015 stand at 12,182 compared to 11,675 for the same period in 2014. This represents a 4.3% increase over the period.

5.7 If we were on track to achieve the 3.5% reduction target by the end of 2015, then we should have seen a reduction from 11,675 to 11,375. This is a reduction of 2.57%.

West Norfolk

- Integrated Care Coordinator capacity increased to enable seven day cover
- Review of practice-based Multi-Disciplinary Team working to support high risk patients has been completed and workshops being held with key stakeholders to implement best practice.
- Care Navigator pilot service (being delivered by British Red Cross, Age UK Norfolk and Independence Matters) is providing holistic, non-clinical support, to high risk patients. 90 patient referrals were received between February and August with referral rates gradually increasing
- Investigating options to enhance capacity of Multi-agency Rapid Assessment Team (based at Queen Elizabeth Hospital) to discharge patients to community services, where appropriate, across seven days
- System wide review of primary prevention of falls under way – focussing on how a virtual team of practitioners across the statutory, independent, community and voluntary sectors could provide a more consistent approach to identifying and supporting adults at risk of falling / with a fear of falling
- LILY (Living Independently in Later Years) initiative progressing into phase 2, including roll out of service via volunteers and community outlets.

5.8 Non-elective admissions for the year to date as at August 2015 stand at 14,842 compared to 14,271 for the same period in 2014. This represents a 4.0% increase over the period.

5.9 If we were on track to achieve the 3.5% reduction target by the end of 2015, then we should have seen a reduction from 14,271 to 13,842. This is a reduction of 3.0%.

Great Yarmouth & Waveney

- The successful implementation of an Out of Hospital Team model has been the key programme that is delivering the requirements of the BCF plan locally.
- Currently meeting target reduction in Non-Elective Admission of 3.5% reduction.
- GYW is also on target for its reduction in care home admissions.
- Close working with Suffolk via the BCF Partnership Board has supported cross county boundary working, an example being the Home Support procurement.
- The 15/16 plan has created mechanisms for challenging discussions on integration which would otherwise have taken longer to develop.

- Provided opportunity to identify areas of potential for further work such as increasing the size of the pooled budget, joint commissioning and truly integrated health and social care working.

5.10 Non-elective admissions for the year to date as at August 2015 stand at 6,071 compared to 6,513 for the same period in 2014. This represents a 6.79% decrease over the period and is 4.55% better than the August 2015 target of 6,360.

Challenges in the BCF delivery

5.11 Although there is real evidence of progress in terms development and delivery of BCF schemes in each area, as outlined above, there are clearly challenges in achieving impact on reductions in non-elective admissions alongside other key indicators. There are demographic pressures that influence this but each area has been reflecting on what challenges and complexities exist in relation to integration and the BCF. The following highlights some of the consistent factors across the localities:

1. Recruitment and retention of skilled and qualified clinical and project staff has impacted progress and capacity to deliver.
2. Challenges in seeking to understand the impact of individual work streams in isolation.
3. The timeline for implementing schemes and seeking impact has been relatively short.
4. The revision and reissue of the national programme created change in primary focus on non-elective admissions.
5. Scale and scope of schemes – some schemes may have a better impact if developed and delivered on a countywide foot print or across localities.
6. Duplication of effort – in line with the point above developing and delivering shared schemes across areas may reduce this and have a bigger impact.
7. Primary care is a key asset in the delivery and coordination of many of the schemes. Capacity to ensure this can happen is key.
8. IT solutions to deliver shared care records, support risk stratification and bring professionals together still requires additional focus.
9. Assistive technology, tele-health and tele-care still require additional development to support the community offer.
10. Self-Care & Self-Management programmes are reflected in all local plans but are relatively embryonic in their development. Additional focus is required to ensure that this options supports Norfolk's ambitions.

5.12 Not all of the challenges and complexities can be addressed easily however they do provide a focus for future developments.

6. Planning for the 2016/17 BCF

6.1 At this stage, consideration of next year's BCF is taking place largely at the locality partnership boards. The following outlines some of the factors which are being considered in developing plans for 16/17:

- Recognise that the BCF reflects and can support the wider partnership and integration agenda, rather than being a stand-alone initiative.

- Continue to develop the evidence base and the complex relationships between data to build the 16/17 plan. This will include not just the specified BCF outcome

measures, but also the local understanding of barriers to implementation and the qualitative impact of schemes.

- Continue to learn from other areas, both within Norfolk and beyond, in order to inform planning. For example, areas which are commonly cited include approaches that focus on reducing admissions to hospital from care homes, developing community based care models (e.g. virtual ward, teams targeted on admission avoidance), rapid/crisis response, primary falls prevention and self-care interventions.

- Ensure alignment with other initiatives and requirements, including CCG operating plans and QIPP programmes and Norfolk County Council's Reimagining Norfolk programme.

- Consideration of additional areas of funding that could be included in the BCF pooled fund.

- There are significant financial pressures across health and social care and given the challenge of reducing non elective admissions the financial rational promoted nationally for the BCF has not been achieved. A significant risk associated with this is that CCGs may not be able to maintain or justify investment at current levels into 2016/17.

BCF Planning Timeline 2016/17

6.2 We have now received confirmation that the BCF will continue and are advised to begin formulating plans for 2016/17. However, we understand full details will be set out after the Comprehensive Spending Review announcement on 25th November 2015.

6.3 The national BCF Support team have said that they are not planning to issue guidance on the planning process for 2016-17 or the nature of planning template that will be required until after the Comprehensive Spending Review.

6.4 However we cannot wait until then to start building the plan for BCF in 2016-17 as it will take time to shape the proposals and negotiate scheme content and financial arrangements most particularly between NCC and CCGs and to include in Council and CCG budgets.

6.5 We have therefore started the process of discussing plans for the BCF with a view to have agreed options in each locality ahead of the spending review and that enable us to respond quickly on receipt of national guidance. We are currently expecting the Better Care Support Team to seek formal approval in February for the plans that will be effective from April 2016.

6.6 There is a risk to this timeline in so far as CCGs will not know what their allocations are until mid-December. CCG's will be unable to confirm funding for 2016/17 until their financial position is clear.

6.7 It is for these reasons that Norfolk's HWBB is asked to contribute to the early development and consideration of forming these plans.

7. Conclusions and Recommendations:

7.1 Norfolk's BCF Programme is ambitious in both its scheme developments and delivery and the intended reduction in non-elective admissions of 3.5%.

7.2 This paper has outlined Norfolk's progress against regional feedback, the most recent BCF quarterly submission and the locality reviews on the progress, achievements and challenges to date and next some step considerations.

7.3 This has highlighted that although there has been considerable progress, particularly in regards to the wider metrics of the BCF, there are also some areas that will require additional focus to ensure that the scale and pace of impact is fully realised with regards to non-elective admissions across the whole of Norfolk.

7.4 This provides us with the strong foundations upon which to start building the 16/17 BCF plan for Norfolk.

8. Action

8.1 The Health and Wellbeing Board is asked to consider the information outlined in this paper and to:

- Agree the direction of travel for developing plans for Norfolk's 2016/17 BCF Programme.
- Provide any additional considerations on shaping and developing plans to deliver against the Better Care Fund Programme requirements for 2016/17.

Officer Contact

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Health and Well Being Board – Update on Responses given in the Quarterly BCF Report submitted 28th August 2015

Tab 2 - Budget Arrangements

Q 1) If it has not been previously stated that the funds had been pooled can you now confirm that they have?

Answer given 28/05/15: Yes

Tab 3 - National Conditions

Q 1) Are the plans still jointly agreed?

Answer given 28/08/15: Yes.

Q 2) Are Social Care Services (not spending) being protected?

Answer given 28/08/15: Yes

Q 3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?

Answer given 28/08/15: No - In Progress – Estimated date condition will be met - 30/04/2017 - All plans are in place and are developing on track to deliver an approach and implement key 7 day services in Norfolk. This is building and sharing on the learning from Great Yarmouth's earlier adopter site which has the components in place. The completion date is in line with that required by the 10 Clinical Standards for 7 Day Services. .

Q 4) In respect of data sharing - confirm that:

i) Is the NHS Number being used as the primary identifier for health and care services?

Answer given 28/08/15: Yes

ii) Are you pursuing open APIs (i.e. systems that speak to each other)?

Answer given 28/08/15: Yes

iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?

Answer given 28/08/15: Yes

Q 5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?

Answer given 28/08/15: No - In Progress - Estimated date condition will be met - 33/03/2016 - The infrastructure and integrated teams are in place to enable this. Next step actions are on course to embed this approach.

Q 6) Is an agreement on the consequential impact of changes in the acute sector in place?

Answer given 28/08/15: Yes - The three acute hospitals in the Norfolk system have acknowledged the impact of the BCF plan. NNUH - the impact of changes to activity has been agreed with NNUH and is reflected in SRG planning. James Paget hospital is aware of the potential impact. QEH has acknowledged the impact of targeted reduction.

Tab 4 – Non Elective and P4P

Confirmed that non elective admissions have increased and not reduced in line with plan, that no payment for performance was due or paid and that funds not released to the pooled fund were used by CCG's to pay for Acute care.

Tab 5 – Income and Expenditure

Selected Health and Well Being Board: Norfolk

Income

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Total Yearly Plan	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£19,293,380	£13,801,260	£14,683,080	£14,683,080	£62,460,800	£62,461,000
	Forecast	£19,599,950	£13,519,950	£13,519,950	£13,519,950		
	Actual*	£17,272,933					

Please comment if there is a difference between the total yearly plan and the pooled fund	Difference between total yearly plan and pooled fund are immaterial rounding differences.

Expenditure

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Total Yearly Plan	Pooled Fund
Please provide , plan , forecast, and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£19,293,380	£13,801,260	£14,683,080	£14,683,080	£62,460,800	£62,461,780
	Forecast	£19,599,950	£13,519,950	£13,519,950	£13,519,950		
	Actual*	£16,738,383					

Please comment if there is a difference between the total yearly plan and the pooled fund	Difference between total yearly plan and pooled fund are immaterial rounding differences.
Commentary on progress against financial plan:	The forecast for Income and Expenditure differs from the original plan as it excludes the Payment for Performance but includes the Integrated Community Equipment Service, a scheme not originally included in the plan, otherwise the forecast is in line with the plan. The Actual income and expenditure differs from the forecast due to timing of the receipt of income and payments where some payments or receipt of income did not happen to Q2

Tab 6 – Local Metrics

Selected Health and Well Being Board: Norfolk

Local performance metric as described in your approved BCF plan	Estimate diagnosis rate for people with dementia
Is this still the local performance metric that you wish to use to track the impact of your BCF plan?	Yes
If the answer is no to the above question please give details of the local performance metric being used (max 750 characters)	

	Plan				Actual			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Local performance metric plan and actual	50	56	62	67	53	0		

Please provide commentary on progress / changes:	We have not previously been asked to provide quarterly targets and these are indicative of the expected trajectory. Work to promote dementia diagnosis in a number of health and community settings is progressing as part of an integrated approach between health and social care services. The end of plan target remains challenging. The latest published figures are up to March 2015.
Local defined patient experience metric as described in your approved BCF plan	Q32 from GP Survey: in the last 6 months, have you had enough support from local services or organisations to help manage your long term health condition(s)? Please think about all services and organisations not just health services.
Is this still the local defined patient experience metric that you wish to use to track the impact of your BCF plan?	Yes
If the answer is no to the above question please give details of the local defined patient experience metric now being used (max 750 characters)	

	Plan				Actual			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Local defined patient experience metric plan and actual:	60	65	70	73	65	65		

Please provide commentary on progress / changes:	We have not previously been asked to provide quarterly targets and these are indicative of the expected trajectory. There has been a strong push to reduce the number of permanent admissions to residential and nursing care for older people in Norfolk by both health and social care, which it is anticipated will be reflected in improving patient experience and satisfaction. The latest data are from the July 2015 publication, collected during July-September 2014 and January-March 2015.

Tab 7 – Understanding Support Needs

Support requests

Selected Health and Well Being Board:	Norfolk

Which area of integration do you see as the greatest challenge or barrier to the successful implementation of your Better Care plan (please select from dropdown)?	4 Aligning systems and sharing benefits and risks

Please use the below form to indicate whether you would welcome support with any particular area of integration, and what format that support might take.

Theme	Interested in support?	Preferred support medium	Comments - Please detail any other support needs you feel you have that you feel the Better Care Support Team may be able to help with.
1. Leading and Managing successful better care implementation	Yes	Case studies or examples of good practice	Examples of national good pratice to date to further enhance schemes moving forward into year 2
2. Delivering excellent on the ground care centred around the individual	Yes	Case studies or examples of good practice	As above
3. Developing underpinning integrated datasets and information systems	Yes	Case studies or examples of good practice	As above
4. Aligning systems and sharing benefits and risks	Yes	Workshops or other face to face learning opportunities	As above
5. Measuring success	Yes	Webinars or other remote learning opportunities	As above
6. Developing organisations to enable effective collaborative health and social care working relationships	Yes	Wider events, conferences and networking opportunities	As above

Tab 8 – Narrative

Data Submission Period:

Q1 2015/16

Narrative	Remaining Characters	31,536

Please provide a brief narrative on overall progress in delivering your Better Care Fund plan at the current point in time with reference to the information provided within this return where appropriate.

Norfolk's Better Care Fund schemes continue to develop and progress well against plans with all S75 agreements agreed, signed and in place.

Where evidence indicates that the schemes are having a postitive impact the learning is being shared and developed. Where evidence of impact is not being demonstrated the schemes are being reviewed and refocused to ensure a proactive and responsive approach.

The local partenerships boards continue to provide the local focus and grip and the County BCF Board the opportunity to manage the significant requirements of the programme, share good practice and build on what works.

There remain significant challenges, due to the demographic pressures, in delivering against the ambitious and stretching BCF target for non elective admissions however plans across the CCG's and NCC are robust and reflective of the local requirements to meet this demand.

It is anticipated as schemes continue to move from development into delivery phases the impact in this area will increase in line with other key BCF indicators, such as the reduction in Delayed Transfers of Care, which is delivering well within target, due to the strong plans, integrated care arrangements and partnership working.

Report to Norfolk Health and Wellbeing Board
4 November 2015
Item 7

Clinical Commissioning Groups – Commissioning Intentions 2016/17

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

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

- Duty to provide an opinion as to whether the CCG commissioning plan has taken proper account of the Health and Wellbeing Strategy and what contribution has been made to the achievement of it
- Duty to assess how well the CCG has discharged its duties to have regard to the JSNA and JH&WBS.

Key questions for discussion

Q.1 How do the CCGs commissioning intentions relate to the overarching goals and priorities in the Joint Health and Wellbeing Strategy 2014-17, as based on the JSNA?

Q.2 What will be the overall contribution towards delivering the priorities of the Joint Health and Wellbeing Strategy 2014-17?

Actions/Decisions needed

The Board is asked to:

- Consider and comment on the engagement with, and contribution towards, delivering the H&WB's priorities and longer term goals

Clinical Commissioning Groups – Commissioning Intentions

Report by Norfolk's Clinical Commissioning Groups

Summary

This report provides information about the commissioning intentions of Norfolk's Clinical Commissioning Groups (CCGs) for the period 2016/17. It brings together the submissions from each of the CCGs at this stage in the annual planning process.

Action
The Board is asked to:

- Consider and comment on the engagement with, and contribution towards, delivering the H&WB's priorities and longer term goals

1. Background

1.1 At its meeting in January 2015, the Health & Wellbeing Board agreed a Forward Work Programme for the year. The Forward Plan included an item for the Board to consider at this meeting the commissioning priorities of CCGs to consider how they contribute to the priorities of the Joint Health and Wellbeing Strategy (see item 8 on this agenda).

1.2 In setting priorities for Norfolk as a whole, through the development of the Joint Health and Wellbeing Strategy, it is acknowledged that there are local variations in the levels of need and that there will be differences in focus in local areas.

2. Annual Planning process and CCGs Commissioning intentions

2.1 As part of the annual planning process, in accordance with national guidance, all CCGs are asked to develop their intentions, in high level terms, for commissioning services from providers during 2016/17.

2.2 This report brings together the commissioning intentions for Norfolk's Clinical Commissioning Groups (CCGs) for the period 2016/17, at this stage in the annual planning process. The purpose is to provide Board members with the opportunity to consider the engagement with, and contribution towards, delivering the priorities of the Joint Health and Wellbeing Strategy 2014-17.

2.3 The five CCGs were asked to submit their commissioning intentions, as they currently stand, and these are attached as follows:

- West Norfolk CCG - Appendix A
- North Norfolk, Norwich and South Norfolk CCGs – Appendix B
- Great Yarmouth & Waveney CCG – Appendix C

3. Action

3.1 The Board is asked to:

- Consider and comment on the engagement with, and contribution towards delivering, the H&WBs priorities and longer term goals

Officer Contact

If you have any questions about the CCGs commissioning intentions please get in touch with:

Name		Email
Sue Crossman, Chief Officer	West Norfolk CCG	sue.crossman@nhs.net
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Jo Smithson, Chief Officer	Norwich CCG	jo.smithson@nhs.net
Jim Hayburn, Chief Officer	South Norfolk CCG	jim.hayburn@nhs.net
Andy Evans, Chief Officer	Great Yarmouth & Waveney CCG	andy.evans2@nhs.net

IN TRAN communication for all

If you need this Agenda 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.

NHS
West Norfolk
Clinical Commissioning Group

West Norfolk CCG Commissioning Intentions 2016/17

1. Introduction and Vision

The strategic context of West Norfolk has been set out in the CCG's 'Evidence for Change' document published in January 2015 as part of the Monitor Contingency Planning Team (CPT) programme. The document sets out clearly the health system context, the challenge faced for both Commissioner and Provider in delivering care and a clear 'case for change' and both system and pathway level. This evidence-based analysis, supported by stakeholder engagement and feedback forms the basis of our commissioning plans and intentions.

The vision for the local health system in West Norfolk is one of sustainable, integrated health and care services for local people. The concept of sustainability refers to services which are both financially sustainable, i.e. not collectively delivering a deficit, and operationally and clinically sustainable, i.e. delivered via a model of care which ensures that they can be delivered in a clinically viable, safe and effective manner at the scale to which they are required locally. During 2015/16 West Norfolk CCG has moved into a more challenged financial position and is therefore pursuing a range of financial recovery measures. The impact on 2016/17 is likely to be a QIPP requirement in the region of £10m (around 4% of total spending), which will necessitate cash-releasing efficiency savings across the range of commissioned services.

Through effective planning, commissioning and contracting for services the CCG intends to improve health and wellbeing, reduce health inequalities, improve the quality of care, prevent disease and premature death and decrease hospital stays for long term conditions. Further, we aim to strengthen and empower local communities to increase independence and shorten the period of needing care to a minimum.

Through the health and social care West Norfolk Alliance both Commissioners and Providers have signed up to work to achieve cross-organisational integration following 4 principles for patient care:

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

To deliver this vision we will need providers of quality, effective health and care, delivering sustainable services drawing on best practice models of delivery. Our Transformation Programme builds on recommendations from the CPT intervention earlier this year along with plans created through clinical collaboration across providers. In line with the NHS England 'Five Year Forward View' we expect to test new models of care delivery in West Norfolk drawing on concepts such as integrated primary, community and acute provision, clinically networked services, and technology-driven delivery solutions.

2. Our ambitions for the future

Our desire as a CCG to innovate service provision, coupled with the growing sustainability challenge across our local health economy has led us to consider fundamentally the design of our local health services. Our approach has been to consider the provision of care across whole health system pathways of care, with an emphasis on those that have particular challenges in terms of performance, quality and financial opportunity to 'do differently' and overall 'fit' with designing a sustainable solution.

We therefore undertook in-depth reviews of the following pathway areas, which continues to inform our planned work for 2016/17:

- Frail and elderly
- Maternity
- Paediatrics
- Planned care
- Urgent care
- Primary care
- Mental health

Examining these pathways of care across primary, community, acute and mental health care has also led us to consider the application of some of the innovative models of care outlined in the NHS England Five Year Forward View.

Our thinking in relation to support for frail elderly and mental health care link to the Multi-specialty Community Provider (MCP) model; the maternity review tests the viability of a small maternity unit, clinical networks and the role of midwives; the work on 7 day extension of service and integrated provision aligns with innovation in Urgent Care provision, and across every pathway the fundamental right sizing footprint of our local small District General Hospital, and its' linkage with neighbouring specialist centre Trusts is tested.

Our West Norfolk Alliance partnership provides the senior leadership and commitment necessary to lead this level of strategic change, with the establishment in 2015/16 of local West Norfolk contracts with providers delivering to Norfolk and beyond, and closer joint commissioning giving us the levers to effect greater local change.

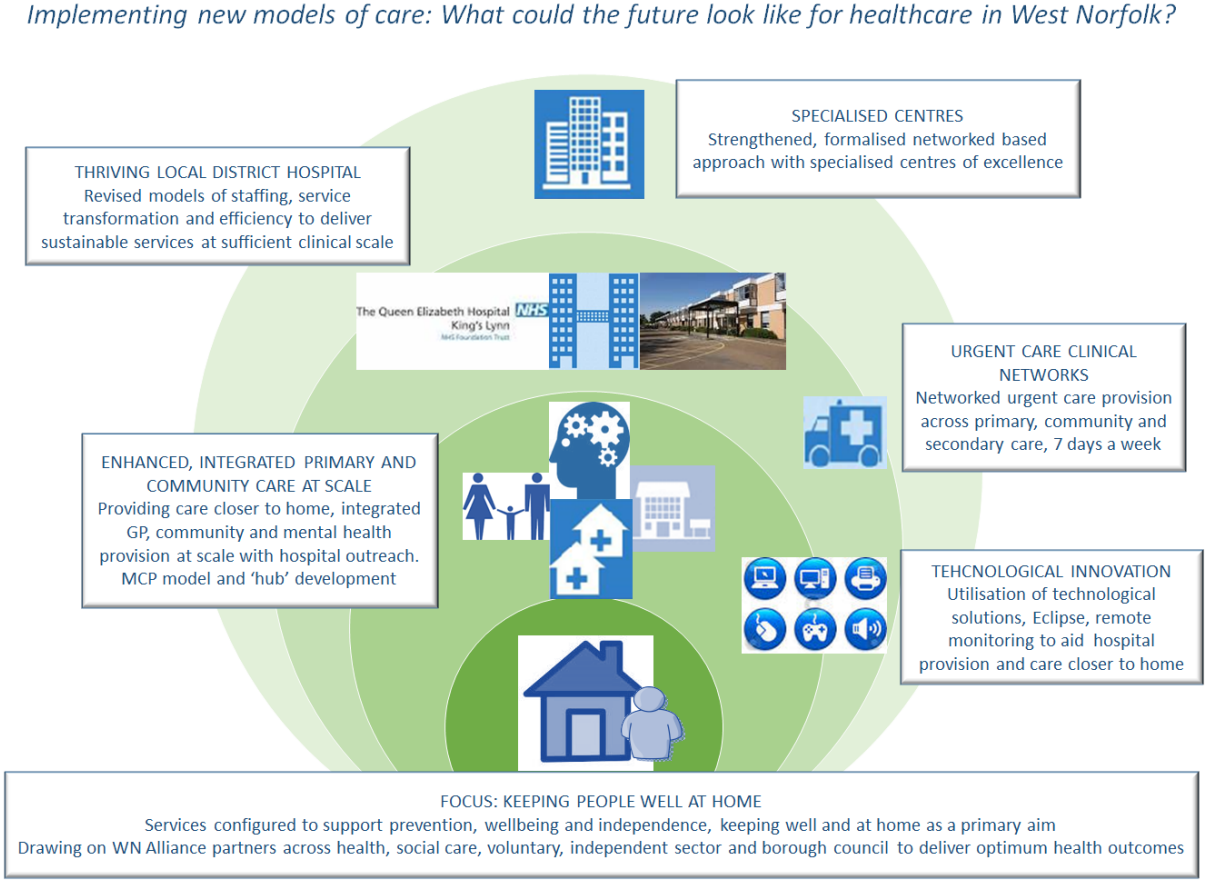
Achieving our vision in the context of the local sustainability challenge will require exceptional system leadership, concerted effort and a targeted change programme at pace and scale. Significant progress has already been made in driving improvement in operational delivery and quality of care, in addition to strategic thinking regarding future service configuration.

2016/17 will be a critical year in this programme; accordingly our immediate joint objectives are ambitious:

- To deliver operational resilience throughout the year, ensuring sustainable compliance with NHS Constitution standards and Mandate commitments.
- To ensure financial sustainability via a robust Financial Recovery Plan to bring us back to financial balance.
- To maintain progress on integration and transformation of high quality service delivery with West Norfolk 'Alliance' partners across health, social care, borough council and third sector.
- Seize the opportunity to proactively embrace and adopt new models of care, developing, testing and implementing innovative initiatives that improve service delivery.

In Figure 1, we have illustrated a high level view of what the future of healthcare provision could look like in West Norfolk, drawing on national thinking about future models of care.

***Figure 1**: 'What could the future look like for healthcare in West Norfolk?'*

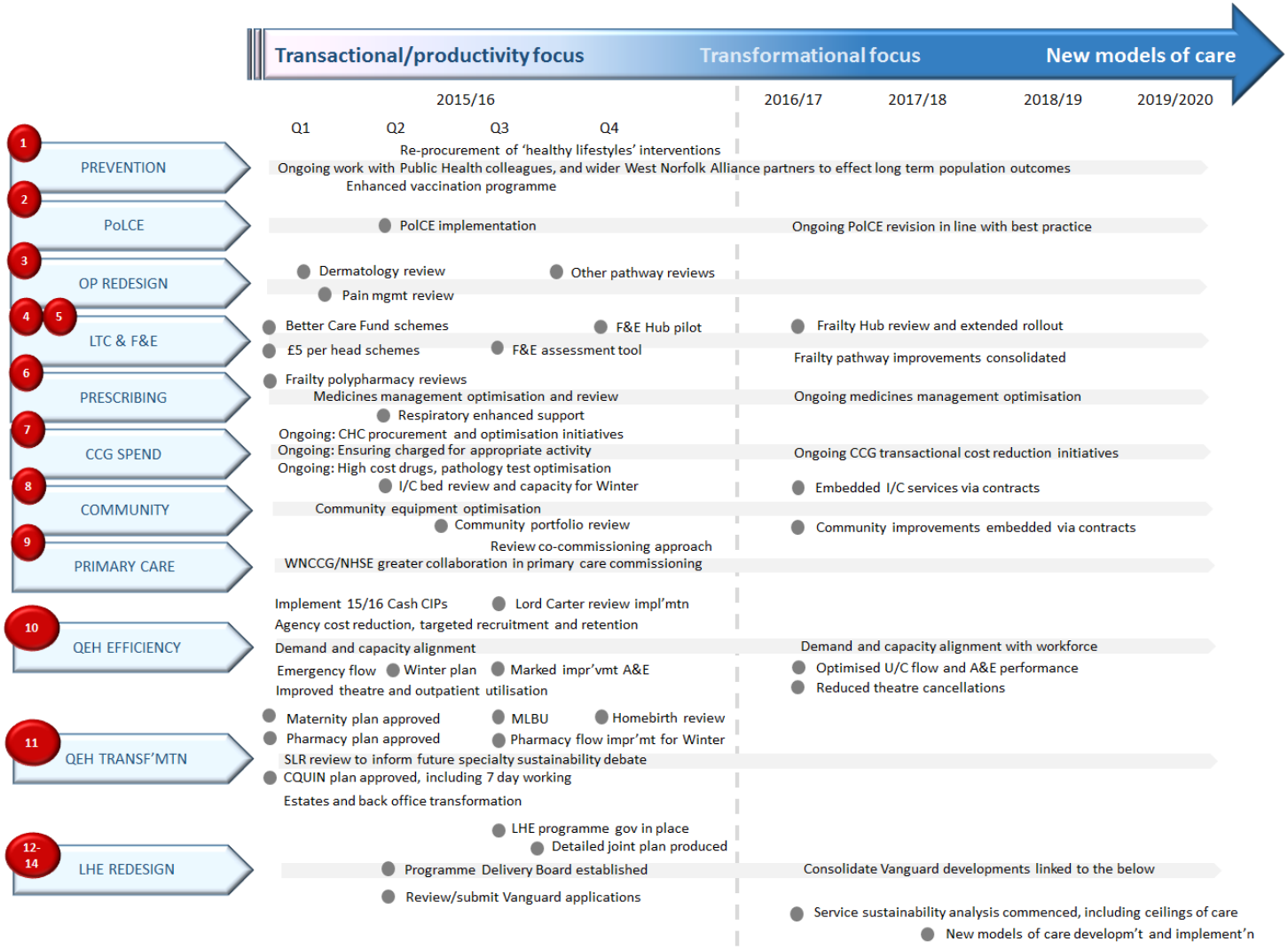


Underpinning this are key principles in the delivery of care, which include:

- Targeted care for the frail and elderly population in line with the Frail and Elderly Clinical Reference Group pathway
- Acute outreach provision at a clinically and economically viable level
- Quality, sustainable maternity provision, including the offering of choice to women in their birthing options
- Elective care, with a focus on excelling at the delivery of elective procedures linked to our population demographics
- Enhanced partnership working across health and social care providers at the front and back door of the hospital
- Review of smaller hospital specialties to ensure long term clinical and financial sustainability, consider innovative models of networking and alternative modes of delivery
- Integrated primary and community care at scale
- Integrated, person-centred end of life care delivery
- Technology as a key enabler of care, particularly in remote rural areas
- Development of models of care that attract and retain staff and allow for multi-skilling
- Consolidation of core urgent care services to ensure effective delivery and operational resilience
- Consolidation of clinical networks, particularly with other acute hospitals

3. Achieving local transformation

Our Transformation Plan captures the immediate and longer term programmes of work as illustrated in Figure 2 below.



4. Collaborative Working

Where new guidance such as NICE is published, it is the Commissioner's expectation that Providers will highlight any potential service configuration or financial consequences before the new guidelines are implemented.

The Commissioner requires ongoing assurance throughout the 2016/17 financial year regarding the Providers' internal Cost Improvement Plans (CIP) including the potential impact of any cost improvement plans on the clinical quality of the service, workforce and front line delivery of care which is of particular importance to the CCG. The CCG therefore requires full sight and understanding of the impact of any cost improvement plans (CIPs).

2016/17 presents our health economy with a number of very significant challenges. Maintaining and improving upon the quality of care provided for our population in the face of ever tighter budgets and demand pressures related to continued demographic change will require the CCG and Providers to work together, and to provide integrated care wherever possible. A shared approach to delivery and development of services is therefore key to our continued success.

The CCG will therefore actively encourage collaborative ventures between Providers of care to reduce transaction costs, share infrastructure investments and building services along integrated care pathways, whilst minimising disruption to patient access and continuity of care.

The 2016/17 Commissioning Intentions for West Norfolk are summarised in 4 tables below, one relating to all providers and then specific tables relating to community, mental health and acute care.

A. All Providers

Resilience Funding	The CCG wishes to ensure that Providers engage in appropriate early planning for the application of any identified resilience funding for the 2016/17 contract year. Providers are expected to proactively contribute to the early evaluation of all schemes in place where additional investment was made from resilience monies during 2015/16 to inform negotiations for the next year. There is no expectation that the non-recurrent funding for resilience schemes will continue into the subsequent year. Providers are expected to have in place suitable arrangements for delivering schemes over the agreed period including exit plans for when these schemes are concluded.
Frail & Elderly	A pathway that is fully integrated with all providers has been developed via the Frail and Elderly Clinical Reference Group. The CCG expects Providers to play a key role in this pathway and therefore remain fully engaged and pro-active in the development of the sustainable solution. Following the wider work within the Frail and Elderly stream nationally the use and sharing of assessment tools are being encouraged, including the Edmonton Tool, as is the multidisciplinary working between providers. The CCG expects all Providers to work jointly to support this Best Practice working.
Palliative Care pathway	A new model of care is due to be implemented in Quarter 4 of 2015/16 and is subject to completion of the current procurement exercise. The CCG expects all provider partners involved in delivery to work together to support the mobilisation and delivery of this new integrated service once the provider has been appointed. The CCG expects that this new service will deliver demonstrable improvements in admission avoidance, timely discharge from hospital and joint management of palliative and end of life patients. The CCG will work with providers of care to review alongside this new service the inpatient bed needs for palliative patients.
Unscheduled and Emergency Care Dashboards	Dashboards are to be developed to support urgent care flow within the health system. Providers are therefore required to continue with proactive engagement in the provision of supporting data as required to support in the operational implementation of these dashboards.
Autistic Spectrum Disorder (ASD)	Further to the service redesign workshops held during 2015/16 the CCG will implement the recommendations of the ASD Steering Group and expect the Providers to work in a collaborative way with other agencies to deliver elements of the service required.
7 day working	The 7 day service agenda remains a key priority for the CCG and reflects the national ambition as set out in the 'Five Year Forward View". The CCG has established a working group as part of the work plan of the System Resilience Group. The aim of the group

	is to map current service provision across 7 days and agree recommendations for service priorities.
Medicines Optimisation	All Prescribers should ensure that the most appropriate choice of clinically and cost effective medicines, informed by agreed local and national guidelines and formularies, are agreed with the patient to best meet the needs of the patient. All Prescribers should ensure that medicines are optimised in line with national and local guidance, particularly in terms of medication provision, safety and communication.

B. Community Specific

Lymphedema	Given the financial investment currently provided for the Lymphedema service, and the forthcoming reductions in Macmillan funding 2016/17, the CCG will review and evaluate the current service to understand the activity levels and service provided.
Intermediate care provision	The CCG will work with all providers to ensure that patients are cared for close to home and within the West Norfolk CCG locality, although the CCG does acknowledge that there are some circumstances which require patients to be treated outside this locality West Norfolk CCG expects to be fully involved in dialogue regarding future intermediate care service provision for West Norfolk patients. The CCG expects that any future changes will be fully considered and instigated on the basis of their benefit to West Norfolk patients, ensuring sufficient West Norfolk intermediate care capacity, and avoiding adverse impact on other providers of service.
Musculoskeletal (MSK)	The CCG plans to continue to commission a Musculoskeletal (MSK) service, however requires assurance that the national and local targets, including the 18 week waiting time target, will continue to be met.
Community Nursing and Therapies	Community Nursing and Therapies service provision forms a central element of the Provider's service offering to the West Norfolk population. Effective implementation and consolidation of service delivery following the Transformation programme, including the efficient operating of the West Norfolk 'hub' is required. To demonstrate this the CCG will require rigorous KPIs that provide assurance of effective performance. Appropriate skill mixing of integrated community teams will be vital, as will partnership working with local primary care and out of hospital providers.

C. Mental Health specific

Monitor and CQC	Given the issues highlighted during 2015/16 by Monitor and CQC, the CCG wishes to ensure that quality improvement plans and associated updates are being regularly submitted and will require involvement in any local service changes or reports. Further monitoring against plans will be required throughout 2015/16 and into 2016/17 at a West Norfolk level and through the NHS Stakeholder Assurance meetings.
Crisis Response	Given the additional 'Parity of Esteem' investment in services for 2015/16 within this work stream to support timely access mental health services, including crisis response and Crisis Resolution Home Treatment (CRHT), the CCG requires the Provider to demonstrate the incremental impact and improvement for 2015/16 for the population of West Norfolk. This will inform the future commissioning of services for 2016/17.
Adult Acute Inpatient Beds	Given the additional 'Parity of Esteem' investment provided for Acute Inpatient Beds the CCG requires the provider to demonstrate the incremental impact and improvement for 2015/16 for the population of West Norfolk. This will inform the future commissioning of services for 2016/17.
Access To Assessment (AAT)	As this service was redesigned and received additional incremental funding for 2015/16 the provider is required to demonstrate that the local changes and service have been embedded. This will inform the future commissioning of services for 2016/17. The benefits of this change will need to be monitored for both 2015/16 and into 2016/17. The CCG will strengthen the performance management processes in 2016/17 and set out rigorous performance indicators and reporting requirements to be monitored by the local performance reports from the Trust.
Acute inpatient beds and out of area placements	The currently commissioned adult acute inpatient beds has been indicated to be sufficient to ensure that patients are not unnecessarily moved out of the West Norfolk locality, (although the CCG understands that in certain circumstances this movement is required for patient need). To enable this, the CCG is finalising during 2015/16 an agreed protocol with the Provider for the arrangement of transfer to out of area providers.
Dementia	The CCG is planning to continue to work with all providers to fully review the Dementia pathway to ensure a cohesive service for patients both at the point of diagnosis and support care in the community going forward. The CCG would therefore expect the Provider to be the expert agency in terms of dementia care, and to pro-actively support partner organisations through advice and educational programmes. Dementia diagnosis rates are a priority area for CCG in 2016/17. The CCG intends to roll out a dementia strategy which will improve processes and reporting. During 2015/16 a pilot model was developed and rolled out for Dementia

	Care in Later Life (DCLL) and this will continue to be monitored in 2015/16 to ensure its appropriateness and capacity going forward into 2016/17.
CAMHS (Child & Adolescent Mental Health Services)	The CCG will work with Providers to ensure that there is an accessible, high quality CAMHS pathway for children and young people. This will include the ongoing work to secure the enhancements made to the pathway and to services for children and young people with eating disorders, in line with the developing Local Transformation Plan. The CCG therefore wishes to engage with the Provider and partner organisations to maximise the impact of the additional funding that has been secured in 2015/16, and potential further funding for 2016/17 to reflect the local delivery of these services and to protect the future local provision.
Community Eating Disorders	The CCG is reviewing the future provision of the Community Eating Disorder Service.
Attention Deficit Hyperactivity Disorder (ADHD)	Given the additional funding provided by the CCG, following the submitted business case by the Provider, for this service in 2015/16 the provider is required to demonstrate that the service has been embedded and the service will be monitored to understand the impact of this funding
Patient Transport	The CCG is working with the provider during 2015/16 to develop an agreed protocol for arrangement of and payment for mental health patient transportation in all circumstances. This is expected to be agreed and embedded for 2016/17.
Early Intervention	From 1st April 2016 national standards around percentage of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral will come into effect. It is expected that the Provider will be prepared for this and these standards will be achieved on an ongoing basis.

D. Acute specific

Prior Approval	The CCG requires Providers to continue to comply with a range of measures to ensure that referrals for treatment are within agreed policies regarding thresholds, adherence to best practice pathways, and Prior Approval for procedures of limited clinical effectiveness (PoLCE).
7 Day Services	The 7 day service agenda remains a key priority for the CCG and reflects the national ambition as set out in the 'Five Year Forward View". The CCG has established a working group as part of the work plan of the System Resilience Group. The aim of the group is to map current service provision across 7 days and agree recommendations for service priorities.

Pre-Renal Dialysis	The CCG will define how this cohort of patients is to be managed during 2016/17 including the prescribing of drugs. This process will be informed by a review of best practice for the treatment of these patients elsewhere in the local economy and nationally.
Pain Management	The CCG wishes to continue work with the Trust to review the Pain Management service and related pathways as part of the agreed deliverables within the post- CPT Transformation Plan. This work has already commenced during 2015/16 and includes review of the community Pain Management Ladder and alternatives models of provision.
Dermatology	The CCG will continue to work with the Trust to identify those minor skin procedures for which a community-based service is preferable to maintaining hospital-based delivery.
Maternity Services	The CCG remains committed to ensuring that the maternity services they commission support women's choice of place of birth. A decision regarding how the Home Birthing Service will be provided will be made between the CCG and Trust during Quarter 4 2015/16 and outcomes enacted in 2016/17. The CCG intends that the Midwife Led Birthing Unit (MLBU) will be delivered based on the service specification before the end of 2015/16.
Psychology Service	The CCG is reviewing the commissioning of Psychology services currently commissioned from the Trust.

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SENT VIA EMAIL BY NEL CSU ON BEHALF OF South Norfolk CCG, Norwich CCG and North Norfolk CCG

Wednesday, 30th September 2015

Dear

2016/2017 Commissioning Intentions for North Norfolk CCG, Norwich CCG and South Norfolk CCG (Central Norfolk CCGs)

This letter sets out the collective commissioning intentions for the Central Norfolk CCGs ("the Commissioners") for the financial year commencing 1st April 2016 to 31st March 2017.
These commissioning intentions have been developed to enable Providers of commissioned NHS Services ("the Provider") to both understand and plan to implement the strategic and service level changes these Commissioning Intentions present. In addition to considering and opening debate with the Commissioners around the potential service transformation opportunities set out within this letter.

This list is not exhaustive, and will be subject to change following the publication of further national guidance and the NHS England Operating Framework for 2016/17. The Commissioners reserve the right to amend or add to the areas listed, the issue of this letter does not limit the opportunity for Commissioners to refine or initiate new service improvements / clinical pathways during 2016/17. Neither does the timing and issue of this letter in any way limit opportunities for the Commissioners to refine or initiate new service improvements /clinical pathways during 2015/2016.

Although not covered by these commissioning intentions, each CCG is also reviewing primary care services and how these could help manage and meet the rising levels of demand being seen across all health services in Central Norfolk. Primary care services are commissioned and contracted via NHS England but CCGs have a strong influence on which services are provided and how they interact with other health sectors. The Commissioners are committed to developing a health system that has patient pathways that flow across health sectors with all providers playing their part to improve the quality of services and the patient experience.

During 2015/16 the Commissioners have formalised and implemented new joint commissioning arrangements. This partnership has seen the formation of a Joint Commissioning Committee (JCC), the review of Clinical Networks and the establishment of a Joint Contracting Executive (JCE). The Commissioners, through these arrangements will develop their strategic commissioning priorities and work plans which will drive and strengthen the management of 'Providers' delivery and performance in 2016/17.

The Commissioners have agreed lead contracting roles for local providers on behalf of the three Central Norfolk CCGs as set out below:

North Norfolk CCG – Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUHFT)

Norwich CCG – Norfolk Community Health and Care NHS Trust (NCH&C)
South Norfolk CCG – Norfolk and Suffolk NHS Foundation Trust (NSFT)

The lead CCG will be the prime point of contact for all contractual work with the 'Provider'. This will include co-ordinating the planning process, leading negotiations and chairing contract management meetings. These lead activities will be supported by or delegated to NEL CSU Anglia POD colleagues through an agreed scheme of delegation.

1. Financial context

The NHS is facing unprecedented financial challenge both nationally and locally. This is certainly the case for the central Norfolk CCGs who will commit to provide sizeable QIPP savings in 2016/17. We are of course, all too cognisant of the financial pressure facing Providers; we will therefore support Providers to deliver the best possible care and value for money for our communities but will work with Providers to ensure that the NHS budget as a whole is used to best effect for the population we serve. At the time of writing this letter the Commissioners do not know the detail of 20161/7 financial allocations however as in previous years, we are making an assumption that there will be no recurring financial resources available for investment into new services.It is critical that services are both improved, transformed and commissioned within current financial allocations. We recommend that budget plans are shared as early as possible in the contract negotiation process in order that we can identify early any significant planning assumption gaps between organisations and across the health system.

The Commissioners have identified cost pressures which include inflationary and other increases in prescribing and drugs costs, continuing healthcare, the impact of tariff and other acute cost pressures. These include non PbR/local prices being subject to the same percentage change as national PbR pricing.

The Commissioners Quality Innovation Productivity and Prevention (QIPP) savings targets for 2016/2017 will reflect the financial environment and highlight the areas where together we can increase quality through joint working. It is essential that QIPP is delivered on a system-wide basis as well as within individual organisations and we expect the full engagement of Providers in QIPP initiatives. The anticipated level of QIPP savings required to deliver the financial expectations of NHS England on each CCG will be significant and present a challenge to all health sectors.

At this point in time the Commissioners are developing QIPP plans, the individual CCG QIPP assumptions and impact on the main provides is set out in the table below. The providers affected should factor these figures into their financial planning assumptions for 2016/17. The figures below are based on current Commissioner plans and could well increase over the coming months.

CCG Planned QIPP by main provider				
CCG	**NNUH**	**NCH&C**	**NSFT**	**Total**
North Norfolk	£3.0m	£0.3m	£0	**£3.3m**
South Norfolk	£6.0m	£0.9m	£0.8m	**£7.7m**
Norwich	£4.75m	£0.03m	£0.44m	**£5.22m**
Total	**£13.75m**	**£1.23m**	**£1.24m**	**£16.22**

Commissioners require ongoing assurance throughout the 2016/2017 financial year regarding the Provider's internal Cost Improvement Plan (CIP) including the potential impact of any cost improvement on the clinical quality of the service, workforce and front line delivery of care which is of particular importance to Commissioners. Commissioners require a full sight of and understanding of the impact of any cost improvement plans (CIPs).

We will actively encourage collaborative ventures between Providers of care to reduce transaction costs, share infrastructure investments, building services along integrated care pathways, whilst minimising disruption to patient access and continuity of care.

The Commissioners acknowledge that all NHS organisations, along with independent sector provider and Norfolk County Council, face unprecedented financial challenges and pressures. The Commissioners are committed to the belief that the only way to manage these is to look for ways of reducing duplication, maximising efficiency across organisations and to work collaboratively as one health and social care system. Organisational boundaries should not and must not be a cause of increased spend.

The Commissioners reserve the right to revisit these Commissioning Intentions in the light of any changes arising from the resource allocation process and national/local guidance. The contract negotiation timeline will allow for open and transparent discussions with Providers regarding funding levels for 2016/17. Funding levels will be considered by the Commissioners in totality across all care Providers and not in isolation for each individual Provider.

At this point in time, although this may be subject to change which would be discussed with providers, the Commissioners intend to base their activity and finance planning for 2016/17 on month 6 freeze activity data.

2. Joint Priority Areas

System Resilience

The Commissioners expect the Central Norfolk System Resilience Group to include membership from all key stakeholders at sufficient level of seniority to allow decision making. There is also an expectation that all local health and social care providers will continue membership of and development work within the Programme Domino. We will continue our focus of strengthening resilience planning and delivering transformational changes in line with the Urgent and Emergency Care review (2015). Through the Capacity Planning Group, System Resilience Group, Programme Domino work streams and key task and finish groups, we will focus on improvement and continued delivery of the Eight High Impact Operational Resilience Interventions and the Nine High Impact Actions to improve ambulance performance outlined by NHSE (2015).

Quality, Safeguarding and Patient safety

The Commissioners expect and will seek from Providers that quality and safety are embedded within their culture. We will seek assurance that all quality standards are met, improvement plans are in place and robustly monitor that standards are delivered throughout 20161/7. We will do this by ensuring that the quality of services against the CQC standards and/or performance remedial or recovery plans is embedded within contract quality schedules. These schedules will clearly outline nationally mandated and local and/or Provider level quality and safety expectations and metrics. We will scrutinise and monitor themes and trends in patient safety and harm and where relevant initiate clinical audits, investigations and harm reviews as considered necessary. The Clinical Quality Review Group (CQRG) for each main contract will monitor service delivery of standards throughout the year, using all contract levers available to us to ensure standards are met.

Winterbourne – Transforming Care

The Winterbourne report set out the care that people with learning disabilities/autism and behavioural issues should receive. All clients subject to 'Winterbourne' have been jointly reviewed by the CCGs and Norfolk County Council (NCC). A joint Winterbourne sub group feeds into a joint commissioning forum to ensure the needs of the learning disability clients within Norfolk have the

right services in place. The CCGs will continue to build upon the work already in place during 2016/17. Particular reference will be made to **"**Supporting people with a learning disability and / or autism who have a mental health condition or display behaviour that challenges" draft guidance 2015 and its final publication.

Norwich Walk In Centre

The Commissioners will work with NHSE, who are the lead, and all local Providers to procure the Norwich Walk In Centre and ensure that the service is integrated and coordinated within the local health system.

Infection Control

The Commissioners will continue to build on learning from local reviews and optimise the use of root cause analysis to drive down the prevalence of infection. We will continue to focus on MRSA and Cdiff to ensure learning and action required to prevent recurrence have been embedded by Providers and improvement trajectories as a result are being delivered. We will continue to apply a zero tolerance to MRSA bacteraemia cases in 2016/17.

Local Audits and Policy Reviews

Commissioners reserve the right to conduct local audits to confirm adherence to pathways and policies and specifically where coding or other anomalies are identified. The audit process will also be used to identify system-wide issues impacting on Providers and inform beneficial changes or decisions in support of these. We will not accept any Provider-enforced limits to the number and scope of any such Audits or Reviews. However in relation to audits, we will as part of the contract negotiation process, agree an in year programme of planned audits with Providers.

The Commissioners have agreed to work together to review, revise and develop policies in relation to the new Operating Model for Continuing Healthcare and to meet the requirements of the Assurance Framework (March 2015). This will include setting up patient forums to inform the policy changes, pricing review and operational activities in relation to the process for assessing patient's eligibility for continuing healthcare funding and the care and support provided subsequent to eligibility.

Cancer Services

The Commissioners expect all relevant providers to engage and work with the newly appointed Central Norfolk Macmillan GPs to reduce the number of premature deaths from cancer; learning from pilot sites.

Commissioners will work with providers to improve the provision and access of cancer services within the health system and invoke all contractual levers available to us where services fall short of nationally expected standards.

Stroke Services and Pathways

The Commissioners give notice to all relevant Providers, namely NNUHFT and NCH&C, within the local health system that we conclude best practice standards are not being met. We therefore give notice that we will carry out a full evaluation during 2016/2017 to clinically review the current delivery model, pathways of care and associated tariffs/funding streams. Dates for commencement, conclusion and implementation of this review will be confirmed as part of the contract negotiation process and a system wide work plan embedded within the main contracts with NNUHFT, NCH&C and NSFT. In addition we will use all contractual levels available to us where services fall short of nationally expected standards.

Commissioning for Quality and Innovation (CQUIN)

The Commissioners will offer nationally mandated CQUINs to Providers, when published for 2016/17. In relation to the agreement of local CQUINs, these will be developed in collaboration with Providers, and relevant local stakeholders, all local CQUINS will be developed to directly support local commissioning priorities. It is likely that the local CQUINs will be focussed around:

1. Urgent Care Transformation
2. 7 day working
3. Frail Elderly
4. Reduction in suicide rates across the population and incidents of self-harm within the 0-19 age group
5. Self-administration of Clexaine injections

Further local CQUINs may well be identified from more localised CCGs plans such as the YourNorwich programme, these will be agreed by the Commissioners and negotiated with Providers as appropriate.

CQUINS will be constructed to reward excellence over and above commissioned standards of care. CQUINS in 2016/17 will not be paid if the contracted level of improvement is not achieved, evidence required to demonstrate improvement will be detailed in each contract.

Excellence has been rewarded through the delivery of CQUINs in previous years, these quality improvement goals will be built upon within the development of CQUINS for 2016/17. Commissioners will seek assurance that CQUIN schemes implemented in 2015/2016 are included in mainstream business activity in 2016/2017 through the agreement of local quality requirements for 2016/17 which will give assurance to commissioners that quality standards achieved and rewarded are sustained.

With regard to the current stroke CQUIN the Commissioners are giving notice that this will not continue into 2016/17, current improvements will be maintained by Providers and the expectation is that all relevant Providers will, in 2016/17, be achieving best practice standards.

Seven Day Working

Seven Day Working is intended to result in better outcomes for patients through better provision of services over a 24 hours period and improved patient flows 7 days a week. The current national timescale for this is delivery by 1st April 2017. Commissioners will work with Providers in developing plans during 2016/17 to prepare for delivery in 2017/18 and assure the Commissioners that the delivery timescale will be met.

Seven Day working will remain a key priority through the System Resilience Group and the associated work programmes e.g. Domino.

Commissioners will work with the Provider to build on the NHSIQ Seven Day Service Self-Assessment carried out in 2015/2016. Patients should be able to access urgent and emergency care services, and their supporting diagnostic services, delivered in a way that meets the clinical standards seven days a week. Meeting the ten clinical standards will require transformational change and collaboration between Providers of services and different sectors of the health and social care system. Commissioners will work with all Providers to support the delivery of the ten clinical standards.

3. Contract Management 2016/17

These intentions, along with any publicised coding, counting and service change letters from the Providers, will be translated into individual Provider focused Contract Negotiation processes which will enable the Commissioners to agree Contracts with Providers by Friday 26th February 2016 for signature by 31st March 2016.

In developing these individual Provider Contract Negotiation Strategies the Commissioners will be mindful of system wide implications and actively discuss these with Providers.

The Commissioners will seek to enter into the National NHS Standard Contract 2016/2017, when published, with all Providers of NHS funded healthcare services, selecting the term of those contracts will be relevant to each Provider. It is the intention of the Commissioners to enter into contracts with a term of more than 1 year where possible; this will be on the basis that they are trying to build longer term supportive relationships with Providers to achieve common goals and improvements in standards of care for the patients. This will be subject to negotiation.

The Commissioners will maximise the innovative contracting models, where we consider appropriate, to support major service redesign projects and integrated care models which support the delivery of the NHS Five Year Forward View.

In addition, we will contract fairly and will use all contractual agreements to assure the Commissioners and their respective Governing Bodies that Providers are delivering high quality, safe and cost effective services. We will develop good relationships with Providers on the basis of mutual openness and transparency; this will go a long way in supporting the agreement of longer term contracts. Therefore it is critical to state that the Commissioners expect full compliance with agreed contract standards in relation to quality, safety, effectiveness and performance in 2016/17 and where standards are not met the Commissioners will use all available contract levers. This includes the withholding and retention of income, the application of all national and local financial consequences and formal contract performance notices where relevant.

The Commissioners reserve their right to reinvest, or not, any funding relating to the application of contract levers/financial consequences and will publicise how we have used such funding in line with national guidance. Reinvestment of financial consequences to support locally agreed service developments and innovation is subject to agreement therefore reinvestment of such funding should not be assumed by any Provider.

The Commissioners will be negotiating 2016/17 contracts on the clear understanding that all items included in 2015/16 Service Delivery Improvement Plans (SDIP), Data Quality Improvement Plans (DQIP) and Longstop items have been delivered. There will be no negotiation or consideration of any additional investment for these items in the 2016/17 contract.

4. Information Schedule

The host Commissioner on behalf of itself and Associate Commissioners intends the following information principles will be followed by all providers:

- **SPECIALISED SERVICES:** Specialised services activity as detailed in the national specialised services definition set will be funded by NHS England, for all activity in England at that provider. All parties will work together to ensure these rules are applied consistently from the 1st April 2016;
- NHS England have indicated that ALL **specialist commissioning** activity will be chargeable using national identification rules., Providers are therefore expected to encode their SUS submissions to clearly identify this activity and its dependent data elements so that the new national IR rules can be correctly applied to the SUS data.

- BLOCK ELEMENTS OF CONTRACTS**:** Where these are continued, the nature of the service and the rules around which activity is included must be made fully available, and where appropriate, must be supported by Patient Level Data.
- MATERNITY SERVICES DATA SET: In accordance with Information Standard Notice Amd 45/2012 and corrigendum ISB 1513 published in March 2015 Maternity Care providers should already be collecting (from 1st November 2014) and submitting (from 1 June 2015) data through the Bureau Services Portal within the monthly submission window as stated on the HSCIC website.
- CHILDREN AND YOUNG PEOPLE'S HEALTH SERVICES DATA SET: In accordance with the information standard SCCI1069 and corrigendum, all providers of services to children and young people are expected to be able to collect this information locally from 1 September 2015 and submit nationally by 1 October 2015. Further information is available on the HSCIC website.
- UNBUNDLED DIAGNOSTICS: Commissioners will require a separate data flow submitted as part of SLAM backing data to validate unbundled diagnostics. This should additionally be submitted via SUS according to the rules for identification of such activity as outlined in national SUS submission guidance. Providers will be required to fully encode this data within national SUS data in line with national guidance, Therefore, Commissioners will only pay for DI activity which is recorded correctly in SUS in 16/17.

NHS England Commissioned Services

Specialised services activity as detailed in the national specialised services definition set or locally agreed definition set (as applicable) will be funded by NHS England, for all activity in England at that provider. All parties will work together to ensure these rules are applied consistently from 1st April 2016.

NHS England have indicated that ALL specialist commissioning activity will be chargeable using national identification rules. Providers are therefore expected to encode their SUS submissions to clearly identify this activity and its dependent data elements so that the new national IR rules can be correctly applied to the SUS data.

For those services where NHS England (NHSE) requires providers to have met eligibility criteria in order to qualify for NHSE payment for those services, the Commissioners will not pay for such services if billed instead. This is because eligibility has not been granted by NHSE. For avoidance of doubt, eligibility implies that clear clinical standards have been met and, if those standards have not been met, Providers undertake such activity at their own financial risk.

Children, Young Persons and Maternity Care

The Commissioners are committed to continue to build upon the work in 2015/16 across the childrens and families agenda during 2016/17 specifically focusing on :

- Early health and intervention services
- Accessible, high quality CAMHS pathway
- Implementing the requirements of the Childrens & Families Act 2014
- Healthy weight & obesity prevention (Tier 3), in support of Public Health
- High admissions pathway
- Looked after children
- Continuing Care service provision for eligible children and young people

They will also specifically focus on the following areas:

- Review the Norfolk pathway for assessment and diagnosis of Autism Spectrum Disorder (ASD) in children and young people against current NICE guidance. Clarify the support

available pre and post diagnosis and identify any service improvements which can be made within current resource.

- Consider and respond to the national maternity review, to include exploring opportunities for increased choice in place of birth and home birthing services
- Continue to review short breaks model for children with complex health needs with current provider (NCH&C)Review services commissioned at individual package level to identify opportunities to redesign mainstream and specialist health and care services for children and young people
- Review Paediatric Emergency Admissions, focusing particularly on those where the primary diagnosis is respiratory or self-harm with a view to reviewing pathways and reducing admission rate
- Review, jointly with Norfolk County Council, models of health care delivery to Looked After Children, this could lead to procurement during 2016/17

5. Acute Care

Setting the Activity and Finance Plan for 2016/17

The Commissioners will set out proposals for establishing the baseline for the activity and finance plan for 2016/17 within the NNUHFT Contract Negotiation Strategy, which will be developed in October 2015. Providers will be required to adhere to the deadlines set out in the negotiation strategy timetable in order to formulate the 2016/17 activity and finance plan. This is paramount due to the significant changes and inherent risks for both the Commissioners and Providers in the move to HRG4+ for nationally priced services. The Commissioners will monitor any impact from specialised services and review the consistency of the application of rules nationally, where it may be impacting on the Norfolk health system.

Productivity Metrics

Commissioners will review available information which indicates further opportunity for efficiency within the local system and will negotiate the implementation of any associated actions with Providers. Failure to achieve the agreed productivity metrics in 2016/17 will carry a financial consequence for providers and this will be set out clearly within the contract. We will build on the work undertaken in 2015/16, including but not limited to:

- **First to Follow-up Ratios**

  The Commissioners will commence a programme of work in 2015/16 to secure clinical engagement and shared benchmarking data to inform the negotiation and development of First to Follow-up Ratios for inclusion and monitoring within the 2016/17 contract. This will result in a clear action plan with milestones which Providers will be expected to meet. Commissioners will only pay for the planned level of activity and in activity above the plan will be at the Providers own cost

- **A&E to Admission Conversion Rate**

  Commissioners intend to set further stretch targets to reduce the ratio of A&E attendees which then proceed to admitted care. The targets set will be calculated to take account of any admission avoidance schemes that are due to be implemented during 2016/17 as well as any alternative services in place to reduce attendance at A&E.

- **Other potential metrics to be included but not exhaustive:**

- Daycase to outpatient procedure ratio
- Consultant to Consultant referral levels
- Outpatient to elective conversion ratio
- Procedures not carried out
- Maternity casemix
- Readmissions
- Delayed transfers of care
- Ambulance handover

Review of Urgent Care Centre (UCC)

The Commissioners need to be assured by NNUHFT that the current model of the UCC is delivering good outcomes, improving patient access to urgent care as measured by the A&E 4 hour standard, and can demonstrate value for money. We will undertake a full review of the service which will be completed by 31st December 2015. However at this stage we can confirm that we are not assured that the Urgent Care Centre is delivering as expected and we are therefore serving notice to decommission the UCC and emergency clinics as from 1st April 2016.

Prior Approval, Clinical Policy & Individual Funding Requests

The prior approval and clinical policy process will continue in 2016/2017 with future phases being data driven and evidence-based. Implementation of future phases will be subject to the agreed consultation process as set out in the Prior Approval Policy.

The Commissioners will maintain a rolling review of clinical policies listed under the Non-Routine Treatments and Treatment Thresholds (NRTTT) policy following already agreed processes.

Any revisions to the Individual Funding Requests (IFR) policy will be implemented following due process where required.

The Commissioners will not pay for any activity that is undertaken by the Provider where prior approval has not been sought in line with the existing policy (incorporated into the contract).

National Tariff Payment System

There will be significant changes in the National Tariff Payment System due to the proposed movement to HRG4+ and rebase of prices using the 2013/14 Reference Costs returns. As such Commissioners expect Providers to fully engage in the planning process to gain clarity on potential financial implications to the Parties in a timely manner as defined in the Negotiation Strategy timetable.

Any nationally mandated deflators/inflators will be applied to non-Tariff prices in line with the 2016/17 NTPS Guidance. No other changes to non-Tariff prices will be accepted without the explicit consent of the Lead Commissioner on behalf of all Associate Commissioners.

Unless otherwise stated explicitly, for 2016/2017, the tariff structure will include the requirement for Providers to deliver all of the NICE Quality Standards within tariff.

Providers must provide formal notification to Commissioners of any planned changes to coding of services observing the good practice behaviour set out previously in the PbR Code of Conduct. Where Commissioners can evidence that due notice was not provided, income related to the change will be retained immediately.

Providers are required to give notice of any changes planned to coding / counting for 2016/2017. Where Providers do not publicise Commissioning Intentions on that date, the Commissioners will not give regard to any changes set out in later notifications unless these are presented through formal contract notice / variation processes. In line with the NHS Standard Contract, where any change in counting and coding practice proposed and agreed is projected, once implemented, to have an impact on the value of services, the prices payable will be adjusted in accordance with the National Tariff to ensure that that impact is rendered neutral for the remainder of the 15/16 contract year and the whole of the 16/17 contract year.

As part of the contract negotiation process Providers will be required to evidence where Best Practice Tariff requirements have been met and qualify for payment or agree a timescale to meet BPT criteria for existing and new BPTs introduced in the 2016/17 NTPS Guidance.

The Commissioners plan to undertake a further review of local prices during 2016/2017 to ensure consistency and appropriate pricing within contracts, and accurate distribution of costs across Clinical Commissioning Groups. Providers will be expected to cooperate in local tariff discussions to underpin transformation work programmes to alleviate system wide pressures.

Commissioners will expect Providers to cooperate fully and provide timely information on the costs of services in order for the outputs of these reviews to form part of 2016/17 negotiations. This review may be conducted by an external organisation.

Dependent on Commissioning decisions on the future of an Urgent Care Centre we will work with NNUHFT to develop a local price model for front of house services to replace the existing payment arrangements.

To inform this review, the Commissioners require details of the Provider's costings for those areas currently covered by local arrangements. This detail is required no later than 31st October 2015.

Local Information requirements

The Commissioners will review the Local Information Requirements for the 2016/2017 contract and amendments may be required to reflect any contract revisions, and to ensure that local information requirements are adequately incorporated. The provisions in the national contract will be enforced rigorously for the Information schedule. For non-compliance this will include the serving of Information Breach notices.

The following information principles will be followed by all providers:

The Commissioners expect that SUS may become the main dataset used for the validation and payment of acute trust invoices in 2016/17.

Commissioners will require sufficient supporting minimum data sets for all service lines from 1st April 2016 to support the continuation of payment. Failure to provide this information will be classed as an Information Breach under the contract and payment for the service will be withheld until supporting information is provided and Breach notices will be issued in line with the process set out in the 2016/17 standard contract.

A standard format for SLAMs and patient-level minimum data sets (MDS) will be agreed during negotiations and will apply from the beginning of the contract year. Any changes must be agreed in advance by both parties;

All activity will need to be reported on at GP Practice level.

The use of the NHS number is vitally important and will still be a key data standard;

Any existing local data submissions will continue unless otherwise agreed;

In order to support the Commissioners' ongoing needs assessment and capacity planning, the Provider will be required to continue providing monthly information about patient referrals into the Trust.

For any non-achievement of DQIP areas the Commissioners will enforce a local 'consequence of breach' for the 2016/17 contract.

Sharing and Processing Patient and other Information

The CCG's will be reviewing its DSCRO provider options which may require the provider to align to a different process when submitting patient Identifiable data in 2016/2017. Notice will be given of any such change however this may fall between financial years and as such amendments to the Information schedule could be required. We expect the provider to work collaboratively with commissioners during any such transition.

Service Changes

The Commissioners intend to review the provision of all commissioned services including those included for the first time in 2015/2016 (i.e. Tracheostomy and Home-Based Therapy) service during 2015/2016. A priorities list and timescales for those reviews will be discussed and agreed with the relevant Providers as part of the contract negotiation process for 2016/2017.

Where a Provider undertakes and implements a service change without the prior agreement of the Commissioners it does so at its own financial risk and cannot assume that the Commissioners will pick up any costs.

Speciality reviews

Commissioners will review existing service delivery models existing pathways using Benchmarking techniques to identify Specialties where redesign will enhance patient outcomes and provide cost benefits to the health economy as a whole.

The table at Appendix 1 lists the main areas where attention will focus on but this list is not exhaustive. Unless explicitly stated these reviews will be conducted on behalf of all Central Norfolk CCGs. Where individual CCGs have specific requirements, these will be identified in the appendices.

6. Community & Out of Hospital Services

Collectively the Commissioners are keen to improve integration with primary care services and keep people well in the community. The overarching intention is to ensure patients receive the right treatment in the place at the right time first time. Therefore we are committed to ensuring that all providers – acute, community, mental health and primary care work together to reduce the need for acute inpatient care where clinically appropriate. We will continue to develop robust joint working and admission avoidance schemes across the health economy, in partnership with key stakeholders. This will remain a priority for 2016/17 with the Commissioners both collectively and individually developing further schemes and initiatives on a system wide and CCG basis.

The Commissioners will continue the work commenced in 2015/16 to review, revise and develop pricing and policy frameworks to support those patients eligible for continuing healthcare funding. This work will also support the further development of the "Out of Hospital" model which will replace placement without prejudice to ensure all patients receive the care and support they require on discharge from the acute and community facilities. This supports the requirement to minimise delayed transfers of care and ensure system flow is maintained. This is anticipated as an in-reach

service going forward, therefore planning this service model is required within 2016/17. Any revised model will need to be delivered within the existing financial envelope and will not attract additional investment from the Commissioners.

7. Mental Health Services

We are aware that NSFT are currently part way through a major programme of change in response to CQC and Monitor investigations. The Commissioners' priority is to continue to work closely with NHSFT to ensure that services provided are safe and deliver high quality care for patients. We will work with NSFT to co-produce a vision and transformation work plan for local services including at CCG level where appropriate e.g. adult community. Elements within the plan will be embedded into the contract for 2016/17, through the negotiation process to assure the Commissioners of delivery. The plan will also clarify the next steps required to transform local services to be fit for purpose, affordable and improved including:

Redesign community services with prevention focus
Improved outcomes with data to support
Improved recovery focus
Better integration with primary care
Redesign of workforce to negate workforce issues

Clear milestones for delivery will be needed on improvements to collaboration, behaviours and ways of working, as well as improvements to information, data and quality.

Contract Rebasing

A robust process needs to be agreed between the Commissioners and NSFT to work through rebasing the contract. This work needs to rebase the contract not only between the Commissioners but also other organisations that commission services from NSFT e.g. Great Yarmouth & Waveney CCG and the Suffolk CCGs. This will be a contentious piece of work but is essential if organisations are truly going to meet the health needs of their population out of the allocated resources. This rebasing needs to be concluded as soon as possible with an agreement to implement, even if retrospectively, from 1st April 2016.

Mental Health Payment and Pricing System

The Commissioners are committed to the implementation of the mental health payment system. While Commissioners anticipate compliance with national recommendations, CCGs wish to move to a variable pricing model based on cluster currencies but only with appropriate safeguards being in place around risk of over or under performance.

Commissioners will need to fully understand any risks relating to data quality that relate to the recent implementation of Lorenzo therefore commissioners reserve the right to request further validation of the impact of the new system before progressing its intentions.

In order to support the implementation of the payment and pricing system, it is necessary to ensure that there is standardised clinical practice with agreed and documented protocols. It is evident from the discussions around the dementia cluster pathways that this is not the case at present. Commissioners therefore seek to jointly develop evidence based packages of care, using standardised assessment tools for each of the mental health clusters.
The development of this system will need to include:

- Development of Cluster pathways
- Identification of cluster pricing methodology used by NSFT : and

- Once these elements are complete, each cluster pathway will undergo an affordability analysis

The order of cluster priority areas are:

1. 18-21
2. 5-8
3. 10-17

Commissioners will ensure that pricing models map to the existing contract value; a move to a single cluster price will only be negotiated once the content of care packages being provided to patients within each CCG area is well defined.

This is a large piece of work which will not be completed prior to commencement of the new financial year therefore CCGs will negotiate a baseline finance and activity plan for 2016/17 which may be varied during 2016/17 based out outcomes of the work plan set out above.

Service Specific Issues for 2016/7

Access and Assessment Team
The Commissioners will require assurance that service delivery standards in this area are being met. We will strengthen our performance management processes in 2016/17 and set out requirements to be met in the depth and timing of performance reports from the Trust.

Adult ADHD Service
The Commissioners will monitor the implementation of this service and work with the Trust to agree and implement measures of service delivery standards and development of models of care.

Ashcroft
The Commissioners wish to work with the Trust in 2016/17 to review the current commissioned service and put in place the developments required to meet patient needs.

CAMHS

Demand for the CAMHS Eating Disorder Service has increased considerably during 2015/16 and secured additional investment from Commissioners. It is anticipated that new national funding will be available at some point, therefore Commissioners will work with the Trust to ensure that the right level of service is commissioned to manage this rise in activity.

Commissioners wish to develop integrated working and information sharing arrangements with Norfolk County Council and other partners. This will include the agreement of a set of protocols that make it easier for patients, referrers and partner organisations to access integrated CAMH services, comply with safeguarding responsibilities and ensure that referrals are made to the most appropriate service.

There are also plans in place to work collaboratively with other providers and local commissioners (under the auspices of the CAMHS Strategic Partnership) to benchmark Norfolk pathways against the priorities and standards in Future in Mind.

Community Mental Health Services

Commissioners will put a great emphasis on the delivery of services in the community and initiatives that provide alternatives to admissions. Improved community services will reduce the need for secondary care initiatives and Commissioners are looking to disinvest from Thurne Ward, reallocating this funding to modernise the community offering. Continued implementation of the FACT model may be part of this.

Dementia

Dementia diagnosis rates are a priority area for CCGs in 2016/17. Commissioners intend to roll out a dementia strategy which will improve processes and reporting. Commissioners will focus on improving early dementia pathways which will support diagnosis in primary care and facilitate earlier access into services as well as reviewing post diagnostic support.

It is the expectation that NSFT will continue to support this piece of work through the robust implementation of ICD10 coding for all patients with dementia and clear communication of diagnosis to primary care through the use of the agreed template letter on Lorenzo. Commissioners will update the current dementia reporting template to include details of waiting times at various stages of dementia pathway such as assessment, referral and treatment.

Commissioners will seek to work with providers to develop effective strategies to maintain independence in patients with dementia and provide support for carers.

Community Eating Disorders

The Norfolk Community Eating Disorder Service is currently provided by Cambridgeshire and Peterborough Foundation Trust. The Commissioners wish to give early notice that they are currently considering the future of this service and the benefits/options of taking this service to the market via a procurement route.

Early Intervention in Psychosis

The new access and waiting time standard that is being introduced nationally requires that, by 1 April 2016, more than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral. Further guidance is due imminently and the Commissioners expect that all Providers will work to implement this during 2015/16.

Commissioners and Providers will continue to work with the regional Steering Group to ensure appropriate services are put in place to meet the new requirements.

The full guidance can be found at: http://www.england.nhs.uk/wp-content/uploads/2015/02/mh-access-wait-time-guid.pdf.

Learning Disabilities

Commissioners will:

- Implement local transformation plan priorities following on from the Winterbourne action plan.
- Develop five high level pilot areas for implementation of the local transformation plan and take the learning from this and implement recommendations.
- Reduce the number of people with a learning difficulty in inpatient care settings.
- Work collaboratively with partners in social care to ensure that people with a learning difficulty are appropriately cared for and supported in the community.
- Ensure equal access to services for people with a learning difficulty and make reasonable adjustments to facilitate this, including maximising availability of primary care interventions.

Lorenzo in Primary Care

The implementation of the Lorenzo portal in primary care is a key Commissioner priority. A jointly agreed timetable for implementation, including the two-way portal and e-discharges is required and will be agreed as part of the negotiation process for 20161/7.

Out of Trust Placements and Adult Acute Care

Commissioners are committed to ensuring that patients are treated in the right place at the right time in accordance with their needs. The Commissioners welcome the steps that NSFT are taking to reduce the number of out of area placements for patients whose care should be delivered within the Trust's existing acute bed capacity. The Commissioners expect there to be no such placements made.

The Commissioners are committed to ensuring that community mental health services and the adult acute provision works together to reduce the need for mental health inpatient acute care where clinically appropriate. This will include ensuring that robust joint working and admission avoidance is supported between the new Wellbeing service and the adult acute services.

The Commissioners will review adult acute bed capacity requirements with NSFT, and following this will agree rules with NSFT relating to the financial liability and reporting of any out of area placements.

Patient Transport

Commissioners seek to put in place an agreed protocol for arrangement of and payment for mental health patient transport.

Prevention Focus

Commissioners wish to redesign community services with a greater focus on prevention.

Rehab Team

It is the intention of Commissioners to develop a distinct rehabilitation team which will provide support and care plans to facilitate reablement. This will support the out of hospital model by ensuring the therapy services required to assist patients to reach their maximum potential whilst out of hospital are in place and available in a timely manner.

Reporting

The Commissioners are expecting full completion of the outcome measure actions agreed within the 2015/16 contract, including those requiring Lorenzo development.

All activity will be reported on a CCG level basis and on a GP Practice level basis. For a small set of performance targets and/or indicators CCGs will seek to agree CCG level performance expectations.

Commissioners will review the Local Information Requirements for the 2016/17 contract and linked to the development of standardised cluster care packages, Commissioners wish to develop key performance indicators for these pathways. Another area for development is specific KPIs relating to the CAMHS IST and CAMHS ED. This will improve understanding of services, outcomes and value for money.

Section 136 Suites

Commissioners require NSFT to implement a new model as the original model proposed has not worked. Commissioners expect Section 136 suites to be staffed on a safe and sustainable basis so that patients in crisis receive the right mental health support promptly.

Service Development and Improvement Plan (SDIP)

Commissioners wish to work collaboratively with NSFT in the development of the SDIP and are keen to explore the Trusts ideas within this area as part of the negotiation process. A joint Service Development Implementation Reference Group was established in 2015/16 and CCGs see this as the place to monitor progress and discuss areas for development.

Of NSFTs current projects the Commissioners are particularly interested in:

- QO001: Safer Ward Environments
- QO013: 24/7 Dementia Intensive Support Services
- QO014: Safety incidents – learning lessons
- QO015: Embedding quality within locality governance
- QO016: Community Caseload Management
- QO023: Physical healthcare form completion
- QO024: Physical healthcare monitoring
- QO031: Review of Inpatient Bed Requirement
- QO034: Section 136 Suites
- QO036: Community Services - Service Development

Voluntary Sector

It is the intention of Commissioners to review services delivered by voluntary bodies, including contracts, pathways and consideration of sustainability. Where relevant, all pathways will be developed to show links to voluntary sector services.

Workforce

Recruitment and retention within mental health services in Norfolk has been an issue and historically caused delays with new service developments. Commissioners are keen to work with providers to look at ways of redesigning the workforce and developing new roles and different skill mixes in order to mitigate this issue, for example increased use of nurse prescribers.

Clinical Networks

The Commissioners will consider any recommendations of the East of England Strategic Clinical Networks to support the Commissioners or the constituent CCG decision making and strategic planning.

8. Conclusion and Next Steps

In addition to these overarching commissioning intentions please find attached the following additional documents:

- Appendix 1 – NNUH Specialty Review Timetable
- Appendix 2 – Medicines Management Commissioning Intentions
- Appendix 3 – Central Norfolk CCGs Joint Commissioning Intentions
- Appendix 4 – South Norfolk CCG specific Commissioning Intentions
- Appendix 4a – South Norfolk CCG – Affected Providers list
- Appendix 5 – Norwich CCG specific Commissioning Intentions

We hope that this letter is helpful to providers in setting out the Commissioners main priorities for 2016/17 and we look forward to receiving your responses and then working with you to negotiate fair and affordable contracts to improve the services and experience provided to patients.

We will write to you shortly to set out the Commissioners proposed Governance arrangements and the working groups required to support the 2016/2017 contract negotiation process. This will include full membership details and draft Terms of Reference for the working groups.

Yours sincerely,



Mark Taylor	**Jo Smithson**	**Jim Hayburn**
Chief Officer	**Chief Officer**	**Interim Chief Officer**
North Norfolk CCG	**Norwich CCG**	**South Norfolk CCG**

Copy:

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NHS
Great Yarmouth and Waveney
Clinical Commissioning Group

HealthEast

Commissioning intentions
2016 – 2017

Contents

Foreword

The Shape of the System - Developing modern and sustainable health services in Great Yarmouth and Waveney

The number of older people in England is increasing and will continue to do so. The percentage of the population aged over 65 years in Great Yarmouth and Waveney is currently 24 percent and this is set to double over the next 20 years. Alongside rising demand, as a health service we are capable of doing much more in the community than we have ever done before, and we owe it to our patients to provide the best care that we can. The public sector is also facing financial constraints and we need to spend what we have carefully.

At the same time our population is changing. People are not only living longer, many of them live with more than one health and social care need, like diabetes, heart disease and all the difficulties of living with dementia. At the moment, our system does not always deliver the joined up care that people need and want to help them with the daily life challenges they face alongside their health issue. There are gaps between different services, duplication and delays for patients. Most people could be treated very well in their own homes. But if they are not actively cared for, their illness could get worse and they could then need emergency care in a hospital. It should be the exception that people have to be admitted to hospital.

Finally, a lack of 'joined-up care' is a huge source of frustration for patients and carers, as well as for health and social care professionals. If health and social care, working together, can deliver integrated services, this will really improve quality and safety for all those that use these services. We will also get better value for taxpayer's money by joining up or 'integrating' services better. We believe that by everyone working together we can cut out waste and maximise the care that our residents receive.

To address these challenges we have held a thirteen week consultation with the public called 'Shape of the System'. We will work closely with all stakeholders to ensure that the changes agreed following the consultation are implemented.

The consultation proposes the following:

- Further roll out of out of hospital teams
- Creation of intermediate care beds in Beccles Hospital
- Commissioning of beds with care
- Creation of community hubs

GP Practice premises in Gorleston and Bradwell consultation
Successful implementation will result in an improvement of the environment for primary care services and the potential to co-locate two or more practices.

This document sets out the Commissioning Intentions of the NHS Great Yarmouth and Waveney Clinical Commissioning Group (known as HealthEast) for the contract year 1 April 2016 – 31 March 2017. These commissioning intentions will form part of the dialogue to agree contract schedules and activity plans with all contracted provider organisations for 2016-17.

Introduction and context

Our vision and commissioning intentions have been designed and developed to ensure that the resultant outcomes are high quality, sustainable and complement NHS England's characteristics of future health and social care systems. The CCG places clinical quality and patient experience at the core of everything it does and will continue to work with (and support) providers to deliver better, safer services, and to improve patient outcomes. The CCG expects all providers to strive to achieve best practice in the delivery of commissioned services, and seek continuous service and quality improvement.

The CCG will develop a clear strategy to address the Diabetes challenges facing the population of Great Yarmouth and Waveney CCG. We will work with patients and providers to jointly deliver this strategy and agree the plan for enhancing and improving diabetes services.

As outlined in our shape of the system consultation, we believe that we should be developing services to care for people in their communities because that is the best place for people to be. To do this, we need to have more services based there, closer to people's homes. As a result of this change in service delivery, we expect provider organisations to agree to rationalise and share staff, and to plan manpower development together so that we can address recruitment problems and skills shortages across the system, rather than by organisation. Doing this will support the ambition, which we will expect to see significant implementation of in 2016/17, of having single operational management across all providers, health and local government commissioned, in a number of areas of current duplication.

People don't really care which specific organisation is providing their health and care, they just want to receive a service that supports them to get better and remain as independent as possible. So we want our providers of health services to work more closely together with social care and voluntary services and of course patients and their carers. We know that people want to receive joined-up services that support them to get better and to remain as independent as possible. The CCG's Most Capable Provider process will accelerate the progress towards integrated service provision.

We also want to take this further and have District Councils offering benefits and housing advice and County Councils to offer social care, all in a joined up way with healthcare services.

The CCG's vision for urgent care services is to provide '**A patient focused, accessible, 24/7 urgent care service for all, with patients utilising primary care services, complimented by NHS 111 and 999 to ensure patients receive advice or treatment quickly, efficiently and in the right care setting.'**

We will continue to work with providers to develop local urgent care services and the findings and recommendations of the Transforming Urgent and Emergency Care Services in England completed by Sir Bruce Keogh to ensure that urgent and emergency care services will -

1. Provide consistently high quality and safe care, across all seven days of the week
2. Be simple and guide good, informed choices by patients, their carers and clinicians
3. Provide access to the right care in the right place, by those with the right skills, the first time
4. Be efficient and effective in the delivery of care and services for patients

The CCG has outlined its integrated commissioning intentions for 2016/17 within this document, with specific intentions and more detailed information in Appendix A.

Acute

NHS Great Yarmouth and Waveney CCG (HealthEast) expects providers to follow national guidance and to provide safe efficient services. The acute commissioning intentions are split into James Paget University Hospitals NHS Foundation Trust (JPUH) specific areas and those that apply to the whole sector. These intentions should be taken as formal notice of changes to commissioned services and of the CCG's objective to have a clear and transparent provision. The agreed aim to move care closer to home should be taken as a key principle.

The CCG will commission in line with national guidance and contract terms and conditions and will apply all mandatory conditions.

Provider contributions to the Clinical Negligence Scheme for Trusts will be deemed to be fully provided within the national tariff. Any additional cost, caused by the tariff uplift being inadequate to cover any increase in premiums will not be passed onto the CCG. Similarly, and benefit gained by increases in premiums that are lower than the increase in the tariff will be retained by the provider.

Unless otherwise stated explicitly, for 2016/2017, the tariff structure will include the requirement for providers to deliver all of the NICE quality standards within the tariff costs. Any prior year agreements will not carry into the 2016/2017 contract.

The delivery of three core Constitution standards (RTT, A&E and 62-day cancer wait) is currently under great pressure. The CCG will work with providers on capacity plans, winter plans and improvement plans to reduce the risk of service failure. However the CCG has a duty to hold providers to account through the contract to ensure delivery of these basic standards. The CCG will ensure that all providers meet the 8 High Impact Interventions.

Norfolk and Norwich University Hospital (NNUH):
NHS Great Yarmouth and Waveney CCG will be moving to a direct contract with NNUH in 2016/17 and will negotiate directly with the trust.

JPUH:
The CCG will work with JPUH to re-patriate activity from other acute providers where the waiting times are greater than at JPUH.

Moving Block services to cost and volume.
A great deal of the services within the historic contracts have been billed within the block element of the contract, against national guidance and not providing a clear and transparent picture of the cost of services. The CCG is therefore giving notice that it will no longer pay for the following services within block. More detailed information is available within Appendix A.
CI02 ICU and HDU
CI03 Excluded HRG spells
CI07 Direct access diagnostic ECG
CI08 Direct access diagnostic exercise test
CI09 Direct access diagnostic other
CI11 Allied Health Professional outpatients

Decommissioning services from the contract:
There are a number of services within the block contract which the CCG no longer want to purchase.
CI01 Decommission Acute rehab
CI04 Decommission Continence specialist nursing
CI05 Decommission Haemophilia specialist
CI06 Decommission Other specialist nursing
CI10 Decommission Stroke telemedicine
CI12 Decommission Diabetic specialist nursing
CI13 Decommission Nursing establishment additions
CI14 Decommission Patrick Stead X ray
CI15 Decommission Louise Hamilton support

All acute
All intravenous eye injections to be undertaken in an outpatient environment and paid for at outpatient tariff. The CCG expects all secondary care providers to work towards moving more activity to an outpatient environment in line with national strategies.

Specific Commissioning Intentions are:
CI16 Commissioning an improved outpatient to follow-up ratios
CI17 Commission a revised pathway for pediatric refractions including provision by optometrists
CI18 Commission a one-stop treatment service for Wet AMD
CI19 Commissioning a community cataract service for post-operative care following cataract surgery
CI20 Pain management services
CI21 Commission a hospital outreach neurology service
CI22 Commission a 'virtual fracture clinic'
CI23 ENT and audiology
CI24 Rheumatology follow-up
CI25 Commissioning a minimum dataset for orthotics
CI26 Decommissioning wigs
CI27 Commissioning an integrated dermatology service
CI28 Commission new policies and procedures via NRTTT and PA
CI29 Stroke
CI30 Commission an integrated diabetes service
CI31 Commission additional procedures via other providers
CI33 Commissioning the implementation of the SAFER discharge bundle
CI34 Commissioning integrated falls service
CI35 Commissioning integrated respiratory service
CI36 Commission ambulatory care
CI37 Commissioning a functionally integrated urgent care access
CI57 Commissioning all providers to follow PBR guidance with the recording of outpatient unbundled radiology activity
CI58 Commissioning day case and elective activity recorded without procedure as ward attenders
CI60 Commissioning a Diabetes system wide approach
CI61 PTL minimum dataset
CI63 Commissioning Advice and Guidance
CI64 Decommissioning Child vaccination within an acute setting

Stroke Association

The aim of the service is to help prepare families for the changes they will need to make as a result of the stroke and to enable an optimum quality of life and ability to self-manage. The objective of the service is to ensure that stroke survivors and their carers, are provided with appropriate personalised information; advice and support to enable them make informed choices, be actively involved in their on-going care, rehabilitation and long term support requirements. This service will be decommissioned from the CCG and transferred to a more appropriate position within the Better Care Fund portfolio to ensure a combined health and social care overview.

Cancer

We expect all providers of cancer services to deliver NICE compliant services at all times. In line with the new national cancer strategy published in July 2015, the CCG will develop a Great Yarmouth and Waveney cancer commissioning framework to:

- Meet the six national strategic priorities
- To performance manage local providers re their achievement of cancer waiting times standards and the revised two week wait NICE guidance, attending relevant PTL's and meetings as required. Local providers will be required to evidence their plans to improve and sustain their performance via their "improving and sustaining cancer performance action plans".
- To commission an integrated acute and community cancer nursing service
- The CCG will coordinate the redesign of local cancer services via a local cancer service improvement plan in partnership with providers and service users. As part of this plan, local cancer care providers will create additional capacity to meet the increasing demand on diagnostic, treatment and follow up capacity due to the aging local population via; straight to test colorectal cancer pathway, one stop MDT clinic for breast and prostate pathways, survivorship/risk stratified follow up for breast, colorectal, urology and lung cancer pathways and an outreach nurse led community chemotherapy service.
- The CCG will also work with public health and primary care to raise awareness of cancer symptoms and a reduction of variation in access to national cancer screening programmes.

It will be the expectation of the CCG that local providers work in partnership to provide these services.

Specific commissioning intentions are:
CI39 Commissioning integrated acute and community cancer nursing service
CI40 Commission a straight-to-test service
CI41 Commission a one stop MDT clinic for breast and prostate
CI42 Commission a survivorship stratified follow up service
CI43 Commission an outreach nurse led community chemotherapy service
CI44 Raising cancer awareness and reducing variation in access

Palliative care

The CCG will continue to implement the CCG's palliative care commissioning framework. This document describes the integrated model of palliative care that the CCG aims to commission which includes; a single point of access, drop in information and support, telephone advice and co-ordination of care, enhanced hospice at home, day care and specialist palliative inpatient care. All care settings will continue to be supported by peripatetic specialist palliative care provided by JPUH.

- The CCG will commission an enhanced hospice at home service and mainstream this with the out of hospital, beds with care and CHC fast track and out of hours services.
- The CCG will commission a "step down, step up" four bed specialist palliative inpatient care service within a community hospital inpatient setting (pending the outcome of the shape of the system consultation).
- The CCG will commission the implementation of the electronic palliative care record (EPACCS) across all relevant care settings to support effective and timely information sharing and improve continuity of palliative and end of life care.

It will be the expectation of the CCG that local providers work in partnership to provide these services.

Specific commissioning intentions are:
CI45 Enhance the hospice at home service
CI46 Commission a "step down, step up" four bed specialist palliative inpatient care service
CI47 Implement the electronic palliative care record

Mental health
The CCG will continue to robustly review all individual packages of care that are funded by health or jointly with social care for people with mental health issues and/or learning disabilities. Where appropriate, the CCG will also introduce personal health budgets for mental health and learning disabilities service users.

The CCG will continue to work in partnership with other agencies in relation to dementia diagnosis and services. The CCG has to achieve a 66.7% dementia diagnosis rate and will continue to work with NSFT and primary care to ensure that people's diagnosis is clearly documented.

The CCG will develop a process to review all of those people in residential and nursing homes to ensure their diagnosis has been appropriately documented. We will draw on the learning of South East Essex CCG who has carried out this piece of work in their area.

The CCG will continue to work with Suffolk County Council in the development of a post dementia diagnosis support service.

The CCG will work with all commissioners across Norfolk and Suffolk to agree a new allocation model of the contract costs. The principles for this project will be agreed during quarter three and the actual model is planned to be completed before the start of the contract negotiations in January 2016.

The CCG determine the commissioning intention of the services identified below, following clinical reviews, based on the outcomes and recommendations which, will be shared with the providers.

- Feedback (service user organisation)
- Norfolk and Suffolk Foundation Trust (44 Kirkley Cliff and the older people's patient beds at Carlton Court)
- Great Yarmouth and Waveney MIND (adult community services, carers service, young people in MIND and BME Community Development Worker)

The CCG will work closely with NHS England and the Healthcare Quality Improvement Partnership to implement the Learning Disabilities Mortality Review Programme. This is a national review to help reduce premature mortality and health inequalities, and will be delivered by the CCG in accordance with nationally defined timescales.

Specific commissioning intentions are:
CI48 Adult learning disability services
CI49 Commission services in line with MH crisis care concordat
CI50 Commission a 24/7 acute psychiatric liaison service

Community
The CCG is committed to the expansion of care closer to home and for the provision of community services to be fully supported and reimbursed. We will focus on closer integrated working that will achieve the maximum impact for both individuals and organisations alike, and we intend to build on existing projects and examples of good practice. The CCG will work with providers to develop a South Waveney Out of Hospital service that utilises the local capabilities and meets the needs of patients.
The CCG requires clear and transparent reporting of costs and activity to enable identification of services which are either underfunded or are not fully resourced. We require ECCH to have fully implemented service line reporting by April 1 2016 and to have agreed the processes and methodology for reporting costs and activity.
The shape of the system consultation could have a significant impact on the provision of community services and the CCG will work closely with ECCH during any transition.
As a result of the Most Capable Provider process the CCG will extend its current contract with ECCH during the development of "bundles" and the integration of services across Great Yarmouth and Waveney.

Specific commissioning intentions are:
CI38 Commission out of hospital team

Children, young people and maternity
The CCG is committed to the healthcare of children, young people and their families. To do this effectively, it is important that we work collaboratively with the Norfolk and Suffolk local authorities, education departments and public health commissioners wherever possible in terms of services for children and young people. We will focus on areas where it has been identified that closer integrated working will achieve the maximum impact for both individuals and organisations alike, and we intend to build on existing projects and examples of good practice, where the benefits of integrated working can be shown and with the children and young people at the centre of all we do. Implement the health requirements of the Children's and Families Act 2014 taking forward the Governments commitments to improve services for vulnerable children and young people and develop and agree joint commissioning arrangements for children and young people. Where appropriate the CCG will explore the development of personal budgets for children and young people.

We will work with our providers and the local authority to improve services and implement recommendations following the OFSTED inspection of looked after children's services.

Following a clinical review, we expect the implementation of the recommendations, for short break/respite services.

We want to ensure that the children's continuing care policy is reviewed once the new national guidance is revised ,all providers of continuing care have service specifications and contracts in place and that there is robust governance and an agreed process for funding of tripartite cases. Currently some continuing care providers for children have no agreed service specifications or contracts in place. There also needs to be some discussion around cost of services to try to achieve a better cost per hour rate. A matrix needs to be agreed for all tripartite funding as this is variable between the two local authorities at present.

GYWCCG will assess and form a local response to the forthcoming NHS England led review of our local maternity service offer, including perinatal pathways. Morecombe Bay investigation highlighted concerns with maternity services that prompted the national review of maternity services.

GYWCCG currently commission the Compass service from NSFT as part of a block contract. Proposal for 2016/17 is that this service will be jointly commissioned with the Local Authority and the 4 Norfolk CCGs, funding of the service is proposed to be managed through a Section 75 arrangement.

Specific commissioning intentions are:

CI52 Commission a community service model for children and young people who have learning disabilities
CI53 Commission improved pathways for community pediatric services
CI54 Commission county-wide systems for children's/adolescent/young people's mental health services with our partners

Community Alternative Providers – Continuing Health Care (CHC)
Consider and approve a wider criteria opportunity - including Discharge to Assess (D2A) - for patients undergoing a full NHS Continuing Healthcare (CHC) assessment whilst in the JPUH. The Blyford Model for CHC assessment has shown that approximately 90% (21 out of 24 patients) of patients who have gone through the CHC assessment process have required a DST have not been recommended as being eligible to receive CHC. To take this forward and to assess the benefits of having a more flexible CHC pilot supporting the current D2A service.
The CCG D2A model currently piloted at Blyford for 12 months will have its 6 month review on 30th September to inform any procurement options for 2016/17.

Specific commissioning intentions are:
CI59 Commission x5 D2A beds at Stradbroke Court, Lowestoft:

Public health
The CCG will ensure that prevention and health care public health principles are embedded into our integrated care approach, and will consider the benefits offered by co-commissioning services when public health colleagues from Norfolk County Council, Suffolk County Council or NHS England re-procure the current lifestyle services or other services. This section outlines the joint Norfolk County Council and Suffolk County Council Public Health priorities for 2016/17.

We have a very productive relationship with our public health colleagues, with a strong emphasis on prevention, and we will continue to work with public health and with the Health and Wellbeing Boards of Norfolk and Suffolk to address challenges such as rising obesity levels.

The CCG will also ensure the recommendations from the healthy child programme maternal/perinatal mental health pathway pilot (led by public health) are developed through the integrated commissioning and delivery of services. In order to maximise both the services and cost benefits of delivering a local integrated workforce development plan, we will work with our partners to ensure that the appropriate systems and processes will be put in place to co-ordinate, manage and commission the necessary training.

We will work with public health, Norfolk County Council and Suffolk County Council to develop and deliver the transformation plans for children and young people's emotional

wellbeing and mental health to include promotion of good mental health and wellbeing alongside timely response using evidence based support and interventions for those presenting with problems. This will include working with families, early intervention services and responding to crisis.

Primary care
In line with the five year forward view and our desire to become delegated commissioners, we will be developing plans with primary care services. The CCG considers GP practice development to be crucial to the delivery of its strategic plans and will work with both practices and NHS England to ensure that primary care is part of the integrated care system going forward.

The primary care contracting sub-committee group (made up of practice managers/clinical support/CCG) will review the current specifications and prepare any amendments/proposals for changes to the provision of the current contracts.

IT is an integral part of delivering safe care, and we will be developing a primary care IT strategy with our CSU colleagues, by the end of 2017.

The post payment verification visits will continue in 16/17, each practice will be visited and audited against all contracts activity and claims submitted. Any inaccuracies will be discussed with the practice and payments recovered where deemed appropriate.

There are growing workload demands on GP practices which are either inappropriate, or outside a practice's capability or competence and which should be delivered by a more appropriate provider. The CCG's will support GP practices to direct inappropriate activity to the correct provider and if the demands continue will look to apply penalties and other contract levers to achieve resolution.

Specific commissioning intentions are:
CI32 Commissioning one information service

Medicines management

The CCG expects providers to follow:

- Best practice guidance as outlined in NICE guidance (NG9) medicines optimisation: the safe and effective use of medicines (2015) to enable the best possible outcomes when caring for people who are using medicines and those who are receiving suboptimal benefit from medicines.
- Best practice guidelines and national standards such as The Royal Pharmaceutical Society (RPS) standards for hospital pharmacies published July 2014 and

accessible at http://www.rpharms.com/support-pdfs/rps---professional-standards-for-hospital-pharmacy.pdf and CQC outcome 9 Medicines management and the safe and secure handling of controlled drugs

Medicines optimisation across the primary, secondary, tertiary and community interface will be expected. All prescribers should ensure that the most appropriate choice of clinically and cost effective medicines, informed by agreed local and national guidelines and formularies, are agreed with the patient to best meet the needs of the patient. To facilitate accurate transfer of information about a patient's treatment, providers must implement the good practice guidance and principles issued by NICE and the Royal Pharmaceutical Society. Due regard, must be given by prescribers, to quantities issued on all prescriptions to avoid waste.

For acute providers our expectation is that patients will have TTOs for a minimum of 14 days or sufficient to complete the course.

Outpatients – where a patient has attended an outpatient appointment and the clinician deems treatment should be started the CCG expects the clinician to provide a prescription that will cover the initial treatment – minimum 14 days. Patient expectation is critical here for waiting for outpatient prescriptions.

Patients must not be left at risk of harm or major inconvenience through lack of supply of necessary medication, and providers will ensure that inpatients are discharged with sufficient medication to complete their course of treatment, or for a period of 14 days – whichever is shorter. Where a provider clinician decides that prompt treatments (i.e. the medicine is required immediately or within seven working days) for the patient, a prescription for that treatment must be provided by the clinician, covering the course of treatment or 14 days, whichever is shorter. If treatment is not deemed 'prompt' at the time of consultation, the patient must be made aware that treatment will be delayed until written clinician-to-clinician communication is received by the patient's GP (within the time allowed) to issue a follow on prescription if required - to allow ongoing supply and to minimise patient harm.

The Norfolk and Waveney Therapeutics Advisory Group (TAG) and the Norfolk and Waveney Drugs and Therapeutics Commissioning Group (DTCG) will continue to manage the entry of new drugs and technologies on behalf of local providers and commissioners (including GYW CCG) across Norfolk and Waveney. Recommendations made by the DTCG will be subject to ratification by the CCG prior to local implementation.

Providers must implement local, regional and national medicines management QIPP guidance in collaboration with the CCG. This will include, but not be limited to the use of lower acquisition cost generics, bio-similar and drug formulations when available.

Current and future providers will need to demonstrate adherence to existing and future formularies e.g. pain, dressings, continence, antibiotics and mental health, cost effective ocular lubricants.

The CCG will require ongoing assurance throughout the 2016/2017 financial year regarding the provider's internal cost improvement plan (CIP). The impact of any cost improvement on workforce and front line delivery is of particular importance to commissioners.

National tariff payment system: We will contract based on the 2016/2017national tariff payment system and update commissioning intentions, as necessary, on publication.

All existing and new drugs and technologies should be provided within the scope of the national tariff unless explicitly excluded through the national tariff 2016-17 exclusions list e.g. excluded high cost drugs, devices or as part of excluded services. Where best practice tariffs are in place, drugs are considered to be included in tariff unless listed as specific exclusions on national tariff exclusions list **or** within the national tariff guidance. Commissioners may require providers to complete pro-forma notifications to monitor and validate the implementation of BPTs for an agreed period of time.

Unless otherwise stated explicitly, for 2016/2017, the tariff structure will include the requirement for providers to deliver all of the NICE quality standards within the tariff costs.

Non-national tariff drugs (High cost drugs): The East of England Priorities Advisory Committee's document (PAC) "High cost drugs and technologies (to include devices) schedule to commissioning arrangements between commissioning organisation and hospital/provider" will be an **integral** schedule in the contract between the commissioner and provider.

Providers must utilise the regionally agreed discounts and frameworks as appropriate, to obtain medicines and devices at the lowest possible cost. The provider must implement patient access schemes where available as a result of NICE guidelines. Where a drug treatment is free of charge, this must be recorded on invoices as zero cost. Where a drug treatment is discounted, this must be recorded on invoices as the discounted cost. Where a drug treatment is rebated, this must be recorded on invoices as the rebated cost. The CCG will fund HCDs at acquisition cost and will work with local secondary and tertiary care pharmacy teams to ensure that value for money from medicines has a whole-system approach. Where providers charge different prices for the same drug, we will use the lower price as the reference cost for reimbursement, unless a representation is made to by the provider.

Data provided to support invoices for high cost drugs (HCD) must conform to the dataset as defined in the PAC document "High cost drugs and technologies (to include

devices) schedule to commissioning arrangements between commissioning organisation and hospital/provider" to be relied on and be received within the timetable agreed in the contract. Charges must not exceed a maximum of one month's cost of supply per patient, at acquisition cost, except where delivered by homecare, outreach or outpatients where the drug supply may be linked to eight or 12 week appointments. Where HCD use is long-term, a maximum of 13 month's supply per patient will be paid by the commissioner per calendar year.

Homecare – the provider should increase patient choice by offering therapies delivered via homecare (i.e. direct to patient's home) where clinically appropriate. Where homecare treatments are subject to PAS, then PAS discount arrangements will apply. Homecare contracts must comply with the regional framework agreements to ensure standard of service, governance and cost. Homecare contracts must be approved by the commissioners before sign off. VAT will not be charged (therefore will not apply to patients not having supplies delivered to their own home, or patients in care homes or institutions). Therapies currently suitable for homecare include, but are not limited to, Biosimilar anti-tnf's, EPO, HIV treatments.

Prior approval and individual funding requests – commissioners will only fund those drugs, where prior approval is necessary, only upon granting of approval. Providers will conform to the IFR policy and commissioners will only be liable to drug costs associated with positive IFR responses. Failure to do so will result in non-payment.

Formularies, treatment pathways, guidelines and horizon scanning - The provider must publish formularies and agreed treatment pathways to confirm implementation of NICE technology appraisals. Assurance with regards to adherence to local and national agreed treatment pathways will be through audit. Commissioners will withhold payment where charged for non-formulary medicines and those drugs provided outside the agreed pathways.

The commissioners will expect providers to identify variation from NICE estimated activity/costs within three months of the TA being published. Where this has not happened the commissioner reserves the right to challenge any charges associated with increased activity/drugs.

The CCG will be asking for expressions of interest in providing a community based INR testing and warfarin dosing service.

The CCG will commission from all local providers to agree an urgent medicine pathway, this is intended to make the best use of supply arrangement that already exists and limit the need for urgent care involvement. Providers will need to demonstrate appropriate signposting of patients.

The CCG will work with local providers to increase appropriate access to Eclipse Live data where needed to improve tailoring of patient care and reduce the need for urgent care involvement.

The CCG will be commissioning an increase of the percentage of medicines reconciliation that occur within 24 hours of admissions with all acute trusts.

The CCG aims to promote the uptake of the national pilot of clinical pharmacists working as clinicians in GP practices.

Currently a good range of gluten free foods are available on prescription, the CCG will be decommissioning all Gluten Free prescribable foods.

Local audits and policy reviews

Commissioners reserve the right to conduct local audits throughout 2016/2017 to confirm adherence to pathways and policies and where coding or other anomalies are identified. The audit process will also be used to identify system-wide issues impacting on providers and inform beneficial changes or decisions in support of these.

Commissioners will not accept any provider-enforced limits to the number and scope of any such audits or reviews.

Clinical audits and discussion will take place during 2016/2017 to review activity that has both a day case and outpatient procedure tariffs. It is the intention of commissioners to pay for procedures in line with the level of care provided and also in line with national guidance.

Patient engagement and involvement

All providers will be expected to actively seek the views of patients, carers and the general public on an on-going basis. This feedback will be used to inform any proposals for changes to services. If a specific service change is being developed then all providers will be required to co-produce any proposals with patients and provide evidence of patient involvement in this to the commissioner at contracting meetings.

In the case of substantial developments or variations to services which are the commissioning responsibility of the CCG then all providers are expected to adhere to section 14z of the Health and Social Care Act 2012. Under the Act when providers have a development or variation ‘under consideration’ they will need to inform the CCG at a very early stage.

Providers are expected to be mindful of the fact that making a decision on a change to services, and then consulting on that decision, is unlawful.

The CCG as commissioners are required to lead any consultation processes on behalf of providers so that the commissioner can comply with the requirements to consult as soon as proposals are under development. It is expected that all providers will co-operate and support the commissioners fully in this.

The CCG will work with all sectors to sign up to the principles and objectives of the wheelchair charter.

Estates and infrastructure

The CCG will work closely with all partners to ensure estates and infrastructure is fit for purpose and developed to support new models of care. As per the five year forward view, we will be commissioning a local estates strategy for the integrated care system.

Integration – Health and Social Care

District Councils

The intention is to work with our District Councils to unlock community and voluntary sector capacity to tackle key health and wellbeing issues. A list of ten issues have been identified where there are opportunities for communities to support individuals, families and carers, with the aim of helping people to stay healthy for as many years of life as possible through prevention and early intervention activities: mental health, dementia, support for carers, falls prevention, self-harm, isolated older men, learning disabilities, dying and death, cancer and self-help/self-management.

We will be seeking to work with District Councils and a wide range of partners across the area to deliver a programme of activities to stimulate voluntary sector activity and raise awareness of the opportunities for communities to play a greater part in supporting vulnerable people. This work will focus on four key priorities:

1) Enable community support for vulnerable individuals and families that ‘wraps around’ GP, hospital and social care services and, ultimately, reduces or replaces the need for service-based interventions
2) Increase voluntary and community sector (VCS) involvement in tackling key health and wellbeing issues
3) Maximise the use of bridging, peer intervention and volunteer health roles – as identified in the ‘community-centered approaches to health and wellbeing’ report by Public Health England and NHS England
4) Increase the level of self-help and self-management, particularly of long term conditions

It is also the intention of NHS Great Yarmouth and Waveney CCG to work with District Councils and other partners to continue to explore the inter-relationships between health and housing, leisure, economic growth, community safety, skills, planning, sustainable use of our environment and opportunities to integrate resources, including staff, buildings and other assets, with the aim of identifying further joint working opportunities.

Better Care Fund (BCF) – Supporting independence through the provision of community-based interventions

The BCF is a key element in developing an integrated care system across Great Yarmouth and Waveney and implementation of the schemes has begun. In addition to these, there are a number of projects being reviewed with the core aim of reducing hospital admissions and improving patient health and wellbeing. These projects have been identified as best practice from other CCGs and are being tested for their impact in this area:

- **Social prescribing**

Patients with long-term conditions often access the GP or contribute to unplanned hospital admissions when alternative provisions could be used. The purpose of this project is to construct a social prescribing service to relieve GP time by increasing non-clinical capacity within primary care settings.

- **Shared lives**

Shared lives schemes offer placements to adult individuals via care and support in the home of a shared lives carer or in a kinship arrangement. These schemes target particular vulnerable groups such as older people or those with a learning or physical disability, providing a flexible range of accommodation, care and support. This aims to "foster independence" so that individuals can learn to live self-sufficiently in the local community. It encourages enablement and attempts to decrease emergency hospital admissions, as well as being an alternative to care and residential homes.

- **Waveney falls response service**

We are exploring extending the existing rapid response project based in Great Yarmouth across Waveney. Norfolk Swift and Night Owl service respond to people who have falls in the home but are uninjured with the primary intention of reducing ambulance call-outs. Data shows a significant difference in call outs to ambulance in Great Yarmouth as opposed to Waveney (currently one in three) and this project aims to determine whether it is possible to implement an effective and appropriate support service that reduces ambulance call outs and in turn reduces hospital admissions. The outcome for patients is a relevant service that can dedicate time to ensuring that patients are safe and well and are able to remain in their own home without experiencing the trauma of entering hospital.

- **Flexible dementia service – urgent homecare for dementia crisis**

The purpose of this project is to extend the Waveney flexible dementia service (FDS). The Waveney FDS is a successful service that can evidence a reduction in 'beds with care' use that is believed to amount to £5k per stay per patient.

- **Strengthening the voluntary and community sector (VCS);**

Through our approach to the Better Care Fund, we want to strengthen our involvement with the VCS. To do this, we plan to review all existing funding arrangements with third sector organisations, including those that are jointly funded with other partners such as social care, with a view to either formalising existing arrangements, redefining the service to be provided to meet future needs, renegotiating funding levels, tendering from services or terminating the existing agreements if the service is no longer required. This could be an opportunity to develop contracts with other voluntary sector organisations.

County Councils

The Intention is to work with partners to develop a more integrated approach to the nursing and residential care home market for older people across NHS Great Yarmouth and Waveney CCG area, using 'systems thinking' methodology.

Norfolk and Suffolk County Councils have a responsibility under the Care Act to ensure a sustainable residential and nursing home market, which will include continuing health care, private placement and placements by both county councils.

We will be seeking to engage with and work with Norfolk and Suffolk County Councils to understand, explore opportunities and make recommendations for a more integrated approach to the nursing and residential care home market for older people across NHS Great Yarmouth and Waveney CCG area, using 'systems thinking' methodology.

The objective is to support the development of an integrated approach to care home provision across Great Yarmouth and Waveney CCG area, seeking:

(a) An adequate supply to meet current and estimated future demand
(b) Cost effective and efficient use of residential and nursing home provision
(c) Joint approach to care home sourcing, placement and admissions avoidance

At the core of an integrated care system is an integrated reablement and rehabilitation (IRR) journey that individuals can access to support them in regaining the independence they want and value. It is our intention to commission a mapping exercise for assessment and implementation.

It is the intention of NHS Great Yarmouth and Waveney CCG to work with partners to support family carers, young carers and young adult carers.

Specific commissioning intentions are:
CI51 Develop and jointly procure home support
CI55 Commission the national clinical seven day services standards

CI56 Commission integrated services under the most capable provider (MCP) process
CI62 Commissioning timescales and funding arrangements post D2A pathway

Report to Norfolk Health and Wellbeing Board
4 November 2015
Item 8

Cover Sheet

Update Progress Report
Norfolk Health & Wellbeing Strategy 2014-17

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

The Board is asked to consider the update report and provide views on whether the Board agrees the strategy is on track.

Key questions for discussion

- Is the Health and Wellbeing Strategy on track to achieve its goals: more focus on prevention, reduce inequalities and increase integration?

Actions/Decisions needed

The Board is asked to:

- Consider the report and provide views on whether the Board agrees the strategy is on track

Report to Norfolk Health and Wellbeing Board

4 November 2015
Item 8

Update Progress Report by the Director of Public Health

Summary

This report highlights some of the progress made over the summer and an outline of some of the plans in the autumn/winter for the implementation of this strategy.

Action

The Board is asked to

- Consider the report and provide views on whether the Board agrees the strategy is on track

1. Background

1.1 Actions to implement the Health and Wellbeing Strategy priorities: Improving the social and emotional wellbeing of preschool children, Preventing Obesity and Making Norfolk a better place for people with dementia and their carers, continue to progress.

1.2 The 'plans on a page' action plans are updated and their latest status can be viewed on www.norfolk.gov.uk/hwbstrategy

1.3 Progress within these action plans are highlighted in this report. Progress status can be seen in Appendix 1 listed against each intention (i.e. evidence based area to focus on that we know will make an impact). Two intentions have moved from grey (no action to report) to amber, 2 intentions move back to amber from green (requiring closer monitoring) and 3 progress from amber to green.

2. Progress to date

2.1 **Key actions to achieve the strategic goals: Prevention**

- The Healthy Child Programme started in October 2015. Maternal mental health, breastfeeding, attachment and HENRY are a focus within this contract.
- A smart survey targeting parents and carers of 0-5s has seen 400 completed surveys. Results will be used to inform relevant action plans.
- The 'Take 7 Steps Out' intervention, aiming to reduce children's exposure to second hand smoke and encourage parents to have smoke free homes, continues.
- 'Future in Mind' transformation plans are progressing, led by NCC Children's Services and the CAMHS team.
- NCC Road Casualty Reduction Team continue to lead on new cycling infrastructure projects promoting active travel and encouraging walk/cycle to school/work schemes
- A Dementia Friendly Norfolk website, funded by the Norfolk and Suffolk Dementia Alliance has been designed in co-production with carers.

- A Dementia Friendly Employers and Businesses Task and Finish group have produced a framework that businesses can adopt if they commit to becoming dementia friendly. The Big C and the 'Connect to Autism' project are also supporting this work.

2.2 Key actions to achieve the strategic goals: Reduce inequalities

- The Integrated Healthy lifestyle service procurement is underway and stakeholder workshops have helped identify how services can be designed with provision for all, while specifically targeting those most at need, will help tackle inequalities.
- The project looking at mental health pathways and services is addressing gaps in the provision of Cognitive Stimulation Therapy (CST), the only non-drug intervention to be recommended for cognitive symptoms and maintenance of function.

2.3 Key actions to achieve the strategic goals: Increased Integration

- The District Council Directors Group have agreed actions impacting on the Social and Emotional Wellbeing of pre-school children and the preventing obesity priorities.
- PIMHS steering group, CAMHS Partnership group, Children and Young Peoples Forum, Norfolk County Community Safety Partnership, the Home Learning Environment, Norfolk Library and Information Service, the voluntary and community sector and Healthwatch continue to identify opportunities for integrated working.
- The Children's Centre leads have been considering how to maximise the impact of the Take 7 Steps Out Campaign (smoking harm reduction), Joy of Food (cooking skills programme) and the Healthy Start scheme (vitamins).
- The Norfolk Healthy Weight Strategy action plans, based on the Tackling Obesity Health Needs Assessment's recommendations and the Health and Wellbeing Board Strategy have been deveoped through 3 multiagency workshops. Mental health and wellbeing has been highlighted in the strategic aims of the Healthy Weight Strategy:
    - Promote self-confidence and sense of self-efficacy in people managing their weight to improve health and quality of life
    - Address stigma and discrimination of people that are underweight, overweight or obese
- Further opportunities have been identified with the Director of Norfolk & Suffolk Dementia Alliance to promote key healthy eating/physical activity messages.
- District Councils have looked at reducing obesogenic environments, promoting healthy food and active travel, at a Town and Country Planning Association workshop
- The dementia information packs produced by North Norfolk CCG were evaluated in October following a six month pilot. Subsequent to the findings of this evaluation, the other Norfolk CCGs will consider introducing such packs.

3. Next steps

3.1 Key actions to focus on through the autumn

- Alignment of the Norfolk Community Safety Partnership domestic abuse strategy with the Health and Wellbeing strategy.
- Norfolk Healthy Weight Strategy to be completed and signed off
- Exploring whether the Norfolk Obesity Network has a role in monitoring the implementation of the Norfolk Healthy Weight Strategy.
- A new pre-school weight management pilot is planned by The Community Sports Foundation. This will use South Norfolk Council's (SNC) Community Connectors to consult with the target communities to inform the design of a programme. This is informed by 'Design in the Public Sector' workshops run by Design Council and attended by SNC, Public Health & Active Norfolk.
- A meeting has been set up with Norfolk Housing Alliance to look to promoting the Health & Wellbeing Board Strategy & Design Council action plan with social landlords
- The Norfolk Physical Activity Strategy for Children and Young People Implementation Group will continue to progress agreed action plans.
- Support promotion of Healthwatch Popup shops planned for 4 locations over 4 weeks.
- New NCC Public Health training suite being developed to include 'Making Every Contact Count' (MECC) training to ensure consistent healthy lifestyle promotion. Dementia Friends courses will be included as will ways organisations can identify staff training needs around combatting prejudice towards obese people in workplace (training including equalities, Royal Society for Public Health (RSPH) qualifications, MECC, Understanding Eating Disorders, Mental Health First Aid).
- NHS Healthy Town application – NCC are coordinating a county-wide bid with District Council partners which is in its final stages of submission.
- NCC PH and 3 central CCGs have put in an EOI application to become a site for the second phase of national Diabetes Prevention Programme implementation.
- A Medication Task and Finish group will look at how some medication can increase the risk of cognitive impairment and how to raise awareness of this.
- The Dementia Strategy Implementation Board will continue to meet to ensure the governance and coordination of plans in addressing dementia issues.

4. Action

The Board is asked to:

- Consider the report and provide views on whether the Board agrees the strategy is on track

Officer Contact

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

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Norfolk Health and Wellbeing Strategy

Strategy Progress Report November 2015

www.norfolk.gov.uk/hwbstrategy

Red = Barriers to progress – action from the board required
Amber = Some progress achieved– monitoring required
Green = Progress is being made – on course
RAG Assessment made by NCC Public Health Strategy Implementation Team

	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	**Amber**
C2	Promote the support parents and particularly fathers in vulnerable groups such as young fathers, war veterans and offenders	**Amber**
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	**Amber**
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	**Amber**
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	**Amber**
O6	Work with local businesses & partners to increase access to healthy food choices	**Amber**
O7	Make the most of the planning system to create a healthier built environment	**Amber**
O8	Work with registered social landlords to implement Design Council and the National Housing Federation recommendations - to provide opportunities for people to be more active and enjoy the space outside	**Amber**

	Strategic Intention	Performance
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.	**Amber**
D4	Make sure that new services are robustly evaluated	**Amber**
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).	**Amber**
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.	**Amber**
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	**Amber**
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.	**Amber**
D17	Ensure independent and voluntary home care agencies provide high quality care for their clients who have dementia.	**Amber**
D18	Identify, assess and meet the ongoing health and wellbeing needs of carers of people with dementia, and treat them as 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.	**Amber**
D19	Ensure commissioners of sheltered housing, housing with care, care homes and nursing homes incorporate best practice design for people with dementia.	**Amber**
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.	**Amber**

Report to Norfolk Health and Wellbeing Board
4 November 2015
Item 9

Cover Sheet

Developing a Mental Health Strategy for Norfolk

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

The Board is asked to take ownership of the delivery of an integrated approach to public mental health in Norfolk, providing effective leadership and governance to a holistic systems change approach, as recommended in the DPH Report in July.

Key questions for discussion

Q.1 What are the Board's views on how best to achieve this holistic systems change approach and develop and implement a Mental Health Strategy for Norfolk?

Actions/Decisions needed

The Board is asked to:

- Agree to set up a workshop to scope a public mental health strategy in full and recommend terms of reference and governance on how this strategy can be agreed and implemented.
- Agree Service user representatives and providers should be included in the planning process
- Decide who is best to lead on this on behalf of the Board to ensure an integrated approach to public mental health in Norfolk is achieved to deliver best outcomes possible.

Report to Norfolk Health and Wellbeing Board
4 November 2015
Item 9

Developing a Mental Health Strategy for Norfolk

Report by the Director of Public Health

Summary

Concerns have been raised about mental health outcomes in our population. The DPH Report in July described these concerns and demonstrated how we know all is not well in Mental Health and Wellbeing in Norfolk. A holistic systems change approach with a community focus is recommended as a Mental Health Strategy for Norfolk.

Action

The Board is asked to

- Discuss and provide views on how best develop and implement a Mental Health Strategy for Norfolk
- Take ownership of the delivery of an integrated approach to public mental health in Norfolk, providing effective leadership and governance to a holistic systems change approach, as recommended in the DPH Report in July.
- Agree to set up a workshop to scope a public mental health strategy in full and recommend terms of reference and governance on how this strategy can be agreed and implemented. Service user representatives and providers should be included in the planning process.

1. Context

1.1 Concerns have been raised about mental health outcomes in Norfolk.

1.2 The DPH report in July showed why public mental health is so important and why there is need to change. Norfolk needs to improve mental health outcomes in particular areas including:

- Emergency Hospital Admissions for Intentional Self harm in Adults. The Directly Standardised Rate in Norfolk is 25% above the national rate and appears to be increasing faster. There were 2113 admissions in 2013/14.
- Emergency Hospital Admissions for Intentional Self harm in Children and Young People aged 10-24 is above the regional average and also rising.
- Latest data on suicide rates (2011-13) in Norfolk are average, but represent around 75 people per year.
- The percentage of adults on the Care Pathway Approach (CPA) in employment is below the national average and is the lowest in the Region. It is not noticeably improving.
- The percentage of adults in contact with secondary mental health services who live in settled accommodation is below the national and regional averages.

- Premature (under 75) mortality in adults with serious mental illness is the highest in the region, above the national average and rising (latest data 2012/13).
- There is generally high prescribing of antidepressants across the county (latest data 2012/13).

1.3 The DPH report in July recommended a system wide change. Social and environmental factors have major impact on mental ill health and many of these factors are potentially addressable with the right support before severe mental illness develops.

1.4 At the July meeting, The Health and Wellbeing Board agreed that mental health is a priority for Norfolk and too important to remain a 'golden thread' within the Health and Wellbeing Strategy 2014-17.

1.5 This paper seeks the Boards views on how best to develop and implement a Mental Health Strategy for Norfolk.

2. Scope

2.1 A holistic approach is required to improve mental health and wellbeing for all while addressing more specific need where and when it is required.

2.2 The DPH Report in July recommended a Mental Health Strategy in Norfolk should provide:

- a comprehensive, integrated and responsive mental health and social care service in community-based settings
- targeted and appropriate support for those who have a likelihood of developing mental illness
- accessible and effective support and treatment interventions for more severe cases; and
- ways to re-establish recovering patients into the community
- a clear policy lead on strategies for promotion, prevention and rehabilitation in mental health

2.3 The 2013 Chief Medical Officer's Report provides an evidence based framework for integrated strategic planning for mental health. This will include the wider determinants of health, prevention and wellbeing, through tiers 1 and 2 to pathways into specialist care across adults and children, to be considered and achieve a holistic system wide change in outcomes.

3. Proposal

3.1 The Health and Wellbeing Board takes ownership of the delivery of an integrated approach to public mental health in Norfolk, providing effective leadership and governance to a holistic systems approach, as recommended in the DPH Report in July.

3.2 Agree to set up a facilitated workshop by invitation to scope the brief in full and recommend terms of reference and governance on how a mental health strategy can be agreed and implemented. Service user representatives and providers should be included in the planning process.

4. Action

4.1 The Board is asked to

- Discuss and provide views on how best develop and implement a Mental Health Strategy for Norfolk
- Take ownership of the delivery of an integrated approach to public mental health in Norfolk, providing effective leadership and governance to a holistic systems change approach, as recommended in the DPH Report in July.
- Agree to set up a workshop to scope a public mental health strategy in full and recommend terms of reference and governance on how this strategy can be agreed and implemented. Service user representatives and providers should be included in the planning process.

Officer Contact

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Report to Norfolk Health and Wellbeing Board
5 October 2015
Item 11

Norfolk's Child Poverty Strategy Task and Finish Group Report

Report of the Director of Children's Services

Summary

At its meeting in July 2014, the Health and Wellbeing Board considered a draft Child Poverty Strategy for Norfolk and agreed that it should set up a Task and Finish Group to narrow down what partners will do and develop the detail of the how the Board might do it.

An invitation was sent to all members of the Health and Wellbeing Board to take part in this Task and Finish Group. The Group was identified and has met on 4 occasions and an Action Plan was developed. This plan was sent out as a draft to all members of the Group for their comments and, as a result a plan was agreed (Appendix C).

Action
The Health and Wellbeing Board is asked to:

- Consider and approve the action plan devised by the Task and Finish Group as work they agree can be taken forward.
- Commit to further meetings of the task and finish group to ensure progress of the work identified.

1. Background

1.1 The Child Poverty Act 2010 places a duty on local authorities and their partners to co-operate to tackle child poverty in the local area, with the requirement to produce a local needs assessment and a joint local child poverty strategy. It also places a responsibility on Central Government to produce a child poverty strategy every three years.

1.2 In 2013, the Head of 11-19 Strategy and Commissioning within Children's Services took the lead in developing Norfolk's multi-agency strategy, with an initial draft strategy circulated to the Health and Wellbeing Board in October 2013, when it was agreed that a workshop approach would be used to engage members of the Board and wider partners in further developing the strategy.

2. Developing Norfolk's Child Poverty Strategy

2.1 At its meeting in July 2014, the Health and Wellbeing Board considered the draft Child Poverty Strategy for Norfolk and agreed that it should set up a small Task and Finish Group to narrow down what partners will do and

develop the detail of how the Board might do it. The Report to the Board can be accessed at the following link.

2.2 An invitation was sent to all members of the Health and Wellbeing Board to take part in this Task and Finish Group and a number of partners came forward. The first meeting of this Group was held early in October 2014 and proposals for Membership and Terms of Reference were agreed. Draft proposals for the Task and Finish Group membership and Terms of Reference are attached as Appendix A and B respectively.

2.3 The Health and Wellbeing Board Task and Finish Group met and identified 12 key priority areas as follows:

Economic / employment

- Better paid job opportunities – encourage new employment to the area.
- Provide help and support to raise the level of skills and aspiration in Norfolk.
- Provide more help and support to those people who would otherwise face difficulties finding or maintaining employment.

Financial support

- Support those families whose benefit entitlement has changed so they are able to maximise their take up of benefits.
- Focus on families with multiple needs to ensure they are able to maximise available support.
- Effectively support young carers to minimise any loss of opportunities.
- Identify priority localities for support based on a range of partnership information.

Life chances

- Continue to work to improve educational attainment and skills of all young people.
- Ensure Children's Centres and other early years provision provide the most vulnerable children with good quality pre-school education, to improve school readiness.
- Continue to work to reduce levels of teenage conception as well as to improve the support to teenage families.

Place / environment

- Support initiatives to improve the quality of housing across the county to ensure young people are not disadvantaged in developing their potential by poor home environments.
- Recognise and tackle pockets of rural poverty in the county, recognising the patterns of poverty in rural compared to urban poverty are different.

2.4 The Task and Finish Group then met again to review these 12 points in order to identify any overlap; and to categorise them around what the Board can influence, hold others to account for and to directly take action on. The emphasis was on identifying any practical opportunities or mechanisms already in place that could be built on.

2.5 The Task and Finish Group met for the final time in July 2015 and put together a suggested action plan (Appendix C) which sets out clearly the actions for the next two years and how this is going to be achieved.

2.6 The identified actions complement other strategies and actions already in existence for the H&WB Board and the LEP.

3. Action

3.1 The Health and Wellbeing Board is asked to:

- Consider and approve the action plan devised by the Task and Finish Group as work they agree can be taken forward.

- Commit to further meetings of the task and finish group to ensure progress of the work identified.

Officer Contact

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IN TRAN communication for all

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Appendix A

H&WB

Norfolk Child Poverty Strategy

Task & Finish Group

Membership

Name	**Representing**
Cllr Brenda Arthur / Phil Shreeve	Norwich City Council
Chris Knighton	Healthwatch Norfolk
Richard Draper	H&WB Voluntary Sector Representative
Dan Mobbs	H&WB Voluntary Sector Representative
Tim Eyres	Children's Services, NCC
Lucy Macleod	Public Health, NCC
Fiona McDiarmid (or nominated representative)	Economic Development & Strategy, NCC
Debbie Bartlett	Corporate Planning & Partnerships Service, NCC

Appendix B

Draft Terms of Reference

Reason for the T&F Group

At the July meeting of the H&WB it was agreed that a small Task & Finish Group would be set up to work on the draft Norfolk Child Poverty Strategy to narrow down what partners will do and develop the detail of the how we will do it.

The task

- Identify three or four key areas of focus for the H&WB – based on what the evidence is telling us, what difference the H&WB can make, and the alignment with the H&WB's strategic priorities
- Develop the detail around these areas and some proposals for what H&WB partners will collectively do and how the Board will do it
- Add into the draft Strategy the key areas of focus for the H&WB, the actions the Board will take, the overall timelines and how we will know what we are achieving

Outcome

- H&WB partners coalesce around 3 or 4 priorities for action and commit to deliver

How the Group will work

The Group will:

- Complete its work through a combination of informal meetings and email communications between meetings and with the active participation of all members
- Hold an initial setting up meeting at which the Group will agree a Chair and draft Terms of Reference
- Disband when the task is complete

Reporting

The Group will:

- Report its membership and Terms of Reference to the H&WB for approval in October 2014
- Report the outcome of its work and submit proposals for action as part of the final
- Norfolk Child Poverty Strategy for the H&WB to consider as soon as is practicable

Membership

- T&F Group membership will be comprised of those members of the H&WB (or their nominated representative) who are willing to work on developing the draft Strategy

- The membership includes the NCC lead on the development of the Norfolk Child Poverty Strategy

Phase 1 – Prepare	6 months	Phase 2 -Transition	12 months	Phase 3 - Transform	18 months
A. INFLUENCE	**What will it look like**		**What will it look like**		**What will it look like**
Strategic objective: *To influence how local wage levels, economic and skills development opportunities, mental health services and transport provision operate within our communities, in order to enable more families in Norfolk to move out of poverty.*					
1. Champion a 'Norfolk Living Wage' based on an agreed definition	*There is shared agreement and commitment across the Board towards a 'Norfolk Living Wage'*	Encourage public sector commissioners and policy makers to build the 'Norfolk Living Wage' into their contracting			
2. Link with the Local Enterprise Partnership (LEP) to better understand and coordinate how the LEP's activity is contributing to reducing child poverty	*The Board's focus on child poverty and the LEP's focus on economic development are complementary*	Promote activity that encourages local businesses to engage with educational organisations & vice versa			
3. Link with health commissioners to support them in ensuring there is better access to mental health services across the County	*The Board's work on mental health is aligned with its work on child poverty*				
4. Link with transport providers to encourage plans for routes and prices that support people to get to training and employment	*Local transport policies emphasise actions that contribute to reducing child poverty*			Encourage Town and Parish Councils to develop local transport arrangements and schemes that support local people to access work	

Phase 1 – Prepare	6 months	Phase 2 -Transition	12 months	Phase 3 - Transform	18 months
B. ACCOUNTABILITY	**What will it look like**		**What will it look like**		**What will it look like**
Strategic objective: *To hold all commissioning and delivery partners to account on their commitment and action to enable more families in Norfolk to move out of poverty.*					
1. Support a nominated child poverty champion to provide challenge to the Health and Wellbeing Board and partners	*The Board's policies and activities reflect a commitment to reducing child poverty*	Ask Board members to report at meetings on how they are taking action to reduce child poverty		Ask partner organisations to account for how their local initiatives are developing and delivering in ways that enable a reduction in child poverty	
2. Ask commissioners and providers to confirm the actions they are taking to address gaps in provision for families affected by child poverty	*Board members know what action the county &, district councils & voluntary sector are taking in their neighbourhoods & communities to raise family aspirations*	Ask district councils and housing providers, including social housing providers, to share their development plans for new housing with reference to young people and affordable accommodation		Ask commissioners and providers to report on outcomes being secured through the Healthy Child Programme (HCP) for children and families affected by child poverty	
3. Use links with schools, academies, and colleges to check what action they are taking, from Key Stage 3 onwards, to improve employability and provide guidance & advice on employment	*Board members know how well young people are being supported to progress from education into employment*	Ask Children's Services to confirm how it is ensuring an effective service is in place across the wider children's workforce to support young people's participation in post 16 education and training.		Ask employment/employer federations what they can offer to increase young people's pre-employment skills	
4. Ask NCC to report on progress in delivering against the council's 'Real Jobs' strategic priority and how it is	*Board members have awareness of where 'real jobs' are making a positive difference for*	Ask the LEP and NCC (economic development) to report on progress against the apprenticeship targets		Ask DWP, NCC, Districts and other partners to report on progress in	

Phase 1 – Prepare	6 months	Phase 2 -Transition	12 months	Phase 3 - Transform	18 months
B. ACCOUNTABILITY	**What will it look like**		**What will it look like**		**What will it look like**
helping to address worklessness and low paid employment	*families and communities*	contained in the LEP's economic and skills plan with particular reference to individuals and communities affected by child poverty		improving outcomes for families furthest away from the labour market	
5. Ask the 'Better Broadband for Norfolk' project to report on progress in addressing 'not spots' with particular reference to communities affected by child poverty	*Board members understand where communities affected by poverty are also being held back by poor ICT connectivity*				
6. Ask Children's Services to report on how children affected by poverty are doing at the Early Years Foundation Stage as well as the sufficiency of child care across the county	*Board members have a clear baseline picture about how well children affected by child poverty are doing* *Affordable and quality child care is enabling families to return to employment*	Ask NCC and their key partners, including the voluntary sector, to report on how their work in developing / delivering: • Re-Imagining Norfolk Programme • A Locality Early Help Offer • A whole family approach is impacting positively for individuals and families affected by child poverty	*Organisations providing early help are flagging the impact that poverty is having on the families they work with* *Progress is being made to tackle child poverty*	Ask partners involved in delivering universal and more targeted services as part of early help in each locality to report on impact being secured for individuals, families and communities affected by child poverty	*Outcomes for children, families and communities affected by child poverty are improving at a rate at least in line with the rest of Norfolk's population*

Phase 1 – Prepare	6 months	Phase 2 -Transition	12 months	Phase 3 - Transform	18 months
C. DIRECT ACTION	**What will it look like**		**What will it look like**		**What will it look like**
Strategic objective: *To take direct action as a strategic board in order to champion, collaborate, communicate, and celebrate best practice, in order to enable more families in Norfolk to move out of poverty.*					
1. Build reporting on child poverty reduction into the Health & Wellbeing Board's Strategy 2014-17	*Child poverty is being reported as part of the Board's Work Programme quarterly reporting*				
2. Develop a communication plan to raise public awareness of child poverty and to report on actions being taken and progress being made	*Links in place with EDP/local media and helping to raise awareness/ public perception on scale and nature of child poverty in Norfolk*				
3. Identify and celebrate models of best employment practice around supporting employees to become financially independent	*Examples of best practice are being regularly disseminated and shared*				

Report to Norfolk Health and Wellbeing Board
4 November 2015
Item 12

Children's Services Improvement and Performance

Cover Sheet

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

The Health and Wellbeing Board has asked for a regular update on the operational performance within Children's Services including Support for School Improvement, Social Care and Safeguarding.

Key questions for discussion

- How can the H&WB support Children's Services to improve performance?

- How does the H&WB tie-in with other multi-agency structures such as Norfolk Safeguarding Children's Board and the Children and Young People's Strategic Partnership in relation to improving and monitoring Children's Services performance?

Actions/Decisions needed

The Board is asked to:

- Consider and comment on the information contained in this report

1. Children's Services Performance

1.1 The dashboards at appendices A, B and C detail performance against key areas across support for education improvement, early help and social care.

1.2 **What's going well**

1.2.1 Early Years Foundation and Key Stage 1 outcomes are similar to national averages.

1.2.2 We are seeing increased referrals to our Early Help service from a range of sources.

1.2.3 There have been improvements in almost all areas within the Social Work Dashboard

1.2.4 The use of Signs of Safety is beginning to be clearly evident in front-line work

1.3 **What are we worried about?**

1.3.1 Key Stage 2 outcomes not closing the gap with national averages

1.3.2 Looked After Children (LAC) performance remains a concern in a number of key areas e.g. Personal Education Plans (PEPs) and Health Assessments (HAs).

- PEP: Overall PEP performance continues to decline but the range of performance across localities (62-92%) strongly supports the notion that, where there is poor performance, it is a locality issue rather than a systemic one.
- HAs: LAC Health assessments have been and continue to be the focus of discussions with health colleagues. The recent appointment within Health of a Designated Doctor for Safeguarding and LAC is seen as a key step in unblocking the Health Assessment system.

1.3.3 Although continuing to reduce, LAC numbers remain high and there are still too many LAC in residential placements with resulting poorer outcomes for children and families and consequent financial pressures for the Authority

1.4 **What do we need to do about it?**

1.4.1 Challenge under performance in schools as outlined in 'A Good School for Every Norfolk Learner'

1.4.2 Ensure LAC performance is a central focus at every level within the organisation and partners through, for example, the Norfolk Safeguarding Children's Board

1.4.3 Ensure we prioritise our attention on placement mix as well as overall LAC reduction.

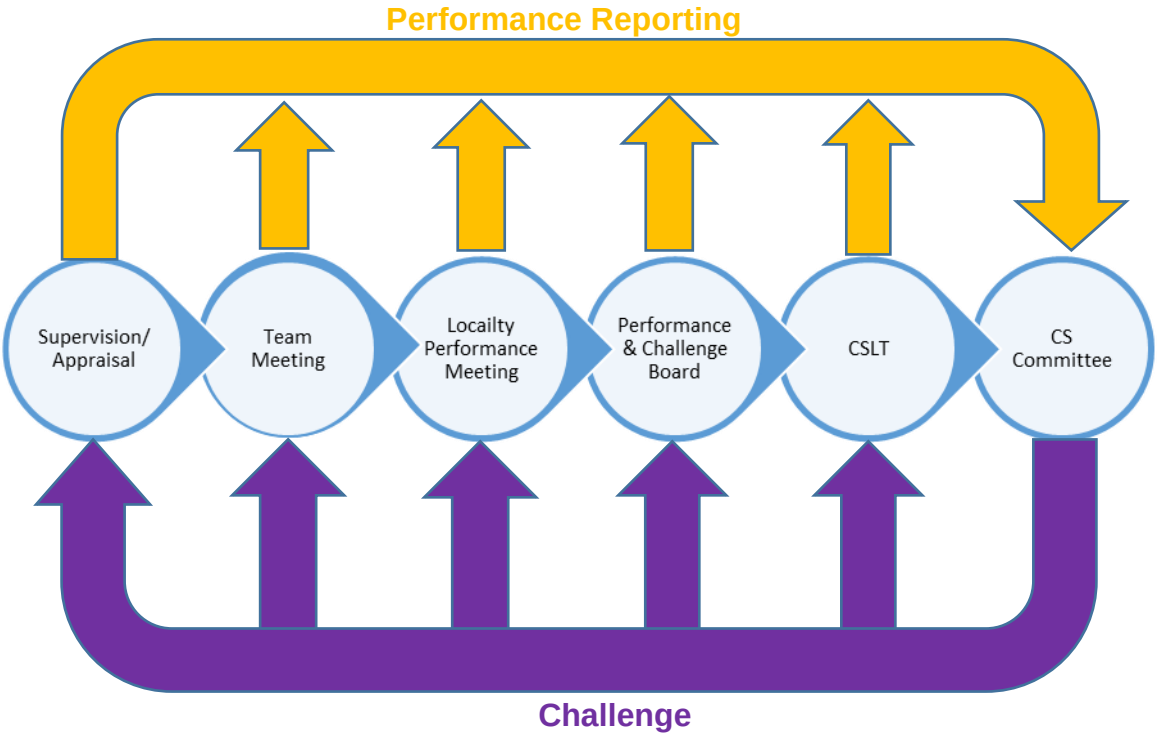
2. Children's Services Performance & Challenge Architecture

2.1 In addition to providing performance information, it might be helpful to alert the Board to the architecture through which we report on and manage performance.

2.2 We know that outstanding organisations fully understand and maximise the interrelationship between individual, team, area and organisational performance. They achieve this by, for example:

- Setting individual, team and area objectives which are clearly linked to organisational objectives.
- Reviewing progress against those objectives regularly.
- Not shying away from the difficult conversations, seeing them instead as opportunities to understand what is happening and drive improvement.

2.3 Whilst we are a considerable distance from being an outstanding service, we do, in fact, have functional architecture in place which offers a clear line of sight from individual through to County-wide performance (see below) - we just need to ensure we use it effectively.



2.4 For ease of illustration, the relationship through the architecture is shown linearly but remember, we are thinking in terms of systems, so the architecture allows for direct relationships between any of the elements within the system, as required.

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 County Council

July 2015

Norfolk Children's Services Education Improvement Plan Scorecard

A Good School for Every Norfolk Learner
2014 – 2015

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

SCORECARD

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

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

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

Performance Monitoring – Against LA High Level Strategic Targets for Improvement

Aim 1: Raise Standards at all Key Stages

Data is collected each half term from all Norfolk schools. The data collected from these schools is analysed school by school by the Education Achievement Service and an interpretation is sent back to the school with comments.The Education Intervention Service then follow up with schools of concern to quality assure the data provided.

Each school's data is aggregated to calculate an overall percentage in order to monitor to the impact of intervention and support on the overall trajectory to meet 2015 targets.

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

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

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

Aim 1: Raise Standards at all Key Stages

1.1 Improve Early Years outcomes - % Achieving A Good Level of Development

Percentages represent the percentage of pupils.

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

All = All pupils in the cohort

2015 predictions are derived from half termly report card data collected from all schools

				2015 Predictions					
		2013	2014	Aut 1	Aut 2	Spr 1	Spr 2	Summer 2015	Sum 2
Norfolk	All	46	58 ↑	58	60 ↑	63 +↑	64 +↑	65	
	FSM	32	43 ↑		45 ↑	52 +↑	51 +↑	51	
Breckland	All	41	58 ↑	55 ↓	58	59 ↑	62 +↑	64	
	FSM	28	49+ ↑		42 ↓	44 ↓	46 +↑	47	
Broadland	All	52	60 ↑	61+	62 +↑	64 +↑	66 +↑	69 +	
	FSM	37 +	41 ↑		46 + ↑	48 +↑	50 +↑	48	
Great Yarmouth	All	40	57 ↑	56 ↓	62 +↑	61 +↑	64 +↑	61	
	FSM	32	48+ ↑		51 + ↑	53 +↑	56 +↑	53	
Kings Lynn & West	All	47	61+ ↑	61+	62 +↑	62 +↑	62 +↑	66	
	FSM	34	43 ↑		48 +↑	52 +↑	54 +↑	54	
Norwich	All	38	51 ↑	52 ↑	49 ↓	58 +↑	58 ↑	62	
	FSM	28	38 ↑		39 ↑	46 +↑	51 +↑	48	
North	All	48	57 ↑	59 ↑	65+ ↑	69 +↑	64 +↑	62	
	FSM	37+	45 ↑		50+ ↑	51 +↑	49 +↑	52	
South	All	55+	60 ↑	59 ↓	61	70 +↑	69 +↑	70 +	
	FSM	32	42 ↑		44↑	66 +↑	48 +↑	51	
National	All pupils	52	60					66	
	FSM	36	45						

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

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

1.2: Improve Outcomes at Key Stage 2 - % Achieving a Level 4+ in Reading, Writing and Mathematics

Percentages represent the percentage of pupils.

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

All = All pupils in the cohort

2015 predictions are derived from half termly report card data from all schools. They do not include special schools whereas final published outcomes do.

				2015 Predictions					
		2013	2014	Aut 1	Aut 2	Spr 1	Spr 2	Summer 2015	Imp since 2014
Norfolk	All (without special schools)	71	74 ↑	75 ↑	76 ↑	78	78	75.4 (76.1) ↑	+1
	FSM	55	59 ↑	62 ↑	63 ↑	67 ↑	67 ↑	62.8 (64.0)	+4
Breckland	All	64	68 ↑	68	69 ↑	68	69 ↑	69 ↑	
	FSM	48	51 ↑	57 ↑	55 ↑	54 ↑	55 ↑	57 ↑	
Broadland	All	78+	82+ ↑	83+ ↑	84 +↑	84 +↑	84 +↑	83 ↑+	
	FSM	67+	69+ ↑	70+ ↑	73 +↑	71 +↑	71 +↑	71 ↑	
Great Yarmouth	All	65	74 ↑	72 ↓	74 ↑	76 ↑	75 ↑	72 ↓	
	FSM	55	62 ↑	58 ↓	65 ↑	65 ↑	65 ↑	60 ↓	
Kings Lynn & West	All	69	73 ↑	73	76 ↑	77 ↑	78 ↑	77 ↑	
	FSM	53	58 ↑	64 ↑	64 ↑	68 +↑	69 +↑	67	
North	All	72	75 ↑	75	76 ↑	79 ↑	77 ↑	75	
	FSM	56	63 ↑	64 ↑	63	72 +↑	73 +↑	64	
Norwich	All	66	72 ↑	72	74 ↑	77 ↑	79 ↑	76 ↑	
	FSM	57	60 ↑	63 ↑	64 ↑	71 +↑	70 +↑	65	
South	All	79+	82+ ↑	82+	82 +	81 +↑	82 +↑	81 +	
	FSM	60	63 ↑	63	65 ↑	65	64	65	
National	All pupils	76	**79**					80	
	FSM	63	**67**						

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

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

1.3: Improve outcomes at Key Stage 4 - % Achieving 5 GCSEs A* - C, including English and Mathematics

Percentages represent the percentage of pupils.

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

All = All pupils in the cohort

2015 predictions are derived from half termly report card data from all schools. They do not include special schools whereas final published outcomes do.

				2015 Predictions					
		2013	2014	Aut 1	Aut 2	Spr 1	Spr 2	Prov Summer	Final Summer
Norfolk	All (without special schools)	55	52.7 ↓	55 ↑	56 ↑	59+ ↑	60+ ↑	54.7 (55.7) ↑	
	FSM	31	30 ↓	33 ↑	35 ↑	40+ ↑	41+ ↑	34 ↑	
Breckland	All	50	52 ↑	54 ↑	55 ↑	56+ ↑	58+ ↑	53 ↑	
	FSM	26	33 ↑	34 ↑	34 ↑	38+ ↑	40+ ↑	38 ↑	
Broadland	All	60	58+ ↓	60+ ↑	64 + ↑	64 +↑	65+ ↑	59 ↑	
	FSM	34	33 ↓	38+ ↑	42 + ↑	44+ ↑	46+ ↑	39 ↑	
Great Yarmouth	All	48	44 ↓	51 ↑	51 ↑	54 ↑	53 ↑	51 ↑	
	FSM	30	29 ↓	37+ ↑	37+ ↑	40+ ↑	39+ ↑	36 ↑	
Kings Lynn & West	All	54	45 ↓	47 ↑	45	54 ↑	55 ↑	51 ↑	
	FSM	34	24 ↓	23	27 ↑	34 ↑	33 ↑	29 ↑	
North	All	57	59+ ↑	62+ ↑	61 +↑	66+ ↑	65+ ↑	56 ↓	
	FSM	34	42+ ↑	42+	41+↓	46+ ↑	45+ ↑	37 ↓	
Norwich	All	46	49 ↑	50 ↑	51 ↑	54 ↑	55 ↑	50 ↑	
	FSM	26	28 ↑	30 ↑	27 ↓	38+ ↑	38+ ↑	32 ↑	
South	All pupils	66+	61+ ↓	62+ ↑	64 + ↑	66+ ↑	67+ ↑	66 ↑	
	FSM	43+	32 ↓	35 ↑	38 + ↑	45+ ↑	46+ ↑	41 ↑	
National	All pupils	60	**56.6**						
	FSM	41	**36**						

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

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

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

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

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

		July 2012		July 2013		July 2014		December 2014			April 2015			July 2015			
		Norfolk Actual	National (June 2012)	Norfolk Actual	National (June 2013)	Norfolk Actual	National	Norfolk Actual	Norfolk Target	National	Norfolk Actual	Norfolk Target	National (prov)	Norfolk Actual	Norfolk Target	National (prov 31/7))	Latest Norfolk
% should increase	%Early Years settings judged good or better	83%	78%	81%	82%	85% +↑	83%	87% +↑		86%	89%	80%			82%		89%
	%Childminders judged good or better	74%	71%	76%	75%	80% +↑	78%	84% +↑	78%	82%	89%	80%			85%		89%
	%Children's Centres judged good or better	82%+	69%	73%+↓	69%	71% +↓	67%	71% +↓		67%	65%	70%			72%		65%
	%Primary phase schools judged good or better	60%	69%	64% ↑	78%	70% ↑	81%	72% ↑	75%	82%	74%↑	77%	82%	81%	80%	85%	81%
	%Secondary phase schools judged good or better	47%	66%	63% ↑	72%	62% ↓	70%	60%↓	65%	71%	65% ↑	67%	73%	68% ↑	69%	74%	68% ↑
	%Special schools judged good or better	91%	81%	82% ↓	87%	91% +↑	90%	91% +	91%	90%	91% +	91%	89%	100%	91%	91%	100%
% should decrease	Reduce % of schools in an Ofsted category	3%	3%	4% ↑	3%	4%	3%	4%	3%	2%	3% ↓	3%	2%	2% ↓	2%	2%	2% ↓
	Reduce % of schools judged to Require Improvement	37%	28%	32% ↓	19%	25% ↓	17%	26% ↑	23%	17%	23% ↓	21%	16%	19% ↓	19%	14%	19% ↓

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

	Autumn 2013	July 2014	December 2014	April 2015	July 2015	Norfolk Latest
Norfolk	66% (270/409)	70% (287/403) ↑	71% (282/396)	74% (288/390) ↑	80% (309 / 388)	80% (309 / 388)
Breckland	64% (41/64)	69% (44/64) ↑	66% (42/64) ↓	68% (43/63) ↓	70% (44/63) ↑	70% (44/63) ↑
Broadland	77% (46/60)	75% (45/60) ↑	77% (46/60) ↑	75% (45/60)	88% (51/58) +↑	88% (51/58) +↑
Great Yarmouth	56% (20/36)	65% (22/34) ↑	67% (22/33) ↑	69% (22/32) ↑	67% (22/33) ↑	67% (22/33) ↑
Kings Lynn & West	52% (51/79)	63% (49/77) ↑	64% (47/73) ↑	69% (49/71) ↑	68% (51/69) ↑	68% (51/69) ↑
Norwich	66% (27/41)	70% (28/40) ↑	69% (27/39) ↓	74% (28/38) ↑	76% (29/38) ↑	76% (29/38) ↑
North	65% (35/54)	73% (39/54) ↑	75% (40/53) ↑	79% (41/52) ↑	93% (49/53) ↑	93% (49/53) ↑
South	80% (59/74)	81% (59/73) ↑	81% (59/73)	81% (59/73)	85% (62/73)	85% (62/73)
National (Data View)		81%	81%	82%	84%	

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

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

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

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

Inclusion Perfomance Framework

Attendance of Looked After Pupils

Shown as a **percentage** of pupils who are in Local Authority Care

		2012-2013		2012-2013		2013-2014		2013-2014		2014-2015			2015-2016		
		Norfolk All Pupils*	National All Pupils*	Norfolk LAC Pupils*	National LAC Pupils*	Norfolk All Pupils*	National All Pupils*	Norfolk LAC Pupils*	National LAC Pupils*	Autumn	Spring	Summer	Autumn	Spring	Summer
Absence	**Primary**	4.9%	4.7%	4.7%	4.4%	4.0%	3.8%	3.8%	3.9%	3.4%	3.2%				
	Secondary	6.5%	5.8%			5.1%	5.6%			5.6%	6.6%				
Persistant Absence (15% + missed sessions)	**Primary**	2.9%	3.0%	4.8%	5.0%	2.1%	2.1%	3.4%	4.6%	4.4%	3.8%				
	Secondary	7.4%	6.4%			5.2%	5.8%			7.8%	10.1%				
% Attending a good or better school		63%	76%			69%	78%			63%	71%				

*Annual absence figures are taken from DfE Statistical First Release (SFR49_2014) show absence from school over five terms for children who have been looked after for at least 12 months,.
Termly monitoring shows absence of all looked after pupils using data collected from schools by Welfare Call.

Access to Education

	Autumn 2014	Spring 2015	Summer 2015	Autumn 2015	Spring 2016	Summer 2016
Children Missing Education (CME)	192	181	195			
Pupils Missing from (full time) Education (PMfE)	TBC	TBC				
Education other than at school (EOTAS)	TBC	TBC				

Participation Post 16

	2013-2014		Autumn 2014	Spring 2015	Summer 2015	Autumn 2015	Spring 2016	Summer 2016
	Nat.	Norfolk						
Not in Employment Education or Training (NEET)	Average Nov13 to Jan14 5.3%	Average Nov13 to Jan14 5.8%	N/A[1]	April 15 6.6%				
Participation at 16	93.6%	95.1%	N/A	91.3%				
Participation at 17	85.2%	81.8%	N/A	75.1%				

[1] Data not available due to closure of Client Caseload Information System (CCIS) database at this time

Exclusions

		Norfolk 2013-14	National 2013-14	Autumn 2014 (No. of pupils)	Spring 2015 (No. of pupils)	Summer 2015 (No. of pupils)	Autumn 2015 (No. of pupils)	Spring 2016 (No. of pupils)	Summer 2016 (No. of pupils)
Permanent Exclusions	0 – 4 years	x	x	1	0	0			
	5– 11 years (YR/KS1)	0.05%	0.02%	17 (5)	22 (3)	26 (6)			
	12 – 16 years	0.19%	0.12%	60	35	45			
	SEN Pupils (Statement / EHCP)			26	33	25			
	FSM Pupils			27	28	24			
	Looked After Children			2	3	5			
Looked After Children – Fixed Term Exclusions *(Norfolk and out of county schools)*						77 (21 x primary 56 x secondary) (34 x alternative provision)			

Education Health and Care Plans

	2013-2014		Autumn 2014				Spring 2015			Summer 2015				Autumn 2015				Spring 2016				Summer 2016		
	Nat.	Norfolk	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Total Number																								
Assessments in Timescales																								
Placement Type																								

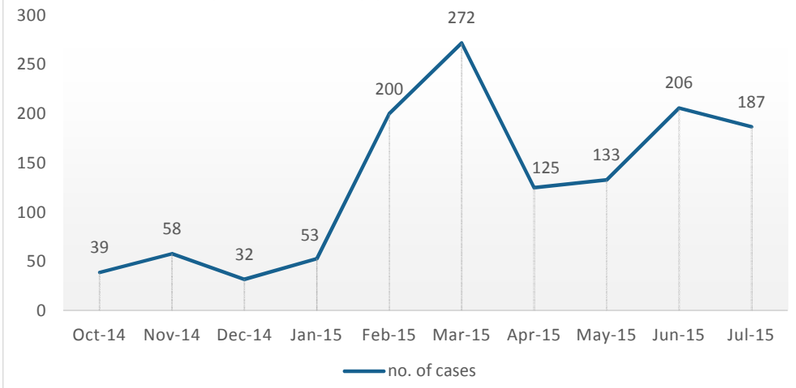
TBC

Achievement of Vulnerable Groups (KS4) % achieving 5 good GCSEs including English and mathematics

	2013-2014		Autumn 2014 Prediction	Spring 2015 Prediction	Summer 2015 Outcome	Autumn 2015 Prediction	Spring 2016 Prediction	Summer 2016 Outcome
	Nat.	Norfolk						
FSM	36	30	35%	41%	36%			
Non-FSM	64.2%	59%	62	66%	62%			
Looked After Pupils	12.0%	8.3%	7%	13%				

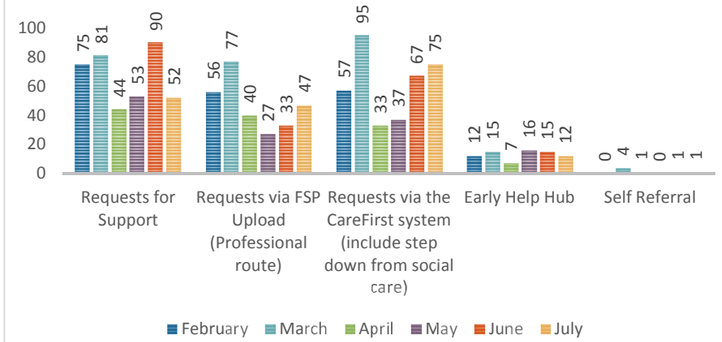
Norfolk Early Help Management Overview Dashboard July 2015

Referrals in - Requests for Support



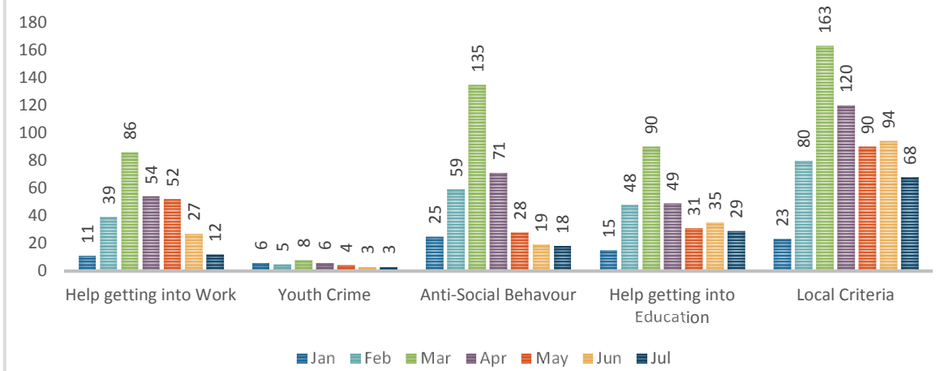
A slow increase in families presenting with need was predicted after the Easter holiday drop. This has been evidenced by the amount of cases coming forward. We can see this pattern repeating now that we have entered the Summer Holiday period.

Early Help Profile - Entry routes into the programme



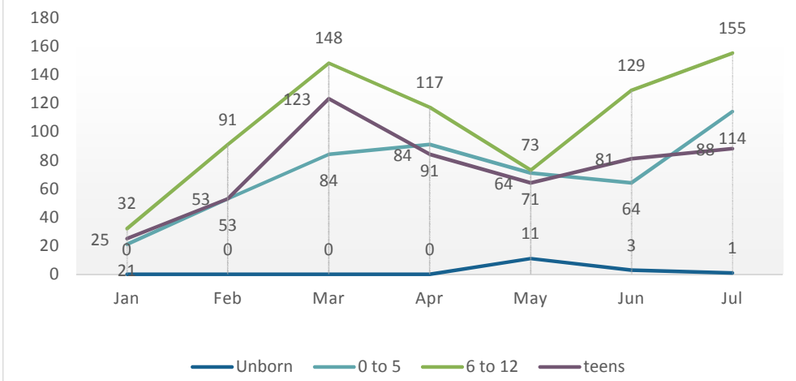
In July, we received 24 FSP's are to be lead by NEHFF and 10 by wider partners. 11 cases were stepped down via an FSP. Electronic means, again, is the favoured pathway, in advance of the implementation of DOREIS (CMS system).

Referrals in - Needs at point of entry



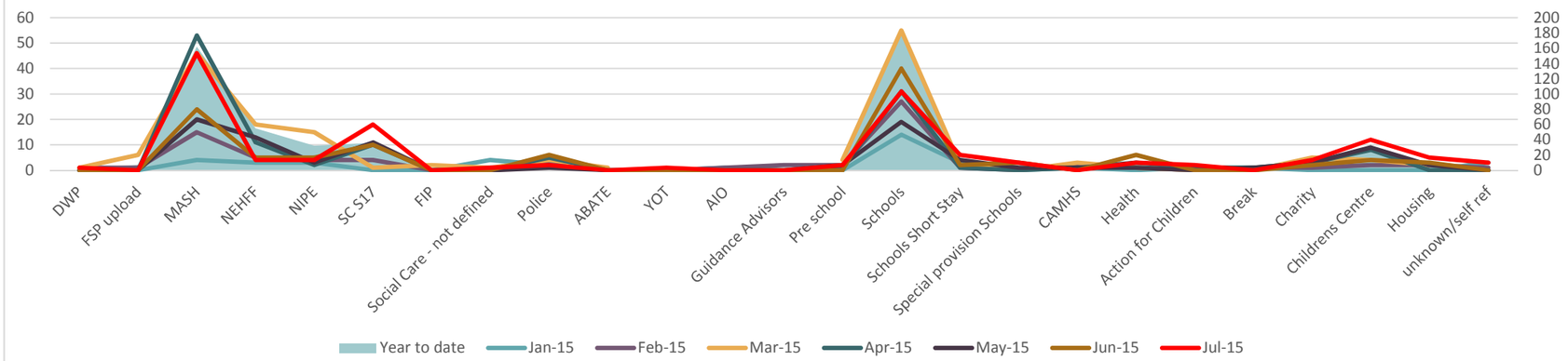
In July, the majority of presenting needs were those with physical and mental health issues, domestic violence and abuse, housing issues and those requiring a multi agency response. This is now being reported separately, in tile 6 (bottom left)

Referrals in - age split



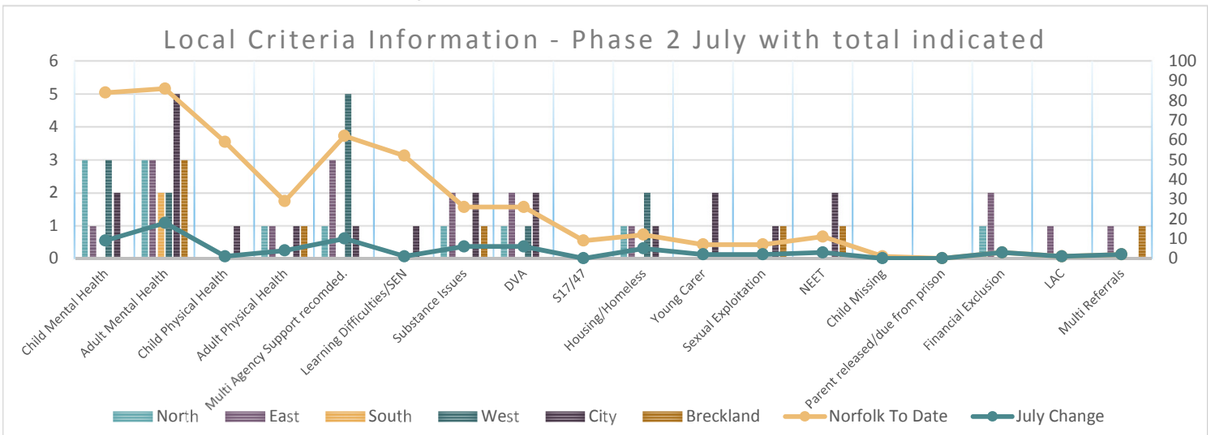
As is consistent, most of our families have 6-12 age groups. This month saw only 1 expectant mother seeking help. For the second month we have seen a raise in teenagers within the families seeking assistance.

Early Help Profile - Request originators



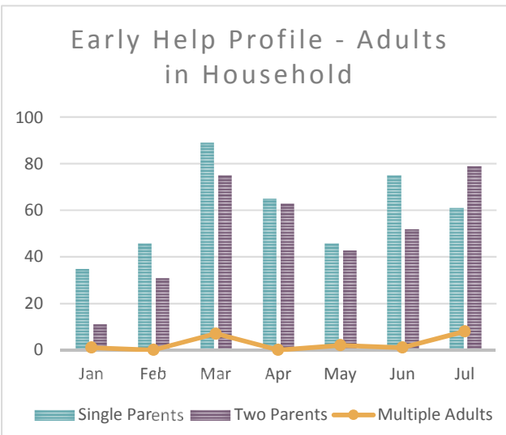
The significant raise in July referrals has come from the Health sources, that has been a target group. The increase is due to engagement with PALS and NEHFF communications through the young carers roadshows. Police have been the second increase in referrals. 11 families are stepping down from social care via the FSP process.

Local Criteria Information - Phase 2 July with total indicated



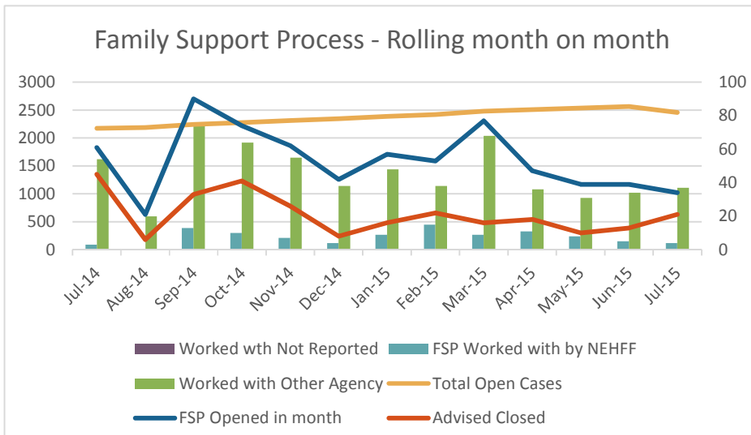
Whilst Young Carers, Sexual Exploitation and Missing Children are high government agendas, the numbers are low at the moment. With work ongoing to raise the profiles, we expect these figures to increase over the next six months. We can see that in Norfolk, Child Mental Health and Child Physical Health are our largest presenting needs.

Early Help Profile - Adults in Household



This month has seen a change in trend. 53% of the caseload for July is 2 parent families. The biggest change has been in families with multiple adults which this month represents 6%.

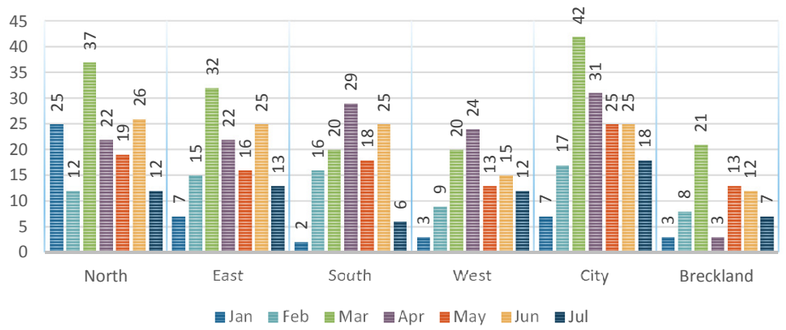
Family Support Process - Rolling month on month



FSP's are uploaded by the lead professional, with consent from the family. Therefore what is represented is a flavour of the activity across the county and not the totality. During July, we expect to see an increase due to recent communications.

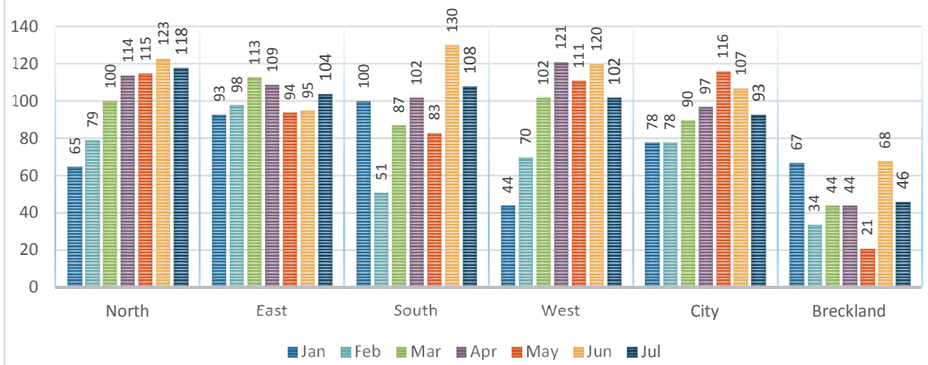
Norfolk Early Help Management Overview Dashboard July 2015

Early Help Profile - Monthly Area Case Allocation



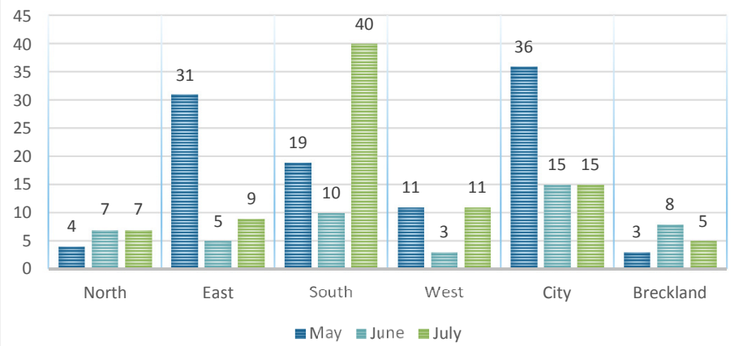
With the exception of the West and Breckland area's, June has seen an even spread of allocations. For the year to date, the average family size is 2.4 children. The smallest is 1 and the largest family size is 6. 34% of families have 2 children. This has been a consistent picture for the last 4 months

Early Help Profile - Current Caseload



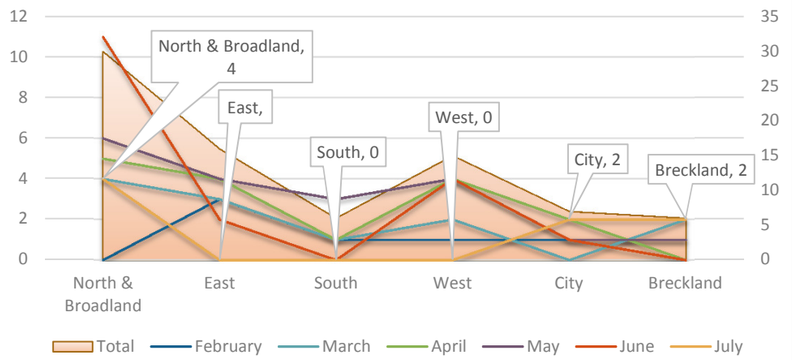
575 cases are currently being actively worked with in Norfolk. The current caseloads held across the 6 areas has remained largely consistent. The only significant change is in Breckland where we have seen a 223% increase.

Cases Closed - Without Monitoring



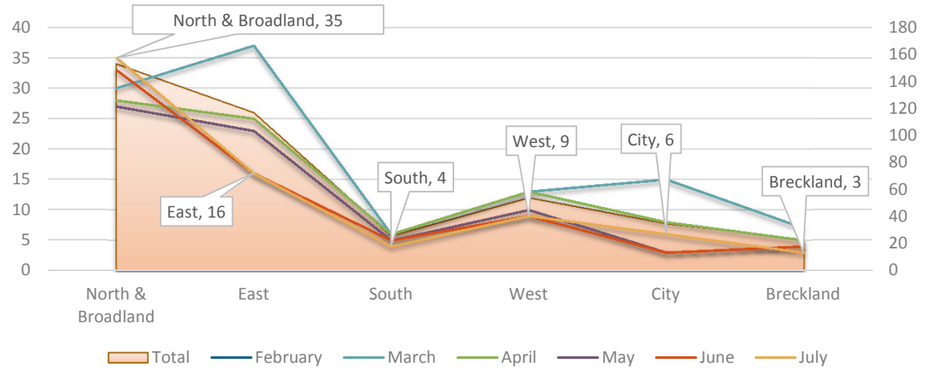
We expect 1 FTE to hold 18 cases (depends upon the size/complexity of the family). Caseloads have remained consistent over the last 5 months.

Referrals Made to Monitoring - monthly



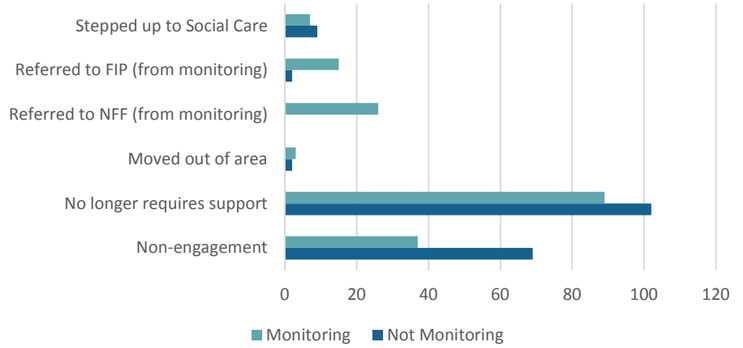
As is consistent, the majority of cases entering monitoring originate in the North, East and West areas. There were no cases from South and Breckland. Previously this has been shown as a stacked table, but this has been changed for clarity

Active Cases in Monitoring - monthly



The service has 73 families in active monitoring. To date, 255 families have taken advantage of the monitoring service prior to exiting the service.

Exiting Service - Totals



Of the cases leaving monitoring in June, only 1 family returned to be supported via NEHFF. 11 families openly stated that they no longer needed support. Whereas 10 families ceased to engage. This could mean that those families felt they no longer need support, and is seen as a good outcome. This is monitored.

Scorecard

	Identified in June			Active	No	No.	No.	No.	Timeframe	No.	Troubled Families programme Phase 2, Year 1 (YR1)		
											Norfolk's target is to improve the holistic outcomes of the whole family for 5650 families over 5 years.		
	Families presenting with Early Help needs.	Troubled Families Register: No of Families identified for Support	Families where baselining is in progress	Family Support Process FSP's received that are externally supported	Cases Worked with by operational teams	Re referrals back into the NEHFF since April 2013	Re referrals back into the NEHFF in July	Cases Stepped down from Social Care during July	Central Referral to operational teams to allocate. Increase due to holiday	Cases awaiting allocation by operational teams at the end of July.	Target for YR1	TF Worked With	Payment by results will be reported following September
											Troubled Families Register: No of Families worked with by NEHFF/partners	Troubled Families Register: No of Families worked with by NEHFF/partners	
County	187	72	100	30	571	12	0	54	20 days	22	960	953	

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

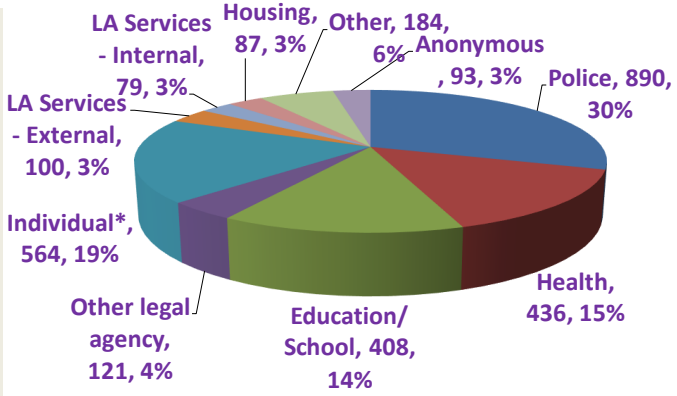
Contacts and Initial Assessments:

Initial Contacts by Source:

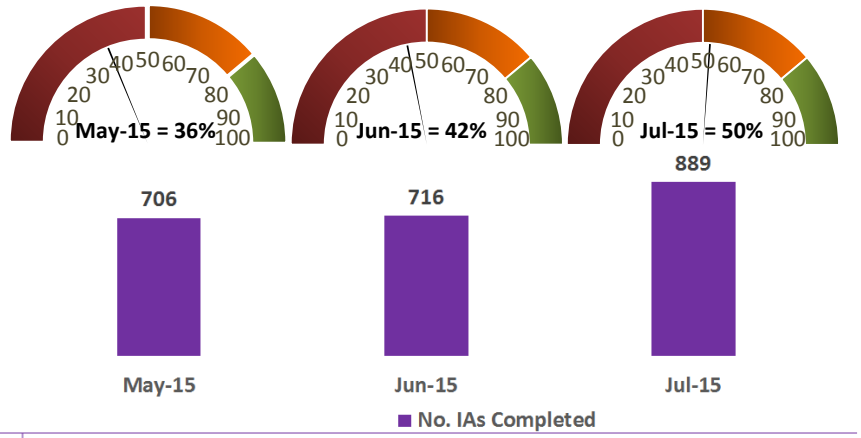
	May-15	Jun-15	Jul-15
Police	937	918	890
Health	379	371	436
Education/ School	352	470	408
Other legal agency	79	88	121
Individual*	497	501	564
LA Services - External	103	102	100
LA Services - Internal	55	72	79
Housing	111	95	87
Other	157	167	184
Anonymous	53	77	93
Total	2723	2861	2962

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

Contacts in June 2015 by Source



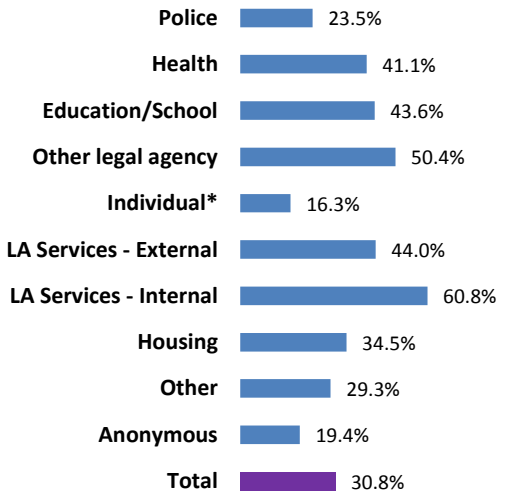
Initial Assessments Completed in Timescales:



Percentage of Re-Referrals:

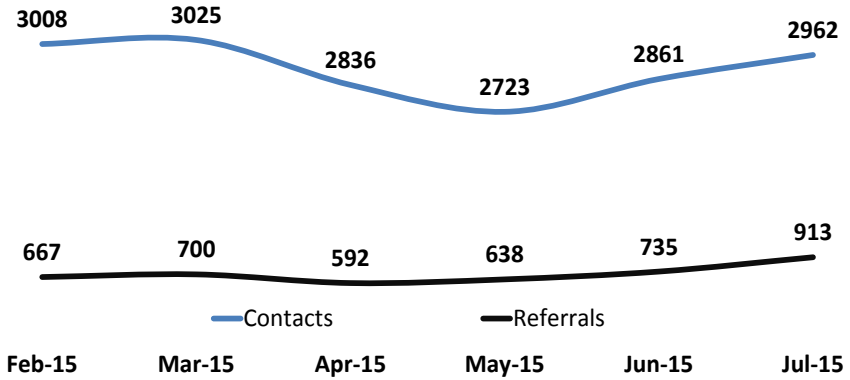
Re-Referrals	May-15	Jun-15	Jul-15
Norfolk	24.9%	24.5%	28.7%
England 2013/14	23.4%		
Statistical Neighbours 2013/14	26.1%		
East of England 2013/14	22.4%		

Conversion of Contacts to Referrals by Source:



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

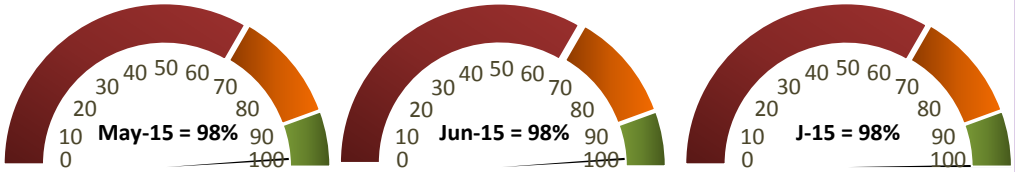
Contacts & Referrals Received February - July 2015



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

Children in Need:

Children in Need Allocated to a Qualified Social Worker:



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

	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
No. s17 Children in Need	974	1004	932	870	889	780
No. s17 with CIN Plan	717	608	567	508	583	603
No. s17 without a CIN Plan	257	396	365	362	306	177
% with a CIN Plan	**73.6%**	**60.6%**	**60.8%**	**58.4%**	**65.6%**	**77.3%**
No. CWD Children in Need	286	277	279	284	288	277
No. CWD with CIN Plan	248	225	231	229	223	245
No. CWD without a CIN Plan	38	52	48	55	65	32
% with a CIN Plan	**86.7%**	**81.2%**	**82.8%**	**80.6%**	**77.4%**	**88.4%**

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

Ethnicitv & Gender of Children in Need:

Ethnicity	Female	Male	Unborn	Unknown	Total
Any other ethnic origin (please specify)	10	6	0	0	16
Any other mixed background	14	14	2	0	30
Arab	2	0	0	0	2
Asian - any other background	1	5	0	0	6
Bangladeshi	1	1	0	0	2
Black - any other background	5	5	0	0	10
Black African	5	8	1	1	15
Black Caribbean	0	0	1	0	1
Gypsy/Roma	0	0	0	0	0
Indian	2	0	0	0	2
Not yet Available / Unknown	23	25	16	0	64
Traveller of Irish Heritage	1	4	0	0	5
White - other background	51	65	1	0	117
White and Asian	2	3	0	0	5
White and Black African	2	6	0	0	8
White and Black Caribbean	2	4	0	0	6
White British	609	711	26	0	1346
White Irish	2	1	0	0	3
Grand Total	732	858	47	1	1638

CIN Reviewed within Timescales:

	Reviewed in Timescales		
	In Time	Out of Time	% In Time
CIN Teams	603	177	**77.3%**
CWD Teams	245	32	**88.4%**
Other Teams	340	241	**58.5%**

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

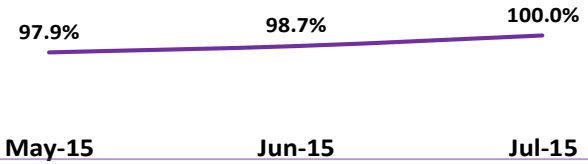
	May-15	Jun-15	Jul-15
Norfolk (Current)	284.0	279.2	
England 13/14		346	
Statistical Neighbours 13/14		339.0	

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

Child Protection:

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

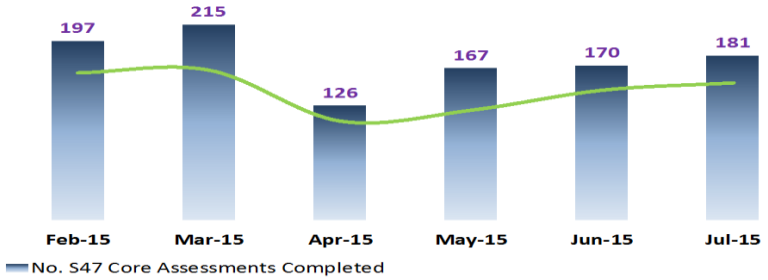
	May-15	Jun-15	Jul-15
No. Children on CP Plan	561	522	509
No. Allocated to Qualified Social Worker	549	515	509
% Allocated to Qualified Social Worker	97.9%	98.7%	100.0%



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

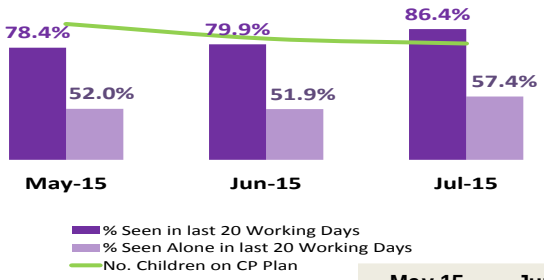
	May-15	Jun-15	Jul-15
Norfolk (Current)	33.9	31.5	30.7
Norfolk 13/14		32.3	
England 13/14		42.1	
Statistical Neighbours 13/14		45	

Section 47 Core Assessments Completed in Timescales:



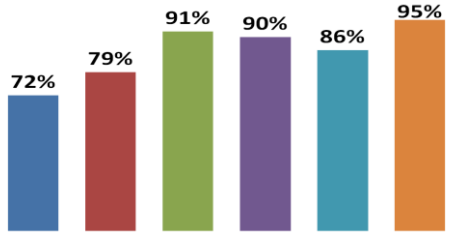
	May-15	Jun-15	Jul-15
No. Section 47 Core Assessments Completed	167	170	181
No. Section 47 Core Assessments Completed within 35 Working Days	121	143	151
% Section 47 Core Assessments Completed within 35 Working Days	72.5%	84.1%	83.4%

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



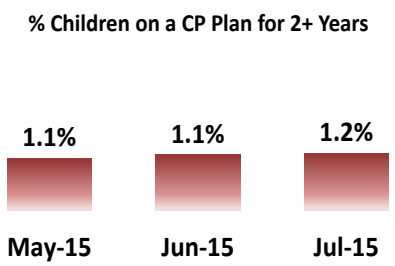
	May-15	Jun-15	Jul-15
No. Seen in last 20 Working Days	423	417	426
No. Seen Alone in last 20 Working Days	252	271	301

ICPCs within 15 Working Days of Strategy Discussion:

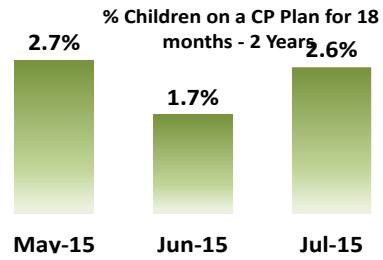


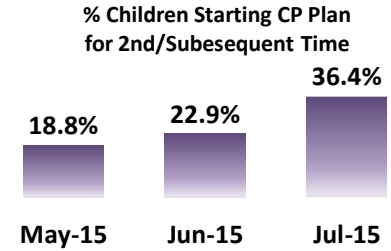
	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
Total ICPCs	113	80	81	67	76	59
Within 15 Working days	81	63	74	60	65	56
Over 15 Working Days	32	17	7	7	11	3

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



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



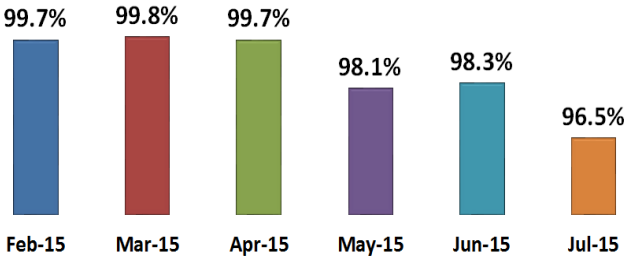


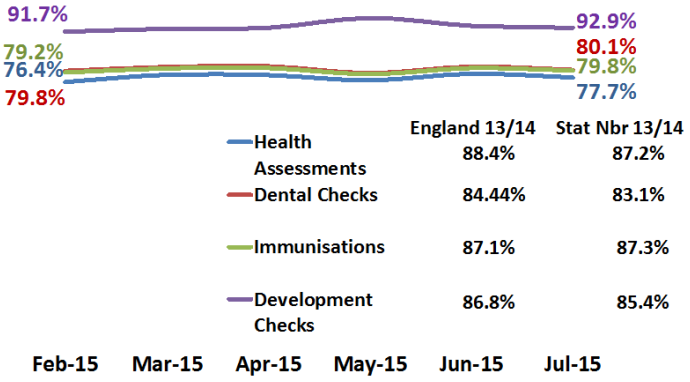
England 13/14 = 15.8%; Stat Nbr = 17.4%

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

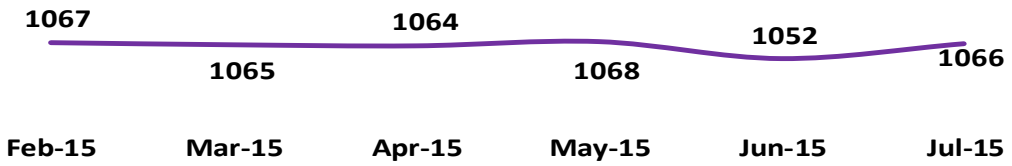
Looked-After Children:

Looked-After Children allocated to a Qualified Social Worker:

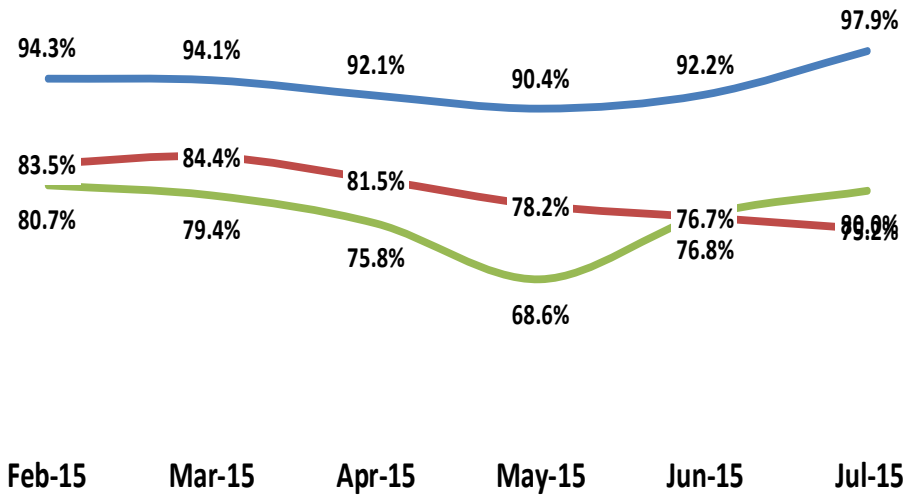




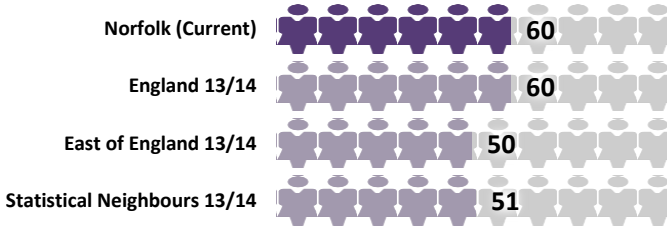
Number of Looked-After Children:



Care Plans, Pathway Plans & Personal Education Plans:



Rate of LAC per 10,000 Under-18 Population



Norfolk Integrated Offender Health and Social Care Group Annual Report

Cover Sheet

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

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

- Duty to prepare a Joint Strategic Needs Assessment (including a Pharmaceutical Needs Assessment) and a Joint Health and Wellbeing Strategy
- Duty to encourage integrated working between commissioners of health and social care services
- Duty to provide an opinion as to whether the CCG commissioning plan has taken proper account of the Health and Wellbeing Strategy and what contribution has been made to the achievement of it
- Duty to assess how well the CCG has discharged its duties to have regard to the JSNA and JHWS

Key questions for discussion

- Do the areas for action set out in the report, accurately reflect the priorities for improving offending health and social care in Norfolk?
- Are Health and Wellbeing Board members able to support the delivery of improvement action through:
    - the alignment of relevant strategy and policy
    - service re-design and operational modifications
    - re-allocation/allocation of resources
    - joint commissioning.

Actions/Decisions needed

The Board needs to:

- agree the priorities of the Integrated Offender Health and Social Care Group
- endorse the work of the Group and actively sponsor and support the delivery of its work programme
- (If applicable) select a lead agency for the development of a Norfolk PD Strategy.

Norfolk Integrated Offender Health and Social Care Group Annual Report

Report of the Deputy Police and Crime Commissioner for Norfolk

Summary
This report provides an overview of the activity of the Norfolk Integrated Offender Health and Social Care Group (NIOHSCG) during 2015 and priorities for the group over the next twelve months to improve offender health and overall rehabilitation of offender outcomes.

Action
The Health and Wellbeing Board is asked to:

- agree the priorities of the Integrated Offender Health and Social Care Group
- endorse the work of the Group and actively sponsor and support the delivery of its work programme
- (If applicable) select a lead agency for the development of a Norfolk PD Strategy.

1. Background

1.1 In Britain:

- 90% of prisoners have substance misuse problems, mental health problems or both
- 80% of prisoners smoke
- 9% of the UK prisoner population suffer from severe and enduring mental health illness
- 10% of prisoners have a learning disability
- 40% of prisoners declare no contact with primary care prior to detention
- people who have been in prison are up to 30 times more likely than the general population to die from suicide in the first month after discharge from prison (10 times more likely when in prison)
- there is commonly poor continuity of health care information on admission to prison, on movement between prisons and on release.

It is therefore imperative that:

- offenders have access to appropriate health services in custody and the community.

- suspects and persons detained by the police under mental health provisions are able to access appropriate health & social care professionals at the appropriate time and in the appropriate place.
- offenders with serious mental healthcare needs are diverted to appropriate health services
- health service links to other services working with offenders are improved.

1.2 The establishment of the NIOHSCG was enacted by the Health and Wellbeing Board in 2014, in recognition of health inequalities for those at risk of offending and offenders, leading to significant health diseconomies. The Group has met three times, including to take part in a one-day multi agency Offender Health Pathway Mapping Workshop facilitated by Professor Eddie Kane of Nottingham University who is recognised nationally for his expertise in offender health, and in particular, mental well health.

1.3 Upon completing a review of pinch points and gaps in the health and social care system for offender centric services, the NIOHSCG has now identified its priorities for action. These focus predominantly on the design/redesign of universal services to reflect the unique and often multiple and complex needs of Norfolk's offender population and will deliver significant health economies.

2. Priorities

2.1 The priorities for the NIOHSCG for the next twelve months are…

- Ensuring continuity of care through the prison gate from better collaboration between the NHS England, National Offender Management Service (NOMS), Clinical Commissioning Groups (CCGs) and the Community Rehabilitation Company (CRC).
- Raising the skills of frontline practitioners across the health and social care system to enable them to communicate more effectively with people with mental health needs and learning disabilities.
- Increasing access to primary health care – including the development of a pathway for offenders into primary health.
- The development and integration of mentoring programmes to achieve efficiencies and improve access to primary and seconded care and to enable individual's with multiple complex needs to take control of all aspects of their rehabilitation.
- Influencing the configuration and services delivered through the early help hubs to ensure they reflect the needs of offenders in the locality.
- Supporting the development of a Norfolk wide strategic approach to personality disorder (PD) to facilitate the synchronisation of commissioning of PD services, and for this to be included within a system wide mental health and wellbeing strategy.
- Reviewing the Health and Well-Being Strategy to establish where offender health and social care priorities need to be recognised and addressed more greatly and ensuring delivery of the strategy is not compounding inequalities in health and social care outcomes for offenders.

- Carrying a needs assessment of women specific services in the community and developing a target operating model for Norfolk.
- Periodic review of the health justice outcome framework.
- Finalising a detailed action plan to deliver against each priority.

3. Key issues for further exploration

3.1 The timeframe for the development of the Norfolk Mental Health Strategy and the opportunities that exist to ensure this reflects the mental health needs of those in the criminal justice system.

3.2 The need for and identifying a lead for the development of a Norfolk PD Strategy.

3.3 Access to primary care and low levels of GP registration for offenders and the extent to which the existing system is equipped to improve these.

3.4 How the Health and Wellbeing Board is engaging with the development of Early Help to deliver against a wide range of health outcomes for groups where these are known to be comparatively and disproportionately lower.

4. Conclusions

4.1 There are a number of areas where the NIOHSCG can progress action to improve offender health and address health diseconomies. However, there are a number where decisive action by the Health and Wellbeing Board and Partners is required. If action is not taken, inequalities in health outcomes for offenders will persist and continue to create extraneous demand on and costs for the health and social care system.

Action

5.1 The Health and Wellbeing Board is asked to:

- agree the priorities of the Integrated Offender Health and Social Care Group
- endorse the work of the Group and actively sponsor and support the delivery of its work programme
- (If applicable) select a lead agency for the development of a Norfolk PD Strategy.

Officer Contact

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

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Report to Health and Well Being Board
4 November 2015
Item 14

Services for Adults with a Learning Disability Transforming Care Programme

Cover Sheet

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

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

- Duty to prepare a Joint Strategic Needs Assessment (including a Pharmaceutical Needs Assessment) and a Joint Health and Wellbeing Strategy
- Duty to encourage integrated working between commissioners of health and social care services
- Duty to provide an opinion as to whether the CCG commissioning plan has taken proper account of the Health and Wellbeing Strategy and what contribution has been made to the achievement of it
- Duty to assess how well the CCG has discharged its duties to have regard to the JSNA and JHWS

Actions/Decisions needed

The Board needs to:

- Recognise that the challenge to discharge patients into the community have targets attached that CCGs are obliged to meet
- Recognise that community placements for patients with significant challenging behaviour are required to be developed in line with the escalated discharge plan
- Recognise that NHS England specialist commissioners are also required to meet the same targets to discharge their patients who are in Low and Medium secure hospitals which will create a pressure upon CCG targets and Local Authority's need to provide community placements
- Recognise the shifts of financial cost occurring due to the programme, from NHSE to CCG's and from CCG's to NCC and the need to address this.

Report to Norfolk Health and Wellbeing Board

Wednesday 4th November 2015

Item 14

Transforming Care Programme Report

Report by the Director of Adult Social Care

Summary

The Norfolk Transforming Care Programme Board, with membership from commissioning, provider representatives from across Norfolk`s health and social care economy, service users and local advocacy organisation representation, oversees the progress towards the target set by NHS England to discharge patients with Learning Disabilities, Autism and / or Behaviour that Challenges, into a less restrictive environment, community placements and closer to home.

There continues to be pressure from the national NHS England to discharge patients from inpatient hospitals and to that end during the summer a number of 'Fast Track' sites were identified within the country to demonstrate how this process could be managed in an alternative way. The outcome of this process was presented in October. The model of a future process of discharging patients is likely to be developed from these results and will have an impact upon the way that Norfolk manages its Transforming Care agenda.

There is significant concern from National NHS England that as many new patients are being admitted into inpatient facilities as are being discharged and consequently the drive for a more community based care for patients is being compromised

As a consequence, the new directive aims to manage the admission of patients into hospitals and reduce the figures by 10%. To ensure that this process is supported by Clinical Commissioning Groups (CCGs), a Care and Treatment Review (CTR) must take place before any admissions but significantly these placements will now not take place unless they are signed off by Chief Officers of CCGs. As part of this process to reduce numbers there is also a drive to increase the numbers of patients who are being discharged by 10%

This report outlines the processes and arrangements put in place to achieve the targets and outcomes required

Action

The Health and Wellbeing Board is asked to:

- Recognise that the challenge to discharge patients into the community have targets attached that CCGs are obliged to meet
- Recognise that community placements for patients with significant challenging behaviour are required to be developed in line with the escalated discharge plan
- Recognise that NHS England specialist commissioners are also required to meet the same targets to discharge their patients who are in Low and Medium secure hospitals which will create a pressure upon CCG targets and Local Authority's need to provide community placements
- Recognise the shifts of financial cost occurring due to the programme, from NHSE to CCG's and from CCG's to NCC and the need to address this.

1. Background

1.1 Norfolk County Council and Norfolk CCG's commission services provides for patients with Learning Disabilities (LD) and /or Autistic Spectrum Disorders (ASD) with mental health difficulties who present challenging behaviours and are unable to be catered for through secondary care mental health services. To support the care and treatment of these patients have used specialist NHS and independent provider hospital placements

1.2 The Norfolk approach of Transforming Care developed after the publication of the Winterbourne View Concordat in 2012, where it was recognised that there was a need to manage the discharge of patients into the community once their treatment in hospital had completed in a unified way across all NHS Clinical Commissioning Group (CCGs) and Norfolk County Council

1.3 Patients who require a period of time in an inpatient mental health facility often remain in hospital for a considerable length of time and although annual Care Programme Approach (CPA) meetings take place, affirming their need for continued treatment and care, NHS England nationally took the view that patients were remaining in hospital too long and therefore their discharged was delayed

1.4 Between 2012 and 2015 NHS England and the Local Government Association (LGA) set a number of targets that have challenged the process of discharge. There was an early drive for all patients to be discharged into community based care by June 2014. This target was not achieved due to the complexity of the specific needs of patients and the paucity of appropriate community placements within Norfolk that were able to manage complex behaviours.

1.5 To oversee the arrangements of achieving NHS England and LGA targets, a Winterbourne View Steering Group was established by Norfolk County Council, chaired by Head of Adult Social Care. Below this group the management of the transfer and discharge of patients was overseen by the Transforming Care Subgroup and locality learning disability case managers. At these meetings, a comprehensive list of patients was reviewed and projected dates for the discharge of each patient is discussed in depth and the reasons for patients remaining in their residency, justified.

1.6 As the Winterbourne View Programme followed an iterative process the steering group developed into The Norfolk Transforming Care Programme Board, with membership from commissioning and provider representatives across Norfolk`s health and social care economy, service user and main local advocacy organisation representation. This body continues to oversee the progress towards the targets set by NHS England to discharge patients.

1.7 Continuing processes have been further developed to manage the programme of stepping down into community placements this vulnerable and challenging group of people to enable them to live in the least restrictive environment.

2. Current position

2.1 The report outlines the process that currently is in place and has been developed over a number of years in response to the original drive to remove all patients from long term hospital placements by June 2014. This now requires review in light of the frequent directives from NHS England and the outcome of the Fast Track initiative.

2.2 To help address the structural management of the Transforming Care agenda, the need to streamline and link all agencies under one overseeing body that reports to CCGs and local authority, will allow for an integrated approach across Norfolk. A key challenge for the future will be how to manage patients with significant challenging behaviour who have autism or learning disabilities if the direction of travel from NHS England is to close mental health hospital provision in private specialist hospitals. This will be addressed only if a clear overarching structure is in place where all agencies will be able to manage the outcomes of such a proposal. The reports demonstrates a governance and reporting structure that aims to present a framework onto which any future NHS England targets and ambitions can be mapped

3. Key issues

3.1 The impact of NHS England specialist commissioning to transfer or discharge patients into hospital placements rather than community setting will have an impact on the CCGs targets to increase discharge by 10% and a 10% reduction in admissions targets.

3.2 The financial challenge to CCGs to fund patients who have stepped down from NHS England where the funding does not follow the patients, will have a significant cost pressure if admitted into local hospital facilities. Currently there are 21 patients across the 5 Norfolk CCGs who have targets dates to be discharged back to their local CCG areas by December 2017. This cohort of patients may be discharged into community settings, however, for some the least restrictive environment will continue to be a locked hospital placement. The financial cost to the CCGs if all the above patients were stepped down rather than discharged would exceed £3.1M.

3.3 The factor, however, that needs to be recognised is that a significant number of patients in Medium and Low secure hospitals, have been detained after a Ministry of Justice ruling and therefore although the current patients have discharge dates, there will most likely be other patients that will be detained in the future and consequently the process of discharge and stepdown into Norfolk will continue to be managed through transfer of funding or a pooled budget approach.

4. Conclusions

4.1 The Norfolk Transforming Care Programme is recognised by NHS England as demonstrating an effective approach the manage the cohort of inpatients who require care and support to move from hospital placements into community

settings and continues to support the direction and pace that is employed within our localities

5. Action

5.1 The Health and Wellbeing Board is asked to:

- Recognise that the challenge to discharge patients into the community have targets attached that CCGs are obliged to meet
- Recognise that community placements for patients with significant challenging behaviour are required to be developed in line with the escalated discharge plan
- Recognise that NHS England specialist commissioners are also required to meet the same targets to discharge their patients who are in Low and Medium secure hospitals which will create a pressure upon CCG targets and Local Authority's need to provide community placements
- Recognise the shifts of financial cost occurring due to the programme, from NHSE to CCG's and from CCG's to NCC and the need to address this.

Officer Contact

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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.

Transforming Care Structure and Reporting Management to meet the needs of people with a learning disability and / or autism who have mental health conditions or behaviours described as challenging

November 2015

Norfolk County Council in partnership with Norfolk Clinical Commissioning Groups

The following narrative demonstrates how a Norfolk wide approach to the care and discharge of inpatients are managed through a Transforming Care Structure and Reporting Management programme that encompasses the current guidance and expectation from NHS England.

Prior to the inception of the Transforming Care Programme, patients with learning disabilities in mental health hospital beds, were managed by an Individual Patient Placement (IPP) officers within the Primary Care Trusts (PCT). The responsibility for IPP was transferred to the Commissioning Support Unit (CSU) when the functionality of commissioning was transferred from PCT to Clinical Commissioning Groups (CCG). North Norfolk however manage this functionality within house

The Transforming Care programme was developed after the publication of the Winterbourne View Concordat in 2012, where it was recognised that there was a need to manage the discharge of patients into the community once their treatment in hospital had completed in a unified way among the CCGs. Review processes and care planning towards discharge was less robust, and in some rare cases non-existent.

Patients who required a period of time in an inpatient mental health facility often remain in hospital for a considerable length of time and although annual Care Programme Approach (CPA) meetings take place, affirming their need for continued treatment and care, NHS England nationally took the view that patients were remaining in hospital too long and therefore their discharged was delayed

Between 2012 and 2015 NHS England and the Local Government Association (LGA) set a number of targets that have challenged the process of discharge. There was an early drive for all patients to be discharged into community based care by June 2014. This target was not achieved due to the complexity of the specific needs of patients and the paucity of appropriate community placements, nationally recognised and mirrored within Norfolk, that were able to manage complex behaviours.

To oversee the arrangements of achieving NHS England and LGA targets, a Winterbourne View Steering Group was established by Norfolk County Council, chaired by Head of Adult Social Care, who held the primary responsibility to manage discharge, while the funding of hospital care was commissioned by CCGs. Below this group the management of the transfer and discharge of patients is overseen by the Transforming Care Subgroup and locality learning disability case managers. At these meetings, a comprehensive list of the Transforming Care cohort, is reviewed and projected dates for the discharge of each patient is discussed in depth and the reasons for patients remaining in their residency to receive treatment, justified.

As the Winterbourne View Programme followed an iterative process the Winterbourne View Steering Group developed into The Norfolk Transforming Care Programme Board, with membership from commissioning and provider representatives across Norfolk`s health and social care economy, service user and main local advocacy organisation representation. This body continues to oversee the progress towards the targets set by NHS England to discharge patients.

Care and Treatment Review Programme

In August 2015, NHS England Area Team, Transforming Care Assurance Board presented at an emergency meeting, new directives from National NHS England, on requirements that CCGs would be expected to achieve.

There is significant concern from National NHS England that as many new patients are being admitted into In-patient facilities as are being discharged and consequently the drive for a more community based care for patients is being compromised

As a consequence, the new directive aims to manage the admission of patients into hospitals and reduce the figures by 10%. To ensure that this process is supported by CCGs, a Care and Treatment Review (CTR) must take place before any admissions, however significantly, these placements will now not take place unless they are signed off by Chief Officers of CCGs. As part of this process to reduce numbers there is also a drive to increase the numbers of patients who are being discharged from hospital by 10%

The instrument to manage the admission and discharge of in-patients is the CTR. All CCGs are responsible for the instigation of a systemic approach that will encompass the elements below. However, to facilitate a cohesive and balanced approach, these processes are led by an officer in the Mental Health and Learning Disability team.

NHS England have outlined further approaches that are designed to enhance the CTR process

- A Ragged, Risk of Admission Register (RAR)

  The purpose of a RAR is to early identify any person with a learning disability and / or autism that is in a community or domicile setting that may be at future risk of requiring an in-patient stay in a mental health hospital. This will allow for bed planning and consideration of alternative community provision as an alternative to a stay in hospital

- Use RAR to ensure reviews, care planning, risk assessment in place

  As part of the RAR there is an assurance that the care planning process will identify the patients' needs within the community setting and the need to be maintained to ensure that a discharge is successful

- Agreement with all stakeholders to ensure sharing of information

  Data sharing is a key component of careful planning and without the full presentation of a patient's specific needs, a breakdown of a placement could result in a return to hospital. To that end all CTR documentation must be consistent across Norfolk and within Information Governance protocols

- Identify leads in all agencies (health, education and social care) when someone identified as at risk or request for admission made

  Currently the officer lead for the management of the Transforming Care Programme sits within the Mental Health and Learning Disability team. The officer reports on behalf of four Norfolk CCGs, however, each CCG has a nominated deputy to facilitate continuity in the officer's absence. Learning Disability leads from social care meet regularly at the Transforming Care Subgroup, where individual patient's pathways are discussed

- Provide Care Programme Approach (CPA) co-ordinator for all at risk of admission/admitted to inpatient services

  This element is already part of Learning Disabilities care coordinators role

- No planned admission without pre admission CTR

  There may be occasions when a person will require a period of time for treatment as a hospital inpatient and this will be monitored through the RAR process. As a protocol the CTR process will work alongside any 'blue light admission', as the likelihood for a CTR may be escalated by a rapid breakdown of a community placement. Any placement must be signed off by a CCG Chief Officer if the CTR recommends a period of hospital treatment

- A CTR to be convened on all 'blue light admission' within 10 working days

  A 'blue light admission' is sanctioned by Chief Officer on advice of the consultant Learning Disability clinician. Within 10 working days a CTR will be convened by the CCG to ratify the admission of the patient. As above if the CTR recommends a period of hospital treatment a CCG Chief Officer must sign off the extension of the placement

- Clear rationale, with clear expected outcome for discharge – for all admitted patients

  Transforming Care guidance states that all in-patients require a clear and actionable discharge plan. Allied to this CPAs must hold all relevant details of the plan to manage the patient towards discharge or transfer to a more restrictive environment within the time frame for appropriate treatment

- Mandatory CTR every 12 months

  A programme of CTRs will be managed centrally by the Transforming Care Lead officer with a timetable of dates for each in-patient

- CTRs can be requested by individual or patient representative, family or CCG where dissatisfaction with progress is raised

  A CTR request must be responded to within 10 working days, with a proposed date offered

- Develop a RAR by the end of September 2015

  A locality based risk assessment of people at risk of an inpatient admission takes place at regular Learning Disability Multi-Disciplinary Team (MDT) meetings. The current MDT structure was formalised under the RAG approach within expected timescales

Further work involves the risk stratification of the local population to enable implementation of appropriate anticipatory support.

Current position

All the above is largely in development and the current CTR process has been established since September 2014.

NHS England has produced a trajectory of discharge that all CCGs will be expected to achieve by March 2016. For example a CCG with currently 3 in-patients, the target will be 1 patient. Against this trajectory an action plan has been prepared that will enable a system wide approach and for clarity of process, as part of the

management of all Norfolk CCG Transforming Care patients, this will be monitored by the Transforming Care Lead within the Mental Health and Learning Disability Commissioning Team

The Mental Health & Learning Disabilities (MH&LD) Network and CCG Clinical Quality and Patient Safety meetings are informed of all Transforming Care developments highlighting specific updates and requirements. The process that is in place though slightly fragmented due to the size of Norfolk, has received a policy review with the aim to align current practice with national demands. Updates are presented monthly at the Mental Health & Learning Disabilities Network explaining that there continues to be pressure from NHS England to discharge patients from in-patient hospitals.

During the summer a number of 'Fast Track' sites were identified within the country to demonstrate how the discharge process could be managed in a faster way. The outcome of this process should be presented in October. The model of future process of discharging patients is likely to be developed from these results and will have an impact upon the way that Norfolk manages its Transforming Care agenda.

NHS England Anglia Area Team receive a regular weekly report on all Norfolk patients and identify their trajectory for discharge with a pathways in place. In addition the NHS England Anglia Area Team, Transforming Care Assurance Board meets monthly or via teleconference to receive locality updates. Nationally all patients are recorded by the Health and Social Care Information Centre (HSCIC) whose data feeds into the regional reports. All new patients and discharges / transfers have to be reported within 28 days. The data also is risk stratified against information in the Learning Disability census of patients in hospitals and requires annual rationalisation of locality Learning Disability hospital population.

CTRs and CPAs have full representation from CCGs and have sight of the programme that manages the Transforming Care agenda that will achieve the best we can for our patients to transform their care and address and achieve the requirements laid out by NHS England

Service Provision

There are a number of organisations that are involved in the care of Learning Disability patients in mental health hospital facilities in Norfolk. CCGs commission beds on a spot purchase basis from a number of NHS and independent providers. These providers are in the main locked hospitals for patients under section or as informal patients.

Management of patients

It is recognised that there is a fast moving agenda associated with Transforming Care and to place Norfolk in the position to react positively and timely to any future

NHS England recommendations, the governance structure below (Appendix a) can be built upon in partnership with the range of health and social care bodies to demonstrate an integrated approach to the management of Transforming Care patients.

A significant challenge to the management of Norfolk patients is the discharge of those who are currently receiving treatment in Medium Secure Units and Low Secure Units (MSU & LSU) and are the responsibility of NHS England specialist commissioning. Many of these patients, it is planned, will be discharged over the next two years into the Norfolk health and care environment and although their needs may be met in the community it is important to recognise that as part of the Transforming Care Concordat the stepping down of patients from MSU and LSU into the least restrictive environment, may result in a locked hospital placement. This outcome would put a significant strain on the CCG targets of decreasing the number of admissions by 10%.

To manage the Transforming Care agenda that addresses all the above challenges the structure, Appendix b, demonstrates a clear pathway of for all CCGs and Social Care when overseeing the care and discharge of patients into community settings.

The model is intended to allow all parties involved in the Transforming Care agenda to be clear of the pathway that should be followed across Norfolk. The components of this model exits but require agreement from the Norfolk system to enable it to identify, support, transition and coordinate the health and social care of those patients who have Learning Difficulties and / or Autism and Behaviour that Challenges within our communities

Conclusion

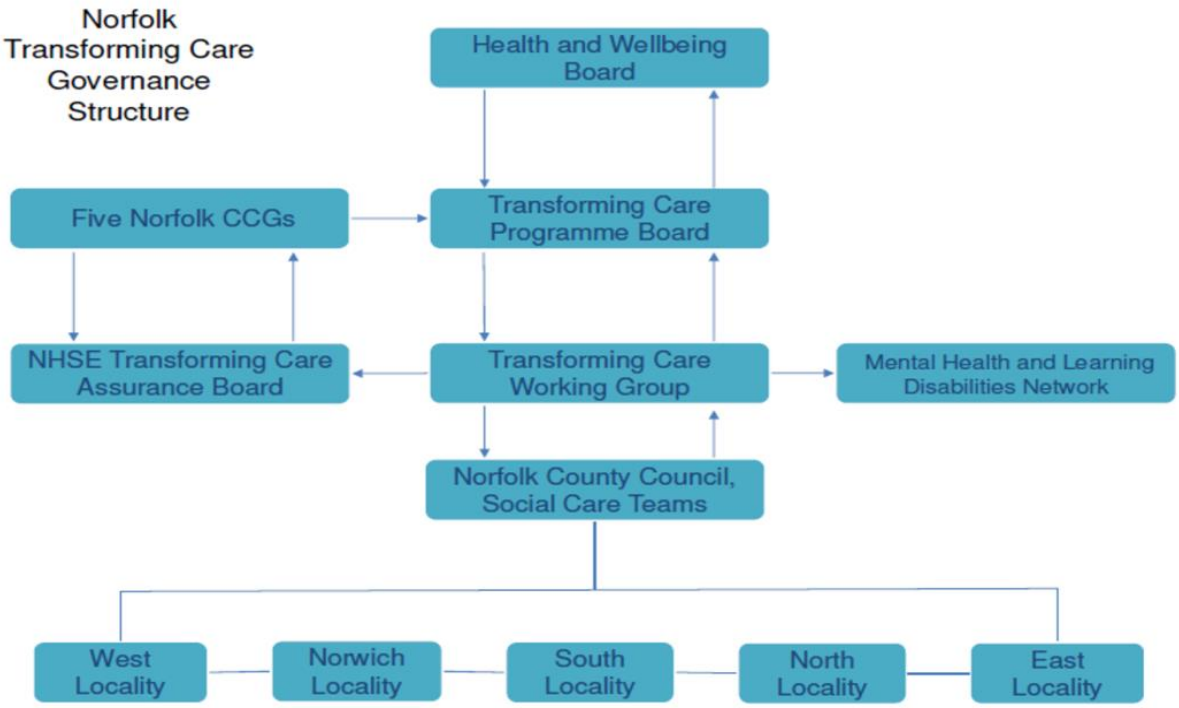
Norfolk has in place well advanced structures that will be able to react and address any future requirements that are placed upon the health and care system to manage the discharge of patients into the community and manage their needs to reduce the likelihood of readmission.

However, the challenge remains to recognise that while hospitals are not a home, a number of patients in inpatient facilities have needs that continue to be challenging within community settings and there is a need to develop innovative approaches that allows people with such presentations to live fulfilling lives.

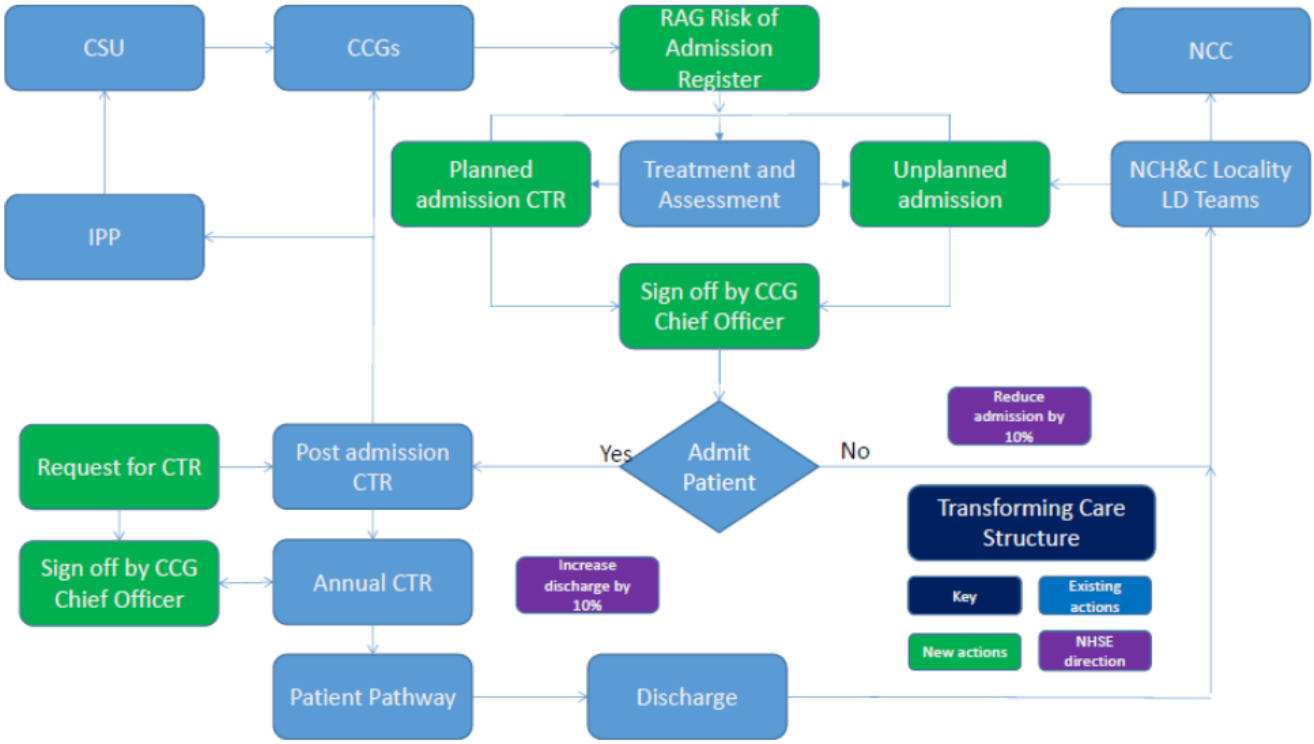
Financial challenges have resulted in funding issues that could result in delayed discharge and to best manage the high cost of the care both in and out of hospital care, a consideration for a pooled budget approach may be the cost effective way of managing this cohort of people

Appendices

Appendix a


Norfolk Transforming Care Governance Structure
Health and Wellbeing Board
Five Norfolk CCGs
Transforming Care Programme Board
NHSE Transforming Care Assurance Board
Transforming Care Working Group
Mental Health and Learning Disabilities Network
Norfolk County Council, Social Care Teams
West Locality
Norwich Locality
South Locality
North Locality
East Locality

Appendix b


CSU
CCGs
RAG Risk of Admission Register
NCC
Planned admission CTR
Treatment and Assessment
Unplanned admission
NCH&C Locality LD Teams
IPP
Sign off by CCG Chief Officer
Reduce admission by 10%
Request for CTR
Post admission CTR
Yes
Admit Patient
No
Transforming Care Structure
Sign off by CCG Chief Officer
Annual CTR
Increase discharge by 10%
Key
Existing actions
New actions
NHSE direction
Patient Pathway
Discharge

Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
On 16 July 2015

Present:

Mr C Aldred	Norfolk County Council
Mr R Bearman	Norfolk County Council
Ms S Bogelein	Norwich City Council
Mr M Carttiss (Chairman)	Norfolk County Council
Mrs J Chamberlin	Norfolk County Council
Mrs A Claussen-Reynolds	North Norfolk District Council
Mr D Harrison	Norfolk County Council
Dr N Legg	South Norfolk District Council
Mrs S Matthews	Breckland District Council
Mrs S Weymouth	Great Yarmouth Borough Council
Mrs S Young	Borough Council of King's Lynn and West Norfolk

Substitute Member Present:
Mrs J Virgo Norfolk County Council

Also Present:

Dr Sue Crossman	Chief Officer, West Norfolk Clinical Commissioning Group
Michael Scott	Chief Executive, Norfolk and Suffolk NHS Foundation Trust
Marcus Hayward	West Locality Manager, Norfolk and Suffolk NHS Foundation Trust
Andrea Patman	Head of Commissioning, NHS England Midlands and East (East)
Fiona Theadom	Contract Manager, NHS England Midlands and East (East)
Robert Kybird	Vice Chairman of the NHS Workforce Planning in Norfolk Task and Finish Group.
Chris Walton	Head of Democratic Services
Maureen Orr	Democratic Support and Scrutiny Team Manager
Anne Pickering	Committee Officer

1. Apologies for Absence

Apologies received from Mr B Bremner, Mrs M Wilkinson, Mrs L Hempsall, and Mrs M Somerville.

2. Minutes

The minutes of the previous meeting held on 28 May were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

3.1 There were no declarations of interest.

4. Urgent Business

4.1 There were no items of urgent business.

5. Chairman's Announcements

5.1 The Chairman made no announcements.

6. Development of dementia services in West Norfolk

6.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to a report from the NHS West Norfolk Clinical Commissioning Group which presented its engagement plans regarding permanent changes to dementia services following the end of a two year trial period.

6.2 The Committee received evidence from Dr Sue Crossman, Chief Officer, West Norfolk Clinical Commissioning Group and Marcus Hayward, West Locality Manager, Norfolk and Suffolk NHS Foundation Trust.

6.3 In the course of further discussion the following key points were made:-

- Following the establishment of the pilot scheme DIST, (Dementia Intensive Support Team) two work streams were identified. Firstly to focus on communicating with service users and families and secondly to work with professionals.

- At the start of the scheme the diagnosis rate for dementia in West Norfolk was 34% which was very low in comparison to the rest of the country. After 1 year, the diagnosis rate had increased to 55%. The rise in the number of diagnoses had meant there was an increase in the need for support which was putting further pressure on services.
  It was important to note that despite the increase in diagnosis the number of admissions for dementia had fallen and it was felt this was due to the multi-disciplinary agency approach with organisations working together which was providing service users with greater options.

- In response to a question raised by the Committee, it was explained that there was a protocol in place for carers to claim for travel costs, which could be received in cash or via bank transfer.
  Care Co-ordinators were required to inform the carer at first admission about the protocol and then one week later ward staff were required to check that the carer was aware of the protocol and provide necessary forms.

- More robust data collection and transparency was needed within the system to ensure that the claims made specifically by carers could be identified separately to other claims.

- Support for carers was essential; information needed to be provided to the families and carers to make them aware of what support is available in the community. Support also needed to be provided to the voluntary sector organisations that gave a lot of this support.

- Dementia friendly towns in the West of Norfolk were Swaffham and soon to be Downham Market.

- Young people needed to be educated around the issues surrounding dementia, to make them aware and help with understanding. Opportunities should be looked into for the Trust to go into schools to provide this information.

- When there was a delay in finding beds for people, they would be put into a holding situation which would involve the individual being returned to their home with a professional to monitor and keep them safe until a bed could be found.

- The DIST service was available 7 days a week and included the use of non-medical prescribers; it was recognised that this role was highly necessary while GPs were not available, especially at weekends.

- Younger people with dementia were a challenging group to help as most were of working age and often even younger carers were involved and most of the issues were concerning social aspects rather than medical.

- The beds at the Julian Hospital were for specialised care of complex cases that required high level expertise, which could not be provided in all areas. The admission of a patient with dementia was a last resort as it was deemed better for them to remain in their own homes but have the option of beds when required. Homes such as the Paddocks provided community support and offered respite for carers.

6.4 NHOSC **agreed** the following comments:-

- Norfolk and Suffolk NHS Foundation Trust (NSFT) should ensure transparent accounting to allow the payment of west Norfolk carers' claims for travelling expenses to the Julian Hospital to be identified.
- NSFT should engage with schools to ensure that children are informed and educated around the issues surrounding dementia.

NHOSC **agreed** that in relation to changes in dementia services in west Norfolk:-

- Consultation with the committee has been adequate
- The changes to the dementia services in west Norfolk are in the interest of the local health service.

7. Access to Primary Care Services in Norwich

7.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to a report from NHS England Midlands & East (East) regarding plans to maintain and improve access to primary care services in Norwich and surrounding areas.

7.2 The Committee received evidence from Andrea Patman, Head of Commissioning, NHS England Midlands and East (East) and from Fiona Theadom, Contract Manager, NHS England Midlands and East (East).

7.3 The commissioners from NHS England Midlands & East (East) had been looking at Norwich Practices Ltd's GP registered list service and the Norwich walk-in service.

The commissioning responsibility for maternity and phlebotomy services, was to be passed to the CCG after the end of the current contract in 2016. The GP registered list service and the walk-in service was to be re-procured by NHS England Midlands and East (East) after an engagement process with patients, the public and key stakeholders.

7.4 The Chairman invited Mr S Bloomfield Norwich Practices Ltd's business manager to join the speakers at the table.

In the course of further discussion the following key points were made:-

- It was claimed that the Norwich Walk-In Centre offered a lower cost option than the GP out of hour's service; the Committee asked that Mr S Bloomfield would provide any evidence that may be available to support this.

- In response to a question regarding the use of the walk in centre by out of area patients the Committee were informed that a large number were holiday makers especially during the summer months.

- GP recruitment to the Walk-In Centre was an issue, however they had seen an increase in applications since the recent advertisement.

- Members suggested that the title of the forthcoming patient survey in relation to a new contract for services at Norwich Practice's Health Centre should explicitly refer to the 'walk-in centre' as this was the name most people would recognise.

- Parking bays outside the front of the Walk-In Centre had been allocated as Blue Badge spaces and it was felt that this provision was sufficient. In addition there was ongoing discussion with the Castle Mall over the possibility of allowing 1 hour free parking at the Castle Mall carpark for those visiting the walk in centre.

- The rationale behind the Walk-In Centre was the need for improved access to primary care which was multifaceted.
  Some people used the Accident and Emergency department at the Norfolk and Norwich University Hospital as their first primary care point, especially at weekends.
  It was important for patients to be provided with the correct guidance and information to allow them to access the most appropriate service.

7.5 The Committee agreed to endorse the approach that NHS England Midlands & East (East) was taking in regards to the walk-in centre and Norwich Practices Ltd's GP registered list service in Norwich.

8. NHS workforce planning in Norfolk

8.1 The Committee received the report from the scrutiny task & finish group on NHS Workforce Planning in Norfolk for approval and endorsement of the recommendations.

8.2 The Committee gave thanks to the Vice-Chairman, Robert Kybird and the rest of the working group for their hard work and to Maureen Orr for support given in producing the report.

8.3 The Committee commented on the recruitment of GP's; it was noted that the University of East Anglia medical school had a higher percentage of GP trainees than the national average.

8.4 The Chairman invited Cllr A Kemp and Mr A Stewart to join the speakers at the table.

- Cllr Kemp gave an update to the third recommendation in the report regarding making arrangements for UEA nursing students to be offered placements in West Norfolk; a meeting had been organised to facilitate this.
- Mr A Stewart gave an update on the number of GP students enrolled to start at UEA in Sept, currently there were 300.

8.5 The Committee discussed the need for planning authorities and NHS organisations to liaise more effectively to ensure that the building of additional homes and care homes could be supported by the current GP surgery in the area. It was discussed that 1 GP was meant to cater for 1800 people, however if a care home was in the area, the residents could occupy 1 GP's entire caseload.
The Committee **agreed** that as part of the first recommendation that a planning protocol be added to ensure that the LPAs consult effectively with the NHS.

8.6 The Committee **RESOLVED** to approve the task and finish group's report and endorse the recommendations with the following amendment:-

Recommendation 1
That Public Health, Norfolk County Council, takes the lead to co-ordinate liaison between local planning authorities (LPAs) and the local NHS to

i) create a county wide protocol to ensure that the LPAs consult effectively with the NHS
ii) ensure that the NHS has the necessary information to be able to respond, based on evidence of growing needs modelled on the LPA geographic area

8.7 The Committee **Agreed** to direct the recommendations to the appropriate organisations /individuals outlined in the report with the addition of:-

- Send the report to the District Planning Authorities for comment.
- Send to Lord Prior, Parliamentary Under Secretary of State, Department of Health in the first instance with an additional letter from the Chairman congratulating him on his appointment
- That the Norfolk MPs are contacted once feedback had been received at the October Norfolk Health and Overview Scrutiny Committee meeting.

9. Norfolk Health Overview and Scrutiny Committee appointments

9.1 The Committee received the report from Democratic Support and Scrutiny Team Manager which asked the Committee to appoint members to act as link members with local NHS provider trusts and Clinical Commissioning Groups.

9.2 The following appointments were made:-
Link member appointments:

Mrs J Chamberlin	Norfolk Community Health and Care NHS Trust
Mr M Chenery of Horsbrugh	Queen Elizabeth Hospital NHS Foundation Trust

Mrs M Somerville	NHS Great Yarmouth and Waveney CCG

Substitute link member appointments:

Mr D Harrison	NHS North Norfolk CCG
Vacancy	NHS South Norfolk CCG
Vacancy	NHS Great Yarmouth and Waveney CCG
Mrs S Young	NHS West Norfolk CCG
Mrs S Bogelein	Norfolk and Suffolk NHS Foundation Trust
Mrs S Young	Queen Elizabeth Hospital NHS Foundation Trust

10. Forward work programme

10.1 The proposed forward work programme was agreed subject to additional topics suggested by Committee members.

1) Locum/agency doctors – vetting process.
2) Provision of mental health services for children.

Chairman

The meeting concluded at

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