Health & Wellbeing Board

Date: **Wednesday 10 July 2013**

Time: **10am**

Venue: **Anna Sewell Room, County Hall Annexe, Norwich**

Membership	Substitute	Representing
Cllr Brenda Arthur		Norwich City Council
Cllr Yvonne Bendle		South Norfolk Council
Stephen Bett	Jenny McKibben	Norfolk's Police and Crime Commissioner
Harold Bodmer		Director Community Services
Dr Jon Bryson	Ann Donkin	South Norfolk Clinical Commissioning Group
Lisa Christensen		Director Children's Services
Pip Coker	Dan Mobbs	Voluntary Sector Representative
T/ACC Nick Dean		Norfolk Constabulary
Dr Anoop Dhesi	Mark Taylor	North Norfolk Clinical Commissioning Group
Tracey Dowling		Director of Operations & Delivery, NHS England East, Anglia Team
Richard Draper	Dan Mobbs	Voluntary Sector Representative
Andy Evans	Kate Gill	Great Yarmouth & Waveney Clinical Commissioning Group
Cllr Angie Fitch-Tillet		North Norfolk District Council
Anne Gibson		Acting Managing Director, Norfolk County Council
Joyce Hopwood	Dan Mobbs	Voluntary Sector Representative
Cllr James Joyce		Cabinet Member, Safeguarding Children, Norfolk County Council
Dr Ian Mack	Sue Crossman	West Norfolk Clinical Commissioning Group
Lucy Macleod		Interim Director of Public Health
Cllr Elizabeth Nockolds		King's Lynn and West Norfolk Borough Council
Cllr William Nunn		Breckland District Council
Dr Chris Price	Jonathon Fagge	Norwich Clinical Commissioning Group
Cllr Andrew Proctor		Broadland District Council
Cllr Daniel Roper		Cabinet Member, Public Protection, Public Health, Trading Standards, Fire & Rescue, Norfolk County Council
Alex Stewart		Chief Executive, Healthwatch Norfolk
Cllr Sue Whitaker		Cabinet Member, Adult Social Services, Norfolk County Council
Cllr Bernard Williamson		Great Yarmouth Borough Council

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

For further details and general enquiries about this Agenda please contact the Committee Administrator:
Julie Mortimer on 01603 223055
or email committees@norfolk.gov.uk

1	**Election of Chair**	Committee Officer	
2	**To welcome new members, receive apologies and details of any substitute members attending**	Chair	
3	**Minutes** To confirm the minutes of the meeting held on 17 April 2013.	Chair	(Page **5**)
4	**Members to Declare any Interests** If you have a Disclosable Pecuniary Interest in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter. If you have a Disclosable Pecuniary Interest in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter. In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with. If you do not have a Disclosable Pecuniary Interest you may nevertheless have an Other Interest in a matter to be discussed if it affects: - your well-being or financial position - that of your family or close friends - that of a club or society in which you have a management role - that of another public body of which you are a member to a greater extent than others (in your ward). If that is the case then you must declare such an interest but can speak and vote on the matter.	Chair	
5	**To receive any items of business which the Chairman decides should be considered as a matter of urgency**	Chair	
	Items for Business		
6	**Director of Public Health – Annual Report** Presentation by the Interim Director of Public Health	Lucy Macleod	
7	**Welfare Reform - understanding and mitigating the impacts in Norfolk on health and wellbeing** Report of the Workshop held 13 June 2013	Dan Mobbs	(Page **13**)
8	**A Review of Norfolk Joint Strategic Needs Assessment – outline approach** Report by the Interim Director of Public Health	Lucy Macleod	(Page **20**)

9	**Norfolk Joint Health and Wellbeing Strategy 2014-17– outline approach** Report by the Head of Planning, Performance & Partnerships, NCC and the Interim Director of Public Health	Debbie Bartlett / Lucy Macleod	(Page **29**)
10	**Integration of health and social care service in Norfolk: an update** Report by the Director of Community Services	Harold Bodmer	(Page **43**)
11	**Accountability framework – outline of performance and quality measures** Report by the Head of Planning, Performance & Partnerships, NCC	Debbie Bartlett	(Page **85**)
12	**In-year monitoring of Health and Wellbeing priorities** Report by the CCGs and Head of Planning, Performance & Partnerships, NCC	Debbie Bartlett & all CCGs	(Page **94**)
13	**Services for Adults with a Learning Disability: Outcomes of the Winterbourne View Enquiry** Report by the Director of Community Services, Norfolk County Council	Harold Bodmer	(Page **138**)
	Standing Items		
14	**Healthwatch Norfolk** • Minutes of the meetings held on 5 March 2013	Alex Stewart	(Page **147**)
15	**NHS England** • Verbal update including feedback from the Local Quality Surveillance Group (QSG)	Tracey Dowling, NHS England	
16	**Norfolk Health & Overview Scrutiny Committee** • Minutes of the meetings held on 11 April 2013	Chair	(Page **158**)
	Items for Information		
17	**Pharmaceutical Needs Assessment –Interim Report** Report by the Interim Director of Public Health	Lucy Macleod	(Page **163**)
	Close		

Future Board meetings dates - all are on Wednesdays and start at 10:00.
Future venues to be confirmed

- 23 October 2013 – The Green Room, Norfolk Archive Centre, Norwich
- 8 January 2014
- 16 April 2014
- 16 July 2014
- 22 October 2014

Norfolk County Council
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Health and Wellbeing Board
Minutes of the meeting held on Wednesday 17 April 2013 at County Hall

Present:

Cllr Yvonne Bendle	South Norfolk Council
Stephen Bett	Norfolk's Police and Crime Commissioner (from 11:15)
Harold Bodmer	Director Community Services
Cllr Bill Borrett	Leader, Norfolk County Council
Dr Jon Bryson	South Norfolk Clinical Commissioning Group
Lisa Christensen	Director Children's Services
Pip Coker	Voluntary Sector Representative
Dr Anoop Dhesi	North Norfolk Clinical Commissioning Group
Ann Donkin	South Norfolk Clinical Commissioning Group
Tracy Dowling	Director of Operations & Delivery, NHS England, East Anglia Team
Richard Draper	Voluntary Sector Representative
Andy Evans	Great Yarmouth & Waveney Clinical Commissioning Group
Cllr Angie Fitch-Tillet	North Norfolk District Council
Cllr Roger Foulger	Broadland District Council
Cllr Shelagh Gurney	Cabinet Member, Community Services, Norfolk County Council
Joyce Hopwood	Voluntary Sector Representative
Lucy Macleod	Interim Director of Public Health
Dr Ian Mack	West Norfolk Clinical Commissioning Group
Dr Chris Price	Norwich Clinical Commissioning Group
Rhianna Rudland	Breckland District Council
Alex Stewart	Chief Executive, Healthwatch Norfolk
Cllr Mike Stonard	Norwich City Council
Cllr Alison Thomas	Cabinet Member, Children's Services, Norfolk County Council
ACC Gareth Wilson	Norfolk Constabulary

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

1 Election of Chairman

Bill Borrett, Norfolk County Council was elected Chair of the Health and Wellbeing Board.

Cllr Bill Borrett, Norfolk County Council in the Chair.

The Chairman welcomed everyone to the first meeting of the Health and Wellbeing Board and round the table introductions were made.

2 Apologies

Apologies were received from Anne Gibson, Norfolk County Council, Cllr Elizabeth Nockolds, King's Lynn & West Norfolk Borough Council, Cllr William Nunn, Breckland District Council (Rhianna Rudland substituted), Cllr Andrew Proctor, Broadland District Council (Cllr Roger Foulger substituted) and Cllr Bernard Williamson, Great Yarmouth Borough Council.

3 Minutes of the Shadow Health and Wellbeing Board meeting held on 9 January 2013.

The minutes of the Shadow Health and Wellbeing Board (H&WB) meeting held on 9 January 2013 were agreed as a correct record and signed by the Chairman.

4 To receive any items of business which the chairman decides should be considered as a matter of urgency.

There were no items of urgent business.

5 Forward Plan and Work programme 2013/14.

5.1 The Board received a report (5) by the Head of Planning, Performance and Partnerships NCC, providing an outline forward plan for consideration by the Board. The Board was asked to agree the draft forward plan, taking into account the notes set out in section 3 of the report and agree the establishment of working groups, as outlined in the draft forward plan.

5.2 The Head of Planning, Performance and Partnerships explained that the list of items on the draft forward plan was not exhaustive and also highlighted that task and finish groups could be set up to look at various topics if there were particular issues the Board wished to consider in greater detail.

5.3 The following points were noted during the discussion:

- It was suggested that, following the recent Ofsted inspections, the Board should include safeguarding issues early in its schedule in order for all partners to drive improvements forward.

- The Board agreed that driving the integration of health and social care was of key importance and referred, for example, to the difficulties recently experienced by some of the acute hospitals in the region and the importance of working together to find solutions.

- A request was made that voluntary sector representatives on the Board be involved in the working-groups outlined in the forward plan (Appendix A). It was confirmed that any member of the Board wishing to take part in a working group should contact Debbie.bartlett@norfolk.gov.uk.

- It was noted that at their meeting in January 2014, the Board would consider the Clinical Commissioning Groups' developing priorities for future years, rather than looking at the issues retrospectively.

5.4 The Board **agreed:**

- The draft forward plan, taking into account the notes set out in section 3 of the report, and
- The establishment of working groups, as outlined in the draft forward plan.

6 Norfolk Joint Health and Wellbeing Strategy – Responding to the Priorities.

6.1 The Board received the annexed report (6) by the Head of Planning, Performance and Partnerships summarising the progress made in exploring the issues behind the priorities in the Health and Wellbeing Strategy.

6.2 The report provided details on two of the 11 priorities that formed the basis of the Joint Health and Wellbeing Strategy 2013-14 - Smoking and Tobacco Control and Alcohol Misuse.

6.3 It was noted that a one-off task and finish group on the wider determinants of good mental health and wellbeing had not yet been convened but this would be taken forward as part of the forward plan.

6.4 In response to a question about whether any Member of the Board had any financial interest in either tobacco products or companies, the Chairman confirmed that the Norfolk County Council Pension Fund had invested in tobacco stocks. He added that the Norfolk Pension Fund provided benefits for the members of the scheme and the remit of the Pension Fund Committee was to act independently in the best interests of the beneficiaries regardless of political concerns.

6.5 The Director of Children's Services NCC, said that following the recent Ofsted inspection reporting, it could be considered that children were not visible enough in the 11 priorities of the Joint Health and Wellbeing Strategy 2013-14. It was noted that members would be looking at Early Help (Early Intervention) in a workshop after the meeting and, building on this, a report would be brought back to the Board.

6.6 The Board:

- Noted the progress that had been made to date on the 11 priorities.
- Commented on the priorities for alcohol and smoking and the possible actions that had been identified.
- Agreed the proposal for the development of a three year strategy to run from April 2014.

7 Community-led Health Improvement Programme – Update Report 2012-13.

7.1 The Board received the annexed report (7) by the Interim Director of Public Health summarising the progress made in setting up a community-led health improvement work programme based on two place-based approaches to health improvement – Healthy Towns and Ageing Well. The report outlined the two approaches, the key activities to date, governance arrangements and the proposed actions.

7.2 The Interim Director of Public Health commented that the report included an update on the Healthy Towns project which had proved very successful in Thetford and was now poised to be rolled out to the suggested10 communities identified from the health evidence base.

7.3 The following points were noted during the discussion:

- It was acknowledged that, due to the considerable 'churn' in the system with the re-organisation of the NHS and with Public Health having seen many changes in personnel, progress had not been as speedy as had been hoped and the budget,

whilst fully committed, had not yet been deployed. Progress had been made, however, and the Public Health team had carried out a desk-based exercise on the evidence to determine the areas for implementation and phases for the roll–out.

- There was some discussion about the evidence base used to support the identification of the 10 communities for roll-out of the community-led health improvement programme. It was noted that the public health indicators which had been used to identify the communities had been allocated an equal weighting, although this could be changed in the future to reflect different health outcomes.

- A question arose about the fact that urban areas, such as Norwich, had not been identified although there were likely to be benefits. It was clarified that the Healthy Towns methodology was designed for market towns and that the Public Health Team were also working with urban areas including Norwich, for example, on the healthy housing agenda.

- There was support for the proposal to use a locality-based approach to taking the work forward - working with local forums, partnerships and organisations and in synergy with existing arrangements.

- In response to a question about the measles outbreak in Swansea, and issues around public awareness, the Interim Director of Public Health confirmed that the measles outbreak was a high priority and outlined the measures being undertaken to increase public awareness of the disease and promote take up of the vaccination by young people, if they have not already been vaccinated. The Interim Director of Public Health also confirmed that the uptake for vaccinations for babies was just over 90% in Norfolk.

The Board **agreed:**

- The overall approach and the 10 communities identified from the health evidence base.
- To work with appropriate local partnerships to identify how and when to take forward either healthy town or ageing well initiative in that area.
- To replace the steering group with a Locality Implementation Group, to coordinate the roll-out of the programme.

8 Voluntary Sector Engagement Project – Update Report, March 2012-March 2013.

8.1 The annexed report (8) by the Head of Operations, Voluntary Norfolk was received by the Board. The report outlined the work of the Voluntary Sector Engagement Project in securing the active engagement of the voluntary sector in the emerging health and social care landscape and the work of the Health and Wellbeing Board.

8.2 The Head of Operations, Voluntary Norfolk introduced the report, outlining the background to the work as well as some forthcoming activities.

8.3 The following points were noted during the discussion:

- It was noted that the relationship between the new Healthwatch Norfolk organisation and the Voluntary Sector Engagement Project needed to be

established.

- It was suggested that it would be useful for those Board members who were directly impacted on by the Project (eg Clinical Commissioning Groups) to take part in the proposed steering group, which would provide the overall steer and formally monitor the project on behalf of the Board.

- The Director of Community Services suggested that the steering group might look to have some involvement from the private sector social care providers who could make a useful contribution.

- Any Board Member who wished to volunteer to join the Steering Group should contact the Head of Planning, Performance & Partnerships by emailing: Debbie.bartlett@norfolk.gov.uk.

8.4 The Board:

- Noted the contribution being made by the Voluntary Sector Engagement Project

- Agreed to set up a small Steering Group to provide the strategic lead and oversee the project for the coming year, and appoint Debbie Bartlett, Head of Planning, Performance and Partnerships, as the Lead Officer for that sub-group.

9 Health and Wellbeing Board – Budget Report

9.1 The annexed report (9) by the Head of Planning, Performance and Partnerships was received by the Board. The report set out the Health and Wellbeing Board's funding arrangements, outlined expenditure to date and proposals for 2013-14.

9.2 In introducing the report the Head of Planning, Performance and Partnerships said that the proposal for allocation of funds for 2013-14 broadly followed last year's arrangements.

9.3 The following points were noted during the discussion:

- It was noted that last year's funding for community-led health improvement had been committed and that it was proposed to earmark a further sum of £290,000 for locally-led health improvement activity for the coming year. It would be held whilst further discussions would take place with local partners about its precise use – for example, it may be that there is capacity for an accelerated roll out of the Healthy Towns and Ageing Well projects, or there might be other locally based health improvement initiatives from CCGs against which this funding could be used as match funding.

- In response to a question about the funding of promotional campaigns about the MMR vaccine the Director of Children's Services confirmed that resources were available to fund a vaccination programme and the issue would be dealt with as a matter of urgency, in liaison with Public Health colleagues. The Interim Director of Public Health said that her team would be working with the clinicians to examine the evidence about where there were measles outbreaks and what work needed to be done urgently. The Director of Operations & Delivery, NHS England, East Anglia confirmed that she would be liaising with PH and CCGs colleagues as a matter of

urgency to identify where the gaps were and what else needed to be done.

9.4 The Board endorsed the proposals as set out in section 3 of the report.

10 The Francis Inquiry and the new Quality Assurance System (Discussion Paper).

10.1 The Discussion Paper (10) by the Head of Planning, Performance and Partnership, NCC was received by the Board. The paper outlined the new quality assurance arrangements in the new system and invited discussions on aspects, including the potential role of the Board in quality assurance.

10.2 The following points were noted during the discussion:

- The Head of Planning, Performance and Partnerships opened the discussion by posing that the role of the Health and Wellbeing Board was to assure itself that the right arrangements were in place for quality assurance, particularly given the changes in organisations in the light of the NHS reforms.

- There followed some discussion about the need to be able to capture 'soft' intelligence rather than relying simply relying on information from 'compliments and complaints' systems and it was noted that, for example, Norwich CCG was setting-up systems to capture real-time 'soft' intelligence from GPs.

- The issue was not simply one for the NHS, but for public services too, particularly around health and social care and there was discussion about the value of developing some common principles for how we go about this - the gathering of 'soft' intelligence, performance data, etc.

- There was further discussion about what the role the Board could, and should, be and the challenge for the Board working at the strategic level to find the right balance between being assured and informed without getting involved in the detail. A strong view emerged that, in finding its role, the Board needed to avoid duplicating effort by creating something when there were other appropriate forums for the activity. The Board needed to be clear that its activity would add value – this might be, for example, through shared learning.

- It was noted that the new quality system included the establishment of a network of Quality Surveillance Groups (QSGs) across the country to routinely and methodically share information and intelligence about quality in order to spot the early signs of problems and that the local QSG East Anglia was established and meeting regularly. The Board felt that regular reports would be a good way of keeping a watching brief.

10.3 The Board **agreed:**

- That there would be a standing item on the agenda for an update from the local QSG
- That the Head of Planning, Performance and Partnerships, NCC, and the Director of Operations and Delivery, NHS England, East Anglia, would agree the best way forward for receiving appropriate updates

11 Services for Adults with a Learning Disability: Outcomes of the Winterbourne View Enquiry.

11.1 The Board received a report (11) by the Director of Community Services, Norfolk County Council, updating members on the progress made in responding to the recommendations from the Winterbourne View Enquiry Report. The report provided details of the action plan that had been developed and explained the progress that had been made in delivering on the actions that related specifically to Norfolk.

11.2 The Director for Community Services drew the Board's attention to the financial issues for providing health and social care by the high number of private hospitals in Norfolk. He added that in the event patients out of provision but remained in the County the Health and Social Care economy would pick up the care costs which could be substantial due to the individual needs of patients. The risks from this would be difficult to quantify as the costs would remain unknown until an event took place.

11.3 Norfolk County Council funded the care needs for the 92 people who were placed out of county in social care funded residential and supported living placements.

11.4 A further report would be brought to the Health and Wellbeing Board once patient reviews had been completed.

11.5 The Board noted the report.

12 Funding Transfers from the NHS for Adult Social Care

12.1 The Board received a report (12) by the Director of Community Services, Norfolk County Council, on the transfer of funding from the NHS to the County Council for social services. The paper confirmed that the amount to be transferred from NHS England to Norfolk County Council for 2013-14 was £14.956m and indicated how the funds would be used to address key shared priorities aligned to the NHS Outcomes Framework and to the respective local authority strategic plans: to strengthen care at home, to prevent unnecessary admissions, to promote discharge and to enable integrated care.

12.2 The Board was asked to agree to the plan for spend of the funding transfer from NHS England to Norfolk County Council; note the requirement for CCGs to agree with the local authority the development and funding of a reablement service and the contribution to be transferred to Norfolk County Council and to note and agree the overarching activity indicators as listed in the appendices to the report.

12.3 In introducing the report the Director of Community Services commented on two areas:

- The fact that there was a lot of work currently being undertaken around the pressure on acute hospitals and the hospital discharge process and flagged the potential need to reflect the challenge in the performance indicators, and
- The need to look to support and promote the integration of health and social care

12.4 There was support for the inclusion of something specifically around the discharge process for community hospitals, to make sure this continued to be provided and budgeted for.

12.5 There was also support for the view that we should also make sure that we are working to help drive integration and it was suggested that there might be opportunities to consider community budgets in certain areas, when looking beyond adult social care and the NHS to the broader integration of health, social care, wellbeing and the wider determinants of health.

12.6 The Director of Operations and Delivery, NHS England, East Anglia Team confirmed that she supported the funding proposals in principle but required more details on the expected return on the investment and on how it would be measured – both the 'hard' and the 'soft' data . Such assurance would be needed before final sign-off by the East Anglia Team of NHS England.

12.7 The Board:

- Agreed the plan for spend of the funding to transfer from NHS England to Norfolk County Council, subject to the comments raised
- Noted the requirement for CCGs to agree with the local authority the development and funding of a reablement service and the contribution to be transferred to Norfolk County Council
- Noted and agreed the overarching activity indicators as listed in the appendices of the report, subject to the comments raised

13 For information

The Chairman reminded members that now the Board had become a formal committee of Norfolk County Council, the NCC Rules for Committee meetings would apply. He also asked members to note that the NCC Code of Conduct now applied to everyone on the Board for the purpose of their engagement in the Health and Wellbeing Board only, and that Declarations of Interest would be required at all future meetings, details of which would be included on the next agenda.

The next meeting would take place on **Wednesday 10 July 2013** at 10am in the Edwards Room, County Hall.

The meeting closed at 11.30am.

Chairman

Report to Norfolk Health and Wellbeing Board
10 July 2013
Item 7

Welfare Reform – understanding and mitigating the impacts in Norfolk on health and wellbeing

Cover Sheet

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

- In January, the shadow Board learnt that some early work had been undertaken by the Norfolk Community Advice Network on the reforms to the welfare system and the potential impact that the proposed changes could bring, including the potential impact on health and wellbeing. The Board commissioned the Network to convene a further discussion, identify actions and report back.

- A workshop was convened by the voluntary sector representatives on the H&WB, with support from NCC officers, and it took place on 13 June 2013. Attendees included representation from the county and district/city councils, a Clinical Commissioning Group, the Department for Work & Pensions, Norfolk Constabulary, the Probation Service, the Office of the Police & Crime Commissioner and the voluntary sector.

- This paper is a report from that workshop.

Key questions for discussion

1. Is there a role here for the Health & Wellbeing Board – ie in terms of adding- value?
2. If so, what is the nature of the role and what should its focus be?
3. What could members of the Board do at this stage - either individually or collectively – that would make a difference?

Actions/Decisions needed

The Board needs to:

- Consider the key issues raised in the report about the impacts on health and wellbeing in Norfolk and decide on the possible actions members of the Board – individually and collectively- might take

Report to Norfolk Health and Wellbeing Board
10 July 2013
Item 7

Welfare Reform – understanding and mitigating the impacts in Norfolk on health and wellbeing

Report from Workshop held 13 June 2013

Summary
A workshop was convened on 13 June 2013, by the voluntary sector representatives on the H&WB, with support from NCC officers, to raise awareness of the impact (both intended, and unintended) of the reforms to the welfare system and identify courses of action. The purpose was to share concerns and consider mutual and effective responses, especially in identifying the needs of those most at risk. The people at the workshop concluded:

- Welfare reform is causing greater inequality because it is disproportionately cutting income from the poorest households.
- Evidence shows inequality is the biggest determinant of health and wellbeing problems.
- Targeting inequality will lead to the biggest increases in health and wellbeing for all and present the best value for money.
- To tackle these issues effectively there needs to be integrated commissioning at all levels.
- The H&WB needs to provide strategic leadership to enable this to happen.

This report summarises the key issues from the presentations, the shared concerns and common themes and suggests possible courses of action.

Action
The Board is asked to:
- Adopt the report and focus on tackling inequality as the most effective means of improving health and wellbeing.
- Provide strategic leadership to all partners involved in the HWB to pursue integrated commissioning, resource sharing and aligning and multi-agency delivery at local levels.
- Communicate its intentions and reasoning to stakeholders (including to local communities).
- Allocate resources from within funding held by the HWB to establish a small unit of staff to co-ordinate, develop and take forward proposals in this report, and to provide expertise to build a 'dashboard' from existing data to monitor, analyse and communicate the key impacts of inequality (including those resulting from cuts to welfare).
- Include this item in the Forward Work Plan for the Health & Wellbeing Board.

1. Background

1.1 The repercussions of welfare reform were discussed at the Health & Wellbeing Board in January. To raise awareness of impact (both intended, and unintended) and identify courses of action, partners from the voluntary sector and Norfolk County Council worked together to run a Workshop. The purpose was to share concerns and consider mutual and effective responses, especially in identifying the needs of those most at risk.

1.2 Attendees included HWB leads from the county and local councils, senior district council housing managers, senior officers from Adult Social Care, Children's Services and Norfolk Public Health. There were also senior leads from a CCG, the Department for

Work & Pensions, Norfolk Constabulary and the Probation Service. The Deputy Police & Crime Commissioner attended, as did the voluntary sector representatives to the HWB. The Workshop was chaired by Harold Bodmer. Presentations were given by Adam Clark, Norfolk Community Advice Network; Lucy Macleod, Interim Director Norfolk Public Heath; Boyd Taylor, Norwich City Council Financial Inclusion Project and Nick Dean, Acting Chief Constable, Norfolk Constabulary.

2. Local impact & impact headlines

2.1 Key issues identified from the presentations included:

- By the end of the tax year (2012-13) only about £8 billion of the £36 billion of benefit cuts over the four years have been implemented.
- 70,000 households in Norfolk are already in poverty and during 2014-15 will lose a further c £17 per week (8% of income).
- The cumulative effect of the wide range of benefit changes is that in 2014-15 it is estimated there will be £182m less money in Norfolk.
- Areas where deprivation levels are already high – such as GYBC and Norwich, are likely to be worst affected. (See Appendix 1.)

Early indicators of impact include:

- Increased demand for advice
- Increase in food bank activity (with peaks during school holidays)
- Increase in personal debt
- Increase in rent arrears (A pilot of direct payment to social tenants by Wakefield & District saw increase of rent arrears from 2% to 11%)
- 'bed-blocking' in hostels e.g. domestic violence refuges
- Evidence of increase in risk factors around homelessness
- Increases in theft from shops for basic items such as food, nappies and baby milk (Some supermarkets now security mark meat.)

Areas of further likely impact

- Household tensions – domestic violence, abuse, neglect
- Increase in crime / ASB/ substance misuse
- Financial pressures to move, take in lodgers, maintain disruptive relationships, instability
- Increased strain on carers, including young and informal carers
- Greater demand on GPs for non-medical help
- Increase in mental ill health
- Risk of eviction/possession proceedings

Longer-term impacts

- Nutritional deficiency on children's brains, relationship to educational attainment, emotional well-being, offending
- Biological 'blood markers' showing differences between chronological and biological age
- Reduced spend on "non essential" items, which may impact on broader health and well being (holidays, toys, leisure, sport)
- Increased homelessness
- Individuals with disabilities less able to manage their condition
- Increased demand on local services and the consequences of this for adult and children's social care and housing providers

3. Shared concerns and common themes

3.1 It was recognised that welfare reform will have a range of impacts which will vary according to household attributes. Some of the reforms to welfare may have positive outcomes, for example those directed at 'making work pay', with living-wage employment ultimately alleviating poverty and improving health and well-being. However for many in Norfolk in low paid employment, or unable to work, the changes are likely to increase levels of poverty and deprivation. People who live in vulnerable situations, and in areas of deprivation, are most susceptible to disproportionate impact and adverse consequences, thus deepening poverty and heightening social inequality.

3.2 There is a clear relationship between poverty and poor health, and social inequality and health inequality. **Tackling inequalities was therefore seen as the primary goal for the Health & Wellbeing Board because this is what will have the greatest impact upon people's health and wellbeing.** There was a strong sense that, given a funding environment of austerity, there is an urgent case for focusing and concentrating resources where they are needed most; so, a move away from universalism and towards **targeting support and services to people most at risk of inequality** was seen as a crucial step in responding to the challenge of welfare reform.

3.3 Following on from this a number of common themes emerged which are grouped below:

Measuring Impact

3.4 Because the changes to welfare are relatively recent, there is currently limited data on impact. It was therefore felt important to develop a shared framework to allow for future measurement. This should reflect the need to:

- Delineate data from intelligence, i.e. understand the difference between simply gathering data and the analysis required to see what the data is saying
- Collate existing datasets from the multiplicity of areas impacted by welfare reform into a single 'dashboard'[1] that tracks changes over time
- Collect additional data e.g. from the voluntary sector, including advice agencies
- Identify the costs arising in other services e.g. health, social care, housing, as a result DWP budget savings ('cost-shifting')
- The Joint Strategic Needs Analysis (JSNA) needs to be informed through the prism of welfare reform

Service integration & collaboration

3.5 As the impact of welfare reform affects people in multiple ways, services need to reflect this and be delivered in an integrated way that makes sense from a customer perspective. Suggestions included:

- Co-location of services by building on good models of practice that are already working e.g. the Multi-Agency Safeguarding Hubs (MASH) and the locally-based Operational Partnership Teams (Norfolk Constabulary)
- Applying effective approaches such as the recovery model used in mental health interventions and the pathways out of offending model used in work with adult offenders
- Use trusted places and organisations as a 'front-door' for accessing multiple services

[1] 'Dashboard' refers to a clear set of indicators which taken together give a sense of current impact and change over time (in the way that a car dashboard gives a series of indicators of how the car is running and travelling).

- Greater engagement between primary health services and social welfare advice agencies
- Interagency information sharing – greater efficiency and improved effectiveness for service users could be achieved by 'telling it once'. (Would need to be underpinned by a proper framework and agreed protocol.)

New & Existing Services

3.6 There is a need to maintain services that are already helping people in vulnerable situations, and to develop new ones to meet emerging and changing needs. Suggestions Included:

- Resourcing advice services to respond to additional demand for debt advice, transition to Personal Independence Payment, introduction of Universal Credit etc. It was noted that increased pressure for information, advice and advocacy was taking place at the very point when funding, including legal aid, was being severely reduced. Key agencies like Shelter (housing and homelessness advice) and the CABx have had to drastically reduce services.
- Widening the skills base of all frontline staff (e.g. social care and health practitioners) to understand and offer basic support around benefits
- Respond to the access gap caused by expectations of 'digital by default' by making better use of existing IT portals and training through libraries, basic skills and employability support so people are equipped to navigate the online benefits world

Integrated commissioning, resource sharing and targeting

3.7 There was a strong sense that it would be difficult to make much progress without a much stronger emphasis on pursuing greater collaboration, integration and sharing/aligning resources:

- There needs to be an integrated approach to service delivery through integrated commissioning. This needs to take place not just between health and social care bodies, but across the broad spectrum of organisations and agencies with a role to play in addressing inequalities.
- Resources should be directed to address inequalities so that commissioning is based on who needs services most (rather than being constructed for universal access). Whilst it is recognised this may involve withdrawing some existing services, the advantages of targeting are that it
- ensures tailored services are accessible to the most vulnerable
- takes account of current limited resource and helps avoid duplication
- allows commissioners to construct services on clearly identified community needs
- To support greater integration and targeting, the appetite for sharing and aligning resources needs to be explored between statutory partners across the county, districts and CCGs. 'Resource pools' could then be used to channel funding and services to those communities and pockets – including those in rural areas – experiencing high levels of inequality.

4. Further material

- For background to the WR changes, there is an interactive website: http://www.benefitsawareness.org.uk/#timeline .
- For a straightforward briefing/overview, see the CPAG or NCVO papers:
  http://www.cpag.org.uk/sites/default/files/CPAG_factsheet_the%20cuts_May13.pdf
  http://norfolkcan.org.uk/media/docs/welfare_reforms_and_voluntary_organisations_april_2013.pdf

- For more detailed briefings please visit http://norfolkcan.org.uk/welfare-reform/
- Copies of the workshop presentations can be found at: http://www.voluntarynorfolk.org.uk/nhawb

5. Action

5.1 The Board is asked to:

- Adopt the report and focus on tackling inequality as the most effective means of improving health and wellbeing
- Provide strategic leadership to all partners involved in the HWB to pursue integrated commissioning, resource sharing and aligning and multi-agency delivery at local levels.
- Communicate its intentions and reasoning to stakeholders (including to local communities)
- Allocate resources from within funding held by the HWB to establish a small unit of staff to co-ordinate, develop and take forward proposals in this report, and to provide expertise to build a 'dashboard' from existing data to monitor, analyse and communicate the key impacts of inequality (including those resulting from cuts to welfare)
- Include this item in the Forward Work Plan for the Health & Wellbeing Board

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

- Claire Collen, Voluntary Sector Engagement Manager, Voluntary Norfolk claire.collen@voluntarynorfolk.org.uk T: 01603 487556
- Adam Clark, Co-ordinator, Norfolk Community Advice Network, Norfolk Community Law Service

  adam@ncls.co.uk T: 01603 496623

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Appendix 1

Below is an extract from the introductory/context setting presentation given at the workshop by Adam Clark, Norfolk Community Advice Network. The slide was entitled "Overall Financial effects on individuals" and was used to illustrate the differing impacts of welfare reforms across the county.

District	Estimated loss (£ per year)	Financial Loss per working age adult (£ per year)
Breckland	£ 32.22m	£405.99
Broadland	£25.21m	£332.36
Gt Yarmouth	£36.38m	£612.75
KLWN	£39.90m	£449.29
North Norfolk	£24.71m	£428.80
Norwich	£46.10m	£504.07
South Norfolk	£26.37m	£350.65
NORFOLK	£ 230.89m	£ 440.56

Source: Sheffield Hallam University http://ig.ft.com/austerity-map

The 3rd column is the average annual impact in 2014/15 per working age adult resident in that area, which includes those on benefits and those not. Actual impact will vary depending on individual circumstances.

Report to Norfolk Health and Wellbeing Board
10 July 2013
Item 8

A Review of Norfolk Joint Strategic Needs Assessment – outline approach

Cover Sheet

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, 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.

In the development of the JSNA these statutory responsibilities will need to be taken in account.

Key questions for discussion

1. Are the 5 key questions set in the report the right ones to be answered
2. Do the summary assessment for each question in the report, based on findings of the review, set out the position effectively and act as the basis for a programme for improvement
3. Does the Board approve the short-term proposals for the JSNA to support the work of the Board in the next year
4. Discuss how a 'steering group' could work and who should be represented on it
5. Approve the proposals and ask the steering group to take this work forward

Actions/Decisions needed

The Board needs to:

- Amend or agree the approach to further development of the Joint Strategic Needs Assessment

Report to Norfolk Health and Wellbeing Board
10 July 2013
Item 8

A Review of Norfolk's Joint Strategic Needs Assessment – Outline approach

Report of Interim Director of Public Health

Summary
As part of the Forward Plan for 2013/ 14, the Board wish to review the current arrangements for Norfolk's Joint Strategic Needs Assessment and how the findings feed into the Health and Wellbeing Strategy going forward. This paper summarises the findings of a number of actions taken to review the Joint Strategic Needs Assessment and sets out proposals for improvement.

The report proposes improvements both to ensure that the JSNA can support the development of the 2014/17 Health and Wellbeing Strategy, and longer term development proposals for the Board to consider.

Action
The Health and Wellbeing Board are asked to:
- Note the findings of the JSNA Review
- Approve the production of an Annual JSNA Report to assist in monitoring needs and to support future planning with the first Report to be published in September to support the development of the 2014/17 Health and Wellbeing Strategy later in the year. In future years, the report would be published in March / April
- Agree the rest of the proposals for development
- Agree the creation of a JSNA Working Group to oversee these developments, agree the prioritisation of the JSNA Work-plan going forward and to deliver on agreed actions

1. Background

1.1 The statutory duty to produce a Joint Strategic Needs Assessment (JSNA) was included in the Local Government and Public Involvement in Health Act 2007, and the first versions were published documents produced in 2009.

1.2 The purpose of JSNAs (along with Joint Health and Wellbeing Strategy) is to improve the health and wellbeing of the local community and reduce inequalities for all ages. It is recognised that they are a key element in the continuous process of strategic assessment and planning, providing the evidence and analysis of needs to help to determine what actions are required to meet needs.

1.3 JSNAs contain a range of quantative and qualitative information for the area, but how this is presented and made available varies across the Country. Some areas have produced large overall JSNA reports and a range of supporting documents but most are now relying increasingly on online resources. It is left to the local area to decide

how best to develop and present their JSNA, but there is a range of national data sources and tools available to support local developments.

1.4 The new JSNA guidance emphasises that JSNA should be a 'picture of place' in terms of the needs of the whole population, including inequalities. Because of the interrelationship of a wide range of social, economic and environmental factors, the expectation of what is included in a JSNA is very wide. The opposite diagram gives an idea of the breadth of information covering the wider determinants of health (based on the Barton and Grant Model).

1.5 In Norfolk, it was decided to develop an online JSNA, embedding the key data on Norfolk Insight (the County's Data Observatory). The online resource is still seen as the best way to present the range of information but the style of content has developed over time to meet needs.

1.6 The online JSNA has a separate identify, accessed off the front page of Norfolk Insight, but utilises the data and resources stored in the website in its pages. A contents list of themes allows access to the various sections, and they then use web-links within the dedicated JSNA pages to access data and documents stored in the website. The online JSNA therefore a sub-set of what is held overall on Norfolk Insight, but it links into any useful information on the wider website.

1.7 In the last year, new style JSNA pages have been developed which makes it easier to find the core and linked information. Following demands to meet particular information needs where requested / commissioned, there has inevitably been differing progress in developing themes for the JSNA. An example of this is the recent focused work on developing a range of products to support the emerging CCGs in Norfolk, which were published on Norfolk Insight earlier in the year (www.norfolkinsight.org.uk/jsna/ccg). The intention is however to continue to progress with updating all themes and sections of JSNA over the next year.

2. Responsibilities

2.1 A statutory duty to produce a Joint Strategic Needs Assessment was originally included in the Local Government and Public Involvement in Health Act 2007.

2.2 The Health and Social Care Act 2012 amends this original legislation, and gives Local Authorities and Clinical Commissioning Groups equal and joint duties to prepare JSNA (and the Joint Health and Wellbeing Strategy) 'through' the Health and Wellbeing Board, and to have regard to guidance from Secretary of State. There is also a duty to involve third parties in the preparation of the JSNA, and specific mention of local

Healthwatch, people living or working in the area, County Councils and all relevant District Councils. There is also a duty to publish the JSNA. Health and wellbeing boards can request relevant information to support JSNAs from organisations represented on the board (core members and others) – and when asked, they have a duty to supply the requested information, if they hold it.

2.3 Statutory guidance on JSNAs (and Joint Health and Wellbeing Strategies) was published in March 2013, but it is very high level and is not specific about what the JSNA should contain or how it should look. Instead it is clear that the JSNA should be developed to provide the evidence to meet **local needs**, and it should make a key link to commissioning. The full guidance document can be found at: http://healthandcare.dh.gov.uk/jsnas-jhwss-guidance-published/

2.4 The JSNA (along with the Joint Health and Wellbeing Strategy) is intended to be a continuous process, and an integral part of CCG and local authority commissioning cycles. Guidance suggests that Health and Wellbeing Boards will need to decide for themselves a process to update or refresh their JSNA to ensure that they are able to inform local commissioning plans over time (no specific update requirements are included in the Guidance document).

3. Review of the Joint Strategic Needs Assessment

3.1 Norfolk's online JSNA is a valuable resource and is used by a range of commissioners, partners and the wider public. However, there are a number of questions we need to consider in developing a JSNA that will provide what we need:

- How well does the online resource work for users?
- Does the website supply the right balance between written analysis and data?
- How can we ensure that the contents /products are being used to inform commissioning?
- How do we focus resources on updating and developing the rights elements of the JSNA?
- How do we engage the wider public in the findings of the JSNA?

3.2 To progress this review in the tight timescales required, thinking was developed through a number of routes:

- An online survey was sent to all wider stakeholders in the health and wellbeing agenda to determine who uses it, what they find most useful and what improvements they are suggesting – finding of the survey (which closed on 14th June) are summarised below
- A workshop was held in early June with HWB members (or their representatives) that allowed discussion on what options there are for improvements
- There have been ongoing review discussions over recent months, including research into good practice

3.3 The findings of the above review activity have now been collated and inform our proposals for future development.

4. Views of Users and Stakeholders on the Joint Strategic Needs Assessment

4.1 The key approach to the review was to talk to people who use or might need to use the JSNA to get their views and develop some proposals for improving or amending the current product. These findings are presented under the headings below.

4.2 A total of 144 people were contacted directly in the online survey, although it is possible that it was more widely circulated. At the close of the survey on Friday 14th June, only 49 responses had been received. The findings set out below combine the views collated from the Workshop and comments / findings from the online survey.

How well does the online resource work for users?

4.3 There was a general view that an online JSNA is the essential to make best use of the wide range of information and resources available, particularly in health. However, concerns were expressed about how easy it is to find the information and that it needs more analysis and headline information to avoid unnecessary navigation at times.

- There is support for the idea of key information being available through resources and web-links in the JSNA – key web-links can encourage users to make best use of national sources and tools to supplement what we have embedded on the site
- We should continue to improve usability of Norfolk Insight in accessing the JSNA – some comments in the survey said that recent improvements have made it much more user friendly, but more needs to be done to help people find what they require.
- There is a need to make it feel a bit more coherent – linking across the wider website seems a bit messy at times
- There should be more easily accessible headline information – many only need this.
- One comment said "Fine as a starting point but not always easy to find what you want. I don't' think you can anticipate every information need – sometimes it will need a bespoke piece of work to provide what is needed."

Does the website supply the right balance between written analysis and data?

4.4 Many made reference to the need for more analysis, but those who are frequent users often also need the raw data. The population section is the most used / viewed section, along with the groups at risk of disadvantage sections. Some of the key products, such as the District Health Pictures and the CCG profiles have been well used and there is a clear wish for more of these products.

- There is a need for some sort of annual report – 'State of Norfolk' with information provided at District and CCG level.
- Views expressed from the survey that there was not enough analysis of data on the site to summarise findings – 30% of users who expressed a view (7 out of the 24 who answered this question) felt it needed more analysis
- Some responses suggested that it would help if we did more horizon scanning and predictive modelling to allow the development of early intervention and prevention
- The JSNA should provide more information on assets available in Norfolk to build into any guidance to tackle some of the issues highlighted in JSNA. One comment from the survey was: ' improved information on services coverage or community assets would facilitate the identification of gaps as well as greater joined up work'
- Some specific information gaps highlighted in the survey included older people, housing / accommodation issues, poverty issues, more on some minority groups such as gay and bisexual, people with learning disability

How can we ensure that the contents /products are being used to inform commissioning?

4.5 There were no specific comments addressing this, but a number of comments proposed ways of ensuring that commissioners would come to the JSNA to look for their evidence. There was a clear wish for the online JSNA to be more integrated with reference to evaluation of interventions, to provide more detailed levels of needs and even building in a forum for sharing information and views were possibilities discussed at the workshop. There is a clear need to engage commissioners more fully in future developments to ensure they help to design improvements.

- More links were requested to useful research material and evaluation of interventions to assist commissioners to use the evidence most effectively
- A request was also made for more lower level geographies to allow greater local understanding and identification of pockets of need often hidden in higher level analysis, particularly true of rural areas
- We should raise awareness of what is there and how it can be used – the newsletters are only a start.
- Better involvement of commissioning partners might be achieved by a regular seminar/presentation by partners, taking a theme and presenting evidence either internal to their organisation or from the JSNA or both. This would also act as a mechanism for adding partner data to the JSNA.

How do we focus resources on updating and developing the rights elements of the JSNA?

4.6 There were some comments both in the workshop and the survey on sections of the JSNA that were not well developed and with resources already out of date. Currently the lack of a 'steering' or officer group to prioritise developments and best use of resources to meet needs means that filling gaps is somewhat ad-hoc. Setting up such a steering group would help focus activity more appropriately.

How do we engage the wider public in the findings of the JSNA?

4.7 There is a requirement to engage the public in the development of the JSNA (see Engagement Section below). No detailed discussions have taken place on this to date, but linking it to engagement in the Health and Wellbeing Board and Strategy would seem to be an efficient approach.

- There was a comment in the survey around the need for more qualitative information / intelligence in particular by tapping into knowledge held by services users and local people. There was a particular comment about qualitative information about older people
- It was felt that it would be helpful if it was more of a shared resource where information and ideas could be shared with others across the county
- It was suggested that the JSNA could be used to challenge some of the expected 'norms' about the population of Norfolk

5. Overall conclusions from JSNA Review

5.1 Based on the above findings, the Review showed:

- There is general support for the online JSNA but the structure needs to be more consistent and include more overall analysis in each theme. This can then be supplemented by additional documents, datasets and web-links to other useful sites
- There is a need to integrate more 'soft' data into the JSNA to add to the datasets and documents published in each theme
- There is a need to build in more information on service provision and assets to assist in identifying and resolving gaps in services
- There is a need to improve engagement with commissioners in developing the elements of the JSNA, to ensure that the information meets their needs and covers all relevant issues in each theme
- A need to investigate how to share information from wider partnership through an online network or chat room

6. Engagement

6.1 The Guidance expects the Board to work with a wide range of local partners and the community beyond the Board's membership in the development of the JSNA so it is possible to ascertain what health and social care information the local community needs, including how they access it and what support they may need to understand it. Linking the emerging evidence on needs and supporting the development of the Health and Wellbeing Strategy, might suggest that consultation on the JSNA is part of the engagement and consultation on the Strategy.

7. Proposals for improvement

7.1 Following the discussions and the survey, it is clear that there are some key developments required in the next few months to support the development of the Health and Wellbeing Strategy, and others that would generally improve the online resource that has been developed in Norfolk Insight. Key in this is ensuring that there is an ability to 'flex' the system to ensure that it meets developing needs.

Immediate proposals

- Produce a summary of the JSNA giving key points to provide the evidence base to support the developing Health and Wellbeing Strategy by September 2013. This will allow the evidence to be built into the Strategy and any subsequent planning.
- Consider the creation of a JSNA Officer Group with representation from commissioners and other stakeholders to oversee the development and prioritisation of the JSNA going forward, and to take deliver on agreed actions
- Formalise the annual review of the JSNA within the HWB Work Programme each March, with a JSNA Report to be published giving key findings / changes over the past year
- Ensure that the information contained and analysed in the JSNA includes the 'soft' data from consultation and engagement.
- Bring the JSNA to life by having a programme of regular briefings on topics of interest drawing information from partners and the JSNA.

Longer term proposals

- Consider how to allow more access to partners to add information on to Norfolk Insight, and to continue to improve accessibility of information and ease of use.
- Develop wider ownership of sections of the JSNA so that content is appropriate and driven by needs of the users / commissioners, and uses innovative and imaginative ways of presenting the information that makes it more user-friendly

- Consider the feasibility of developing a virtual intelligence network linking to the JSNA

8. Action

8.1 The Health and Wellbeing Board are asked to:

- Note the findings of the JSNA Review
- Approve the production of an Annual JSNA Report to assist in monitoring needs and to support future planning with the first Report to be published in September to support the development of the 2014/17 Health and Wellbeing Strategy later in the year. In future years, the report would be published in March / April
- Agree the rest of the proposals for development
- Agree the creation of a JSNA Working Group to oversee these developments, agree the prioritisation of the JSNA Work-plan going forward and to deliver on agreed actions.

Officer Contact

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

Name	Tel	Email
Judy Lomas	01603 223442	judy.lomas@norfolk.gov.uk
Lucy MacLeod	01603 638407	lucy.macleod@norfolk.gov.uk

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APPENDIX 1

Health and Wellbeing Board workshops – Wednesday 5 June 2013
Key issues arising from discussions

Workshop 1 - Joint Strategic Needs Assessment (JSNA)

Why we are doing this – to undertake a review of the JSNA, determine whether any changes, additions and amendments need to be made to its content and use, making recommendations to the Board.

Content

- The bulk of the information needed, such as disease prevalence and population trends, is already in the JSNA. Anything above that can be provided by one off, specialist reports that then become part of the JSNA
- Have more qualitative information/intelligence, particularly tapping into the knowledge held by service users and local people – HealthWatch may have a role to play here
- More analysis to provide the basis for more informed questioning – helping commissioners and providers to understand what it is they need to find out/challenge
- More predictive elements to enable horizon scanning, early intervention and prevention
- Detail the range of assets available in Norfolk to help tackle some of the issues highlighted in the JSNA
- Add some project evaluation including: what works; what doesn't work; and best practice – to help tie up the commissioning cycle. This could also be the basis of a broader 'network' of people working on health and wellbeing and may also provide a basis for informal integration of activity
- Include research materials and/or make links to materials on other sites.

Customer experience

- Improve the usability of Norfolk Insight and the JSNA – enabling more people to feed into it and add fresh data and analysis
- Raise awareness of what is there and how it can be used – at a number of levels
- Need to be able to quickly and easily access headline information – as this is often what people need
- Make links from JSNA to other sources of information – the JSNA is a starting point and not the end point.
- Timeliness of raw data – soon goes out of date and so must be regularly refreshed

Purpose

- An annual 'State of Norfolk' picture to inform Strategy and commissioning more widely – with CCG and DC boundary breakdowns
- Myth buster – challenge some of the accepted norms about the population of Norfolk.

Report to Norfolk Health and Wellbeing Board
10 July 2013
Item 9

Norfolk Joint Health and Wellbeing Strategy 2014/17 – outline approach

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, 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.

In the development of a JHWBS 2014/17 these statutory responsibilities will need to be taken in account.

Key questions for discussion

1. Are the proposed draft vision and principles supported?
2. Is the idea of having a limited number of priorities of different types supported and is option A or option B preferred by the board?
3. Does the outline project plan cover the right steps in a challenging but achievable period of time?
4. Does the Board agree to the establishment of a sub-group of the Board to progress the development of the JHWS and enable momentum to be built and maintained?

Actions/Decisions needed

The Board needs to:

- Amend or agree the approach to the development of the Joint Health and Wellbeing Strategy.

Report to Norfolk Health and Wellbeing Board

10 July 2013
Item 9

Norfolk Joint Health and Wellbeing Strategy 2014/17 – outline approach

Report of Head of Planning, Performance and Partnerships
and the Interim Director of Public Health, NCC

Summary
This paper consolidates thinking that has been done to date on the development a 3 year Health and Wellbeing Strategy, which adds value to all the work on Health and Wellbeing that is already underway in Norfolk. The key points from a recent workshop and other meetings are highlighted as are a number of different options for the Board to consider. It is recognised that the content and delivery of the JHWS 2014/17 will be dependent upon the development of the JSNA and some form of performance monitoring process. Therefore, this report needs to be read in conjunction with those on the approaches to the development of the JSNA and an accountability framework.

Action
The Norfolk Health and Wellbeing Board review and comment on the content of the report, specifically that the:

- Board supports the principles and content outlined that would underpin the development of the JHWS 2014/17
- Decides on using Option A or Option B as the basis for the development of the strategy
- Steps identified and the key milestones are reasonable
- Board enables the momentum of work outside of formal Board meetings to be kept up through the establishment of a sub-group of the Board to progress the development of the JHWS
- That the Board is committed to early engagement with service users, providers and commissioners from the outset

1. Background

1.1 At the last meeting of the shadow Health and Wellbeing Board on 17 April 2013, Board members agreed that a piece of work be undertaken to "to consider what approach to take to the development of the 3 year health and wellbeing strategy for Norfolk, making recommendations to the Board. This will include the consideration of how we engage with the people of Norfolk on health and wellbeing priorities and the work of the Board".

1.2 To progress this, a workshop was held on 5 June 2013 to look at the process for the development of a three year Joint Health and Wellbeing Strategy along with a plan for engagement. The workshop was attended by 18 representatives of the Health and Wellbeing Board, either Board members or people delegated to attend on their behalf. The key issues arising from these facilitated discussions informed the first draft of this report, which was then further validated by a subsequent working group on 19 June 2013.

2. Workshop on Joint Health and Wellbeing Strategy

2.1 The high level summary of key points from the workshop that was held on 5 June 2013 is appended to this document in Appendix 1. What follows is a pulling together of these key points to determine the underlying principles for, scope of and an approach to performance monitoring by the Board.

General principles by which the HWB works

2.2 The Health and Wellbeing Board, during its shadow period, agreed a set of 12 general principles to inform the work undertaken. These principles set out some of the high level outcomes that the Board is trying to achieve and also some of the ways in which it will prioritise its work. The 12 principles are listed below.

2.3 The Health and Wellbeing Board will work to:

- Promote healthy lifestyles
  Strengthen investment in prevention and early intervention
- Promote integration of care pathways
  Reduce health inequalities

2.4 The Health and Wellbeing Board will add value by working in those areas where responses:

- Require collective action
- Tackle a problem that no one else has been or is able to tackle
- Align with the (health and social care) outcomes frameworks
- Tackle a major issue for the long term health and wellbeing of the County
- Draw upon a strong evidence-base, including the views of citizens
- Provide value for money
- Promote equality and diversity
- Result in measurable, sustained improvements in the health and wellbeing of the people of Norfolk.

Specific criteria for the development of the JHWS

2.5 Following on from the discussions at the workshop in June 2013, which were informed by the learning from the process of developing the 13/14 strategy, it is proposed that the following are used as specific criteria for the development of the JHWS.

- Keep it simple and targeted – do not try to do everything,
- Focus upon outcomes – be clear what it is that the Board is trying to achieve,
- Do different – use the opportunity to adopt innovative approaches,
- Accountable – present the JHWS - or a public summary of it - to the public as a promise or contract for which the Board and its members will be held accountable,
- Engagement – involve service users, providers and commissioners at key stages throughout the development of the JHWS. Also, in any consultation or engagement focus upon not what the priorities are but upon the ways in which they will be addressed.

Content of the Strategy

2.6 Vision – there is a need for a simple statement of what it is that the Board is trying to achieve that provides common purpose for Board members, is non-technical and outcome focussed.

2.7 First thoughts on what a vision for the strategy might look like are as follows:

In Norfolk people will say: "That those who need them experience safe, integrated, care and support that is personalised and coordinated" and "That health and wellbeing resources are used in a way that encourages healthy life styles, prevents problems developing and reduces health and wellbeing inequalities".

Priorities Option A

2.8 Priorities - the workshop were strongly of the view that a very small number of priorities (three was talked about as an optimum number) should be the focus of the strategy and it was suggested that these might usefully be of three different types to both reflect the Board's core purpose and increase engagement of people from different organisations and with different perspectives. Option A, based on this thinking is set out below.

- **One priority** might be to drive the integration agenda – at both a service delivery and at a commissioning level with an emphasis in both cases on prevention it is recognised that, in times of economic retrenchment the commissioning horizon is fore-shortened and yet a strong focus upon prevention and early intervention in the JHWS will help to manage demand and save both money and time.

  Integration is a priority because it is one of the core areas of Board responsibility which the board has said it wants to drive, it can play a significant role in prevention, reduce duplication and so save time and money and can significantly improve outcomes.

- **One priority** might be to reduce inequality of health and wellbeing outcomes for people in Norfolk.

  Reducing inequality is a significant strand of Government policy featuring strongly in the national outcomes frameworks. That it is important in Norfolk can be seen from the fact that there is an 18 year gap in disability free life expectancy between the 'best' and the 'worst' areas of Norfolk.

- **One priority** might be to significantly shift a key area which is known to impact negatively/has the potential to impact positivity on health and wellbeing in Norfolk. Obesity, on the one hand, or ways of reducing it, on the other, was proposed at the workshop.

  The significance of obesity on the health and wellbeing of individuals and on the resource pressures faced by partners is summarised in a briefing note from the Director of Public Health (DPH) as Appendix 2.

Priorities Option B

2.9 An alternative way of ordering these priorities and taking into account the other significant priority areas identified by the DPH in Appendix 2 would be as follows:

Overarching Goals Drive integration Reduce inequalities Promote healthy lifestyles and prevent problems		
Progressed through three priorities*		
Early life (0-5)	Obesity	Dementia

* The top priorities in the attached briefing note (Appendix 2) which were identified by the DPH based on a review of the context in Norfolk/Joint strategic Needs Assessment

2.10 Whether the Board chooses option A or option B each of the priorities in the strategy will need to be further clarified/defined, set out the outcomes sought, actions to be taken by when, responsibilities and the measures that would demonstrate whether progress was being made. More detail would be provided in the strategy for year one with subsequent years being populated as part of an annual review process. An outline timeline for developing the outcomes, actions and measures, and for engaging with the public on them, is provided in paragraph 18 below.

2.11 Although the strategy would provide key planks of the Board's work it would not be the only item on Board agendas. The board would continue to be able to consider issues, developments and plans/strategies across the wider Health and Well-being landscape when they were in accord with the principles set out above.

2.12 The Board may also need to consider how it is assured of the quality of the work that is undertaken in its name, either as part of the implementation of the JHWS or in relation to other pieces of work.

3. Engagement

3.1 There is an assumption in the national guidance that there will be engagement with a broad range of interested parties as an integral part of the development of the JHWS. The Board may wish to test this assumption. This is a different approach to that adopted for the 2013/14 JHWS, where it was agreed that formal consultation was not required as all of the identified priorities had previously been consulted upon as part of agency specific activity.

3.2 The nature of the engagement and consultation will depend on the discussions today and on the shape of the strategy but options for engagement include:

- **Who do we engage with?** Engagement could be with the public direct and/or with Health and wellbeing partners (including those, like providers, not formally represented round the board table.
- **At what points in the process do we engage**? In the formulation of the vision and the three (or more) priorities (although some of these are drawn from the HWBB's core purpose)? In the more detailed planning about how

the priorities should be addressed? Or solely through a formal consultation process on draft strategy?

- **How do we engage?** A range of engagement tools are available (see box below)

- Surveys / questionnaires - online and/or paper
- Social media – Facebook, Twitter, YouTube, Flickr
- News media, publications, magazines
- Conferences, workshops, meetings, focus groups
- Exhibitions, road shows, open days
- Online engagement, crowd-sourcing, wikis
- Written consultation, feedback forms, postcards
- Service user groups / forums
- Existing engagement mechanisms, such as 'Your Voice'.

3.3 During the formal consultation period for the JHWS 2014/17, the Board may wish to identify a series of key questions that used as a reference point to help ensure that the strategy is an open and accessible document that resonates with the public, service providers, service commissioners and politicians. For example:

- Is the Strategy clear?
- Is there anything that you don't understand?
- What do you think of the vision?
- Is there anything obviously missing?
- Is there anything you disagree with?

4. Developing the strategy – next steps

4.1 Taking into account all of the above the following steps and stages are proposed for developing the JHWS for 2014/17.

What	When
Agree a working vision and priorities Establish strategy/board reference group	July
Hold board workshops to develop priorities	July August
Engagement with stakeholders and the public on how to tackle priorities	August September
Working draft strategy	October board
Detailed drafting and formal consultation	January/February
Formal sign off	April Board
Implementation	April onwards

4.2 At the workshops there was some interest in keeping up the momentum of work outside of formal Board meetings and so establishing a sub-group of the Board to progress the development of the JHWS. This group may then evolve into a body that actions key issues identified by the Board, in effect becoming the doing element.

5. Action

5.1 The Norfolk Health and Wellbeing Board review and comment on the content of the report, specifically that the:

- Board supports the principles outlined that would underpin the development of the JHWS 2014/17
- Decides on using Option A or Option B as the basis for the development of the strategy
- Steps identified and the key milestones are reasonable
- Board enables the momentum of work outside of formal Board meetings to be kept up through the establishment of a sub-group of the Board to progress the development of the JHWS
- That the Board is committed to early engagement with service users, providers and commissioners from the outset.

Officer Contact

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

Name	Tel	**Email**
Daniel Harry	01603 222568	daniel.harry@norfolk.gov.uk
Debbie Bartlett	01603 222475	debbie.bartlett@norfolk.gov.uk
Lucy Macleod	01603 638407	lucy/macleod@norfolk.gov.uk

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

Appendix 1

Key messages from workshop – 5 June 2013

Approach

- Add value – do more together than we can do individually - including a focus on the economic argument.
- Keep it simple and targeted – do not try to do everything but focus in on 1 or 2 things that demand different approaches, such as 'integration' and 'alcohol harm reduction'
- Focus upon what we do and the outcomes that we are seeking to achieve - not what the priorities are
- Use new approaches to behavioural change, such as 'nudge'
- Use workshops/a sub-group to develop the Strategy and then implement it – not appropriate for the formal meetings of the Board
- The work of the Board will not be defined solely by any '3' priorities that are chosen, there is plenty of other work to be done
- Include a 'reality check' from all current commissioners – look for areas where we can 'push' better – where there are opportunities and the challenges
- Involve key partners in its development who are not directly represented on the H&WB, such as housing associations
- Learn from and reflect upon 2013/14.

Content

- Need a clear vision of what it is that we are trying to achieve
- Promote integration – defining what we (the H&WB) mean by it and what we are trying to achieve
- Reduce inequality is health and wellbeing outcomes across Norfolk
- Include clear milestones of where we want to get to in 3, 6, and 9 months
- Need a set of criteria to enable a reduction down from a JSNA long list to a couple of 'wicked issues' that the Board can respond to and add value
- Make the link between priorities and resources
- Focus on prevention

Engagement

- Do not consult on the content of the Strategy - instead, consult on the solutions to the issues that have been highlighted
- It needs to be relevant to the public – and we will need to use clear language to explain what the evidence is telling us, what we propose to do and what the expected outcome will be
- A pact/promise/covenant with the people of Norfolk – the members of the HWB will be held to account
- Co-production – develop with service users and a wider range of interested parties
- Transparency and accountability are key – report progress every 6 months
- Actively involve the members of the Board in its development and give people opportunities to take on a role.

Key Issues Briefing Paper

1. Obesity

Studies by the National Obesity Observatory (http://www.noo.org.uk/) show that Obesity in England has increased across all social classes for men and women except for women of the professional social class. Great Yarmouth is estimated to have the highest proportion of obese adults at over 28% and Norwich has the lowest at less than 21%. At small area level obesity ranges from about 13% for a MSOA in Norwich to over 30% for a MSOA in Great Yarmouth.

Percentage of the adult population with obesity 2006-2008	Local Number	Local Value	Eng Avg	Local Worst	Norfolk and Waveney Range	Local Best
Breckland	27,487	25.7	24.2	27.9		23.7
Broadland	25,543	25.1	24.2	28.6		21.7
Great Yarmouth	21,711	28.1	24.2	30.5		25.0
King's Lynn and West Norfolk	29,425	24.9	24.2	28.0		22.4
North Norfolk	20,833	24.4	24.2	26.1		20.9
Norwich	24,190	21.7	24.2	27.8		12.8
South Norfolk	23,526	24.5	24.2	27.4		20.2
Waveney	26,060	27.0	24.2	29.8		24.3
Norfolk	172,715	24.8	24.2	30.5		12.8

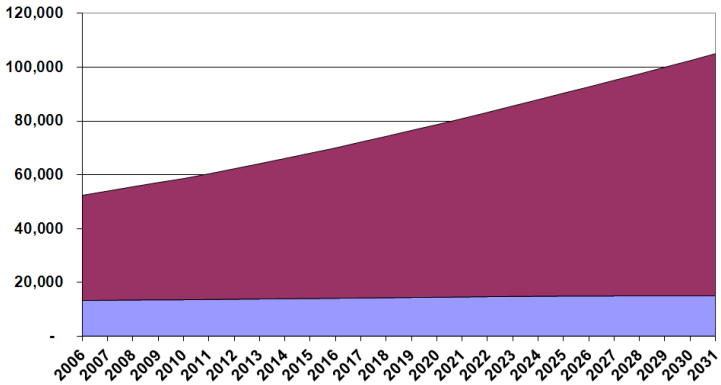
Better than England average
Not significantly different from England average
Worse than England average

The estimated percentage of the population aged 16+ with obesity. Individuals are regarded as obese if they have a body mass index greater than 30 Source: JSNA Small Area Dataset http://www.apho.org.uk/

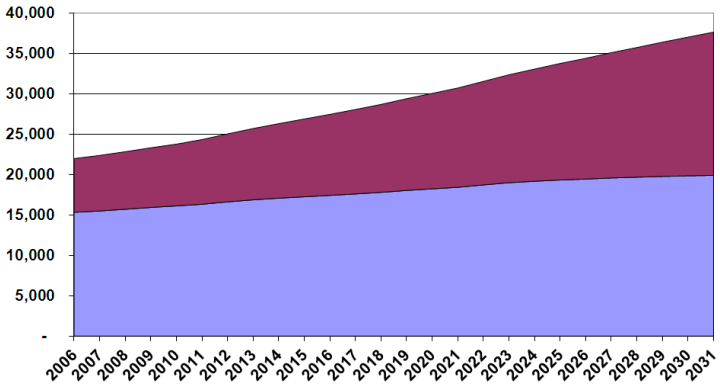
What this means for Services

Obesity carries associated risks of developing conditions such as Diabetes, Stroke, CHD and Cancer. Over the next 25 years if trends continue then across Norfolk and Waveney it is estimated that there will be an additional 50,000 diabetics due to obesity and an additional 9,000 strokes due to obesity. This will have a considerable impact on demand for services.

Estimated impact of rising obesity on Diabetes prevalence in Norfolk and Waveney



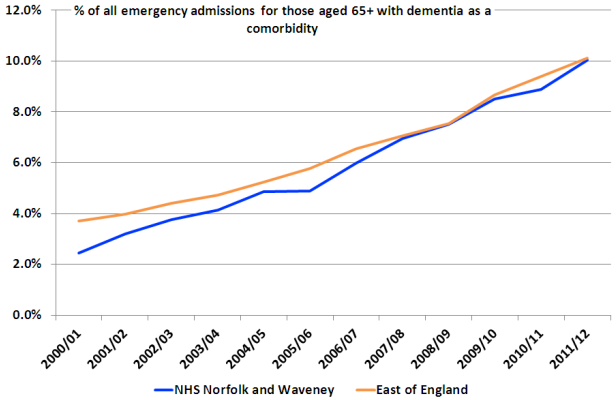
Estimated impact of rising obesity on Stroke prevalence in Norfolk and Waveney



Numbers from Non-Obese Population Numbers From Obese Population

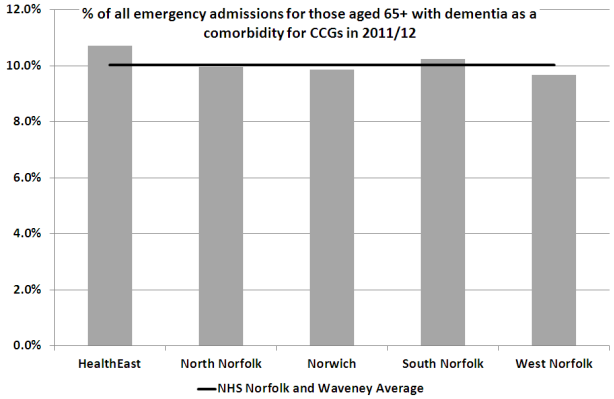
2. Dementia

Trend in % of emergency admissions with dementia as a comorbidity



Source: Dr Foster

% of emergency admissions with dementia as a comorbidity for CCGs 2011/12

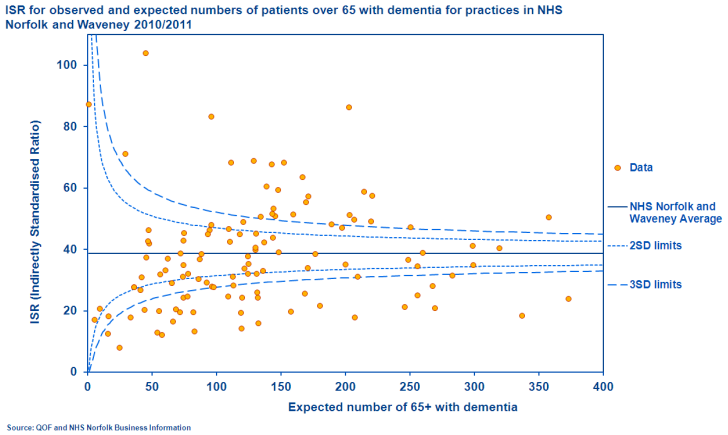


Source: Dr Foster

Local Authority	2012	2017	2022
Breckland	2,100	2,490	2,960
Broadland	1,960	2,270	2,640
Great Yarmouth	1,520	1,740	2,010
King's Lynn and West Norfolk	2,400	2,750	3,190
North Norfolk	2,240	2,560	2,970
Norwich	1,620	1,730	1,900
South Norfolk	1,900	2,190	2,570
Waveney	2,140	2,440	2,810
Norfolk	13,740	15,730	18,240
Norfolk and Waveney	15,880	18,170	21,050

Forecast numbers of people 65 and over with dementia POPPI and PANSI 2009 age /sex prevalence estimates applied to population forecasts

Variation in observed and expected numbers of dementia patients for practices 2010/11



Source: NHSIC and NHS Norfolk and Waveney Business intelligence

With an aging population the numbers of people with dementia is likely to increase. The proportion of hospital admissions for the over 65s with a comorbidity of dementia is increasing. The proportion appears to be consistent across the CCGs in NHS Norfolk and Waveney at about 10% of admissions and is in line with the East of England. The increase probably reflects a combination of better coding and information together with the increasing numbers of patients with dementia. Patients who have dementia experience many more complications and stay longer in hospital than those without dementia. At a practice level comparing observed numbers of people with dementia to the numbers expected indicates that there is a large number of “missing” cases. Over the next ten years the numbers with dementia is forecast to increase by about 5,000 across Norfolk and Waveney. At a more local level the estimated number of people aged 65 and over with dementia ranges from about 45 for a MSOA in Breckland to about 280 for a MSOA in North Norfolk. This probably reflects the distribution of older people. A detailed dementia needs assessment for Norfolk is available http://www.norfolkdata.net/jsna/olderpeople

3. Early Life 0-5

Early life is hugely influential in relation to adult life chances and adult health. A number of indicators will provide a picture of the current situation, help us pose questions that deepen our understanding and stimulate ideas for action. More detail on two of these, Foundation Stage Attainment and breast feeding at 6-8 weeks, is given below.

Foundation Stage Attainment

Foundation stage attainment in Norfolk is improving but not as fast as in England or the East of England. However, for Norfolk as a whole foundation stage attainment is significantly lower than the England average. Only in South Norfolk does the proportion of children classed as having a good level of development exceed the England average. The inequality in foundation stage attainment ranges from 22% for a MSOA in North Norfolk to 79% for a MSOA in Broadland.

Foundation stage pupils achieving a good level of development 2009/2010	Local Number	Local Value	Eng Avg	Local Worst	Norfolk and Waveney Range	Local Best
Breckland	565	46.0	56.0	25.0		68.0
Broadland	748	60.0	56.0	48.0		79.0
Great Yarmouth	394	40.0	56.0	27.0		63.0
King's Lynn and West Norfolk	708	50.0	56.0	32.0		72.0
North Norfolk	456	54.0	56.0	22.0		78.0
Norwich	581	44.0	56.0	30.0		68.0
South Norfolk	667	57.0	56.0	46.0		68.0
Waveney	599	52.0	56.0	36.0		67.0
Norfolk	4119	50.2	56.0	22.0		79.0
Better than England averag Not significantly different fr Worse than England averag					England average Worst local authority range	

Percentage of pupils classed as having a good level of development. A pupil achieving 6 or more points across the 7 Scales of PSE and CLL and who also achieves 78 or more points across all 13 scales is classed as having "a good level of development". Source: Neighbourhood Statistics

Breastfeeding at six to eight weeks 2010/2011	Local Number	Local Value	Eng Avg	Local Worst	Norfolk and Waveney Range	Local Best
Breckland	407	46.4	45.7	31.5		66.7
Broadland	387	49.3	45.7	34.6		66.7
Great Yarmouth	366	37.1	45.7	25.4		58.3
King's Lynn and West Norfolk	390	38.3	45.7	25.7		54.2
North Norfolk	272	44.9	45.7	23.1		57.1
Norwich	591	49.3	45.7	32.0		83.3
South Norfolk	405	54.9	45.7	33.3		75.0
Waveney	426	37.3	45.7	22.5		64.9
Norfolk	2818	45.4	45.7	23.1		83.3
Better than England average Not significantly different from England average Worse than England average					England average Worst Best local authority range	
Percentage of babies being either partially or fully breastfed at six to eight weeks Source: NHS Norfolk and Waveney provider data						

Breastfeeding initiation is generally increasing across Norfolk and Waveney. However, the proportion of babies breastfed at six to eight weeks is not showing the same increase. Broadland, Norwich and South Norfolk have six to eight week breastfeeding rates significantly higher than the national average. Great Yarmouth, King's Lynn and West Norfolk and Waveney have breastfeeding rates significantly lower than the national average. Breastfeeding at six to eight weeks ranges from about 23% for a MSOA in North Norfolk to over 83% for a MSOA in Norwich.

Integration of health and social care service in Norfolk: an update

Cover Sheet

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, 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.

In reviewing its Terms of Reference on transition from shadow to statutory form, the Health and Wellbeing Board agreed that its duty to encourage integration should be strengthened to reflect the clear intent of the Board. The Terms of Reference state that the H&WB will:

- Drive the further integration of health services and social care services, and other public services and hold each other/the Board to account for it

Key questions for discussion

1. Does the Board wish to endorse locally the National Voices work as setting out the difference it wishes integration to deliver for Norfolk people?

2. Does the Board have any comment on the nature of the approaches to integration which are taking place across Norfolk?

Actions/Decisions needed

The Board needs to decide on:

- Its support for the three Norfolk bids to the Integration Pioneer programme
- Whether it is useful to set up a task and finish group - or a one-off meeting - to develop 3-5 practical deliverables around integration in service provision as well and a Norfolk-wide commitment to put each of them in place within a defined time period.
- Future reporting requirements

Integration of health and social care service in Norfolk: an update

Report by the Director of Community Services

Summary
Health and Wellbeing Boards have a duty to 'encourage' integration and the Norfolk H&WB has agreed to 'drive' integration – a strengthening of the approach to reflect its clear intent, for example in terms of accountability. In July 2012 the Board received a paper which set out the approaches to integration which are being taken in Norfolk and this paper provides an update on activity towards integration in Norfolk.

The paper also outlines the recent launch of the Integration Pioneer programme, where invitations are sought from local areas to spearhead implementing models of integration. There are three bids being prepared in Norfolk. To be successful, bids are required to have the support of their Health and Wellbeing Board.

Action

- The Board is asked to comment on the progress and proposed approaches to integration in Norfolk.
- The Board is asked to confirm its support of the three Norfolk bids to the Integration Pioneer programme from:
  a) West Norfolk
  b) North Norfolk
  c) Great Yarmouth and Waveney.
- The Board may wish, through a task and finish group or a one-off meeting, to articulate 3-5 practical deliverables needed to progress integration in service provision and seek Norfolk-wide commitment to put each of them in place within a defined time period.
- The Board may wish to determine further reporting requirements it would like in relation to the progress of integration.

1 Background

1.1 The Health and Wellbeing Board has a duty to 'encourage' integration and has taken the view that it wishes to more actively drive integration in Norfolk. In July 2012 the Health and Wellbeing Board received a paper which set out the approaches to integration which are being taken in Norfolk, outlining the impact of the Integrated Care Pilots and endorsed the principles which underpin the activity around integration.

1.2 This paper provides the Board with an update. In particular it sets out:

a. Current national policy context including the recent publication of 'Integrated Care and Support: Our Shared Commitment'

b. A summary of progress that has been made on integration in Norfolk

c. The Integration Pioneer programme and the Norfolk bids. (see attached)

2 A new framework: 'Integrated care and support: our shared commitment'

2.1 The publication of "Integrated care and support: our shared commitment" in May 2013 and the associated Ministerial announcements, is a significant development in the integration agenda. 'Integrated care and support' is published by the National Collaboration for Integrated Care and Support, a group of major stakeholders in the delivery of integration.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf

2.2 The framework is firmly founded on the views of and outcomes for people using services, with National Voices describing integration as 'patient-centred co-ordinated care'. The paper gives a detailed description of what integration means through outcome statements for individuals, built on the Making it Real programme for social care. This is an important challenge to 'think people' rather than systems in our approach to integration.

2.3 Norfolk is well placed to move forwards in this framework. Norfolk County Council in partnership with Equal Lives (formerly Norfolk Coalition of Disabled People) is signed up to the national Making it Real programme and has a steering group, chaired by the Director of Integrated Commissioning, which is established to challenge the changes in care to deliver the aspiration of making a difference to individuals. This could form the basis for an integrated approach to testing outcomes.

3 Integrated care and support: ministerial statements

3.1 Along with the publication of 'Integrated care and support' recent ministerial statements set out expectations of the health and care systems in terms of progressing integration. Key messages include:

a. Reinforcing the National Voices definition of integration as 'patient-centred co-ordinated care'
b. Locally based determination of how integration will be achieved rather than a nationally prescribe approach
c. An expectation of major change in existing service outcomes
d. High quality, compassionate care as essential
e. Integration which is broader than health and social care: public health, education and the third sector are all noted as key partners
f. A focus on avoiding crisis and avoiding unnecessary hospital admission
g. Ensuring the use of new technology
h. A call for scale and pace
i. Learning fast, sharing the lessons
j. An emphasis on people and leadership, not systems
k. Underpinned by personalisation and outcomes for individuals
l. Integration to become a standard approach in every area for everyone with health and care needs over the coming five years.

3.2 The Department of Health Integration Pioneer initiative was launched in May. See

below.

4 Progress on integration at local level

4.1 There has been development of integration across Norfolk determined by CCGs within their partnerships. The following are local summaries:

4.2 **West Norfolk:**

4.2.1 West Norfolk was a site for one of the initial integrated care organisation (ICO) pilots which has provided a foundation for integration which has seen subsequent development to increase impact.

4.2.2 From the ICO pilot, there is an established integrated infrastructure between Norfolk Community Health and Care and Norfolk County Council, with community health and social care teams co-located in community hubs to facilitate joint working and holding joint team meetings. Since then, an integrated senior management structure has been established, with a single leadership post for West Norfolk to drive integration between the services. The Norfolk First Response reablement service is also linked to this structure.

4.2.3 To support integration, there are four integrated care co-ordinator posts who:

a. Provide a single point of case of access for health and care professionals
b. Facilitate multi-disciplinary team (MDT) meetings with primary care
c. Collate admission data and identify frequent users of services for discussion at the MDT meetings
d. Act as a face to face link to community services
e. Provide a point of access for signposting and referral to other agencies, whether they are health, social care or voluntary sector agencies.

4.2.4 In addition, the West Norfolk Prevention First project has been created with sponsorship of the System Leadership Group. Prevention First focuses on the integration of prevention services in the area to maximise the opportunities to identify and support older people in particular. Key to the model is the creation of a hub and contact centre which the Borough Council of Kings Lynn and West Norfolk are leading on. Alongside is the development and engagement of community resources and community networks within a community capacity-building approach. This is aimed to maximise and build on the existing assets in the community.

4.3 **North Norfolk:**

4.3.1 Integrated care and support in North Norfolk is driven by the Long Term Conditions (LTC) Programme and steered by the North Norfolk Integrated Care Board. The Integrated Care Board has representatives of clinical, commissioning and operational leads within the CCG, Norfolk County Council Community Services, Norfolk Community Health and Care and Norfolk and Suffolk Foundation Trust.

4.3.2 The programme aims to

1. Identify a cohort of patients with long term conditions by the use of a risk stratification tool
2. Deliver through an integrated teams approach a range of services to those LTC patients identified by the risk stratification tool
3. Increase opportunities for self-care and self-management

4.3.3 Key areas of development this year include:

a. Development of a local predictive risk profiling tool to identify, through health, social care and mental health indicators, those people with long term conditions who require targeted interventions

b. Four integrated Community Hubs have been developed, encompassing all practices in North Norfolk. There are 4 Care coordinators who will coordinate regular multi- disciplinary team meetings at each practice. There are also plans to align voluntary sector support services and other community support services.

c. Development of integrated self-care and self-management support services

d. Integrated professional development approach agreed

e. Integrated monitoring and performance framework – the performance & monitoring framework is being further developed to demonstrate the wider impact of the LTC Programme across the system.

f. Patient experience of care – community nursing teams are administering a qualitative assessment questionnaire to monitor the impact on patient experience.

4.4 **Norwich**

4.4.1 Developing from the initial ICO pilots, Norwich is focusing on integrated case management (ICM) comprising the case managing nurses and matrons (respectively two and one for each of the four City teams). This is now complemented by the four ICM integrated care co-ordinators. Three are funded by the CCG and one by NCC. They work with, not only case managed older people, but also other older people in crisis and younger people in some practices, including people with learning difficulties. This new service is successful and is valued by GPs and nursing staff.

4.4.2 Following restructure, staff in Social Care have now been linked to a surgery, so each surgery now has a named social worker and practitioner, one of whom will attend the ICM multi-disciplinary team GP practice meetings.

4.4.3 Policy within the CCG is debated and taken forward through a number of clinically led Clinical Action Teams. The Integrated Commissioning Team, participates in these meetings to help develop integrated approach to policy and practice across health, social care and supported housing.

4.4.4 A pilot to integrate housing related support into primary care has sited a housing support service in a GP surgery. It is nearing completion and has been very successful. Formal evaluation is soon to be completed.

4.5 **South Norfolk**

4.5.1 South Norfolk CCG has set out its commitment to integration as a guiding principle for the commissioning strategy: *"Delivering fully integrated community health and social care teams as the norm, working in full partnership with local General Practice to support people in their homes."*

4.5.2 Integration within South Norfolk has benefited from a having one of the ICO pilot sites which established an improvement in patient outcomes and professional communication and understanding, also demonstrating reduced planned and unplanned hospital admissions. Success of this integrated way of working has included:

a. Regular practice-based multidisciplinary team meetings at all practices.

b. Establishing an Integrated Care 'Hub' that includes care co-ordination.

c. Integrated care list of patients and a developing database.

d. Engaging with all stakeholders including acute hospitals, mental health, third sector organisations, housing, care homes, ambulance trust, pharmacy, patient and carer groups

e. Joint appointment of a community geriatrician with the hospital

f. Practices and their integrated teams receiving 'live' unplanned admission data from the acute hospital.

g. A focus on working differently rather than creating new roles.

4.5.3 South Norfolk was the site for a pilot to integrate the reablement services between health and social care. One of the best things to emerge from this, and that has now been rolled out across the county, is direct referrals from the acute hospital to the NCC reablement teams by an occupational therapist. This has allowed people to get home on average three days earlier, cutting hospital delays and waiting times and having a positive impact on the longer-term reablement and independence of the patient. This work will be continued through 2013/14.

4.6 **Great Yarmouth and Waveney**

4.6.1 A major focus is the System Leadership Partnership (SLP) which is a well-established and mature forum, which has been recognised as an example of good practice. The SLP encompasses senior leaders from health commissioners and providers, both county councils, the two district councils, the voluntary sector from Norfolk and Suffolk, police, public health and HealthWatch. The progression towards integration is the 'golden thread' running throughout the SLP's activities and annual work plans. It is underpinned by an operational delivery group, which has already demonstrated improved cohesion by the co-location of health and social care teams. Teams operating within GYW CCG are already integrated.

4.6.2 The CCG has integration running as a strong theme through its 'Plan on a Page' as submitted to NHS England.

4.6.3 The Out of Hospital Strategy sets out the approach to reducing reliance on acute care, providing care within integrated out of hospital teams, improving prevention and reducing emergency activity. This captures the ambition and programme for integration in the locality. It builds on the existing model which has been established at Gorleston: co-location of health and care teams, multi-disciplinary team meetings, access to ICT from both partners and the clear evidence that this is really making a difference. The strategy is congruent with the approach to increased prevention being adopted within Norfolk and Suffolk County Councils and has the support of partner organisations.

4.7 **Integration across the county:**

4.7.1 Norfolk County Council and Norfolk Community Health and Care have been progressing their integration of service delivery as is reflected in the locality updates. The opportunities for building on the model of integrated management will be developed. The partners continue to consider strategic options for the next steps in working together.

5 Integrated commissioning and aligned/pooled budgets

5.1 As already noted, Norfolk has an established integrated commissioning arrangement

for adult care across the CCGs and Norfolk County Council. We now have an integrated mental health and learning disability commissioning team hosted by the County Council and secured in a section 75 agreement. Examples of recent integration commissioning approaches include:

a. An integrated community equipment service for Norfolk providing a 'one stop shop' and a more efficient service to support care at home and hospital discharge.

b. The medicines support service providing specialist intervention to retain people with complex medication regimes in their own homes and to avoid hospital admission. It is secured via a pooled budget.

c. An integrated carers support service in place from July 2013 which will provide a consistent network across the county to strengthen carers access to support, whilst supporting local carers support initiatives.

d. An integrated information, advice and advocacy service from April 2013, again retaining specialist advice services within a countywide network.

e. Joint work on continuing health care, securing and making use of beds available in the community, developing the market to provide the range of services and quality we need for the future

f. Reviewing help to enable people to live at home, to encompass consideration of how personal care at home links with community and voluntary support and specialist professional input.

5.2 We will continue to prioritise integrated commissioning that will prioritise a seamless approach to people with complex needs, reduce the need for acute services by investing in prevention and early intervention, building on the resources in communities and securing integrated service delivery that will improve service user/patient experience and make better use of resources by, for example, reducing the number of separate visits needed to help an individual with health and social care needs.

6 Overcoming the barriers

6.1 There are common themes which repeatedly arise in seeking to integrate outcomes for individuals:

6.2 **Finance streams**: as budgets are under pressure and there is generally not new money for integration, partners need to find ways to change the way funding is used. One of the routes in to facilitating integration is to bring together an understanding of funding streams and to consider how these could be used differently. This can be shaped around a community - what do partners spend in a geographical area- or around communities of people such as the Troubled Families initiatives. Pooled budgets are well established; around the country some areas are developing local integrated trusts to form a joint commitment to fund new approaches.

6.3 **Data sharing**: there are technical barriers in sharing information which result from the number of IT systems holding data across the partners and there are also governance issues in sharing personal and identifiable data. One way to consider addressing this is to build up from the individual as the person who controls their own data and permissions to share. There are a number of smart card initiatives which can enable the individual facilitating the sharing of their data.

6.4 **Culture**: our systems are often sustained not just by rules, but by the habits of those of us working in them. The delivery of the transformative integration set out in the 'Shared commitment' requires us to create a system which is driven by personal outcomes and which may require both staff and citizens to behave differently.

Creating a framework for doing differently is a key challenge in integration which his signalled by the attention to leadership.

7 Integration Pioneers

7.1 As noted above, in May a call was made for bids to become Department of Health integration pioneers – systems which will be early implementers of integration, which will benefit from national support and which will share their learning.

7.2 The pioneers need to demonstrate they address the following criteria:

a. Articulate a clear vision of its own innovative approaches to integrated care and support
b. Plan for whole system integration
c. Demonstrate commitment to integrate care and support across the breadth of relevant stakeholders and interested parties within the local area
d. Demonstrate the capability and expertise to deliver successfully a public sector transformation project at scale and pace
e. Commit to sharing lessons on integrated care and support across the system
f. Demonstrate that its vision and approach are, and will continue to be, based on a robust understanding of the evidence.

7.3 Bids needed to be received by 28 June 2013. The requirements note: 'the involvement and support of Health and Wellbeing Boards (as a minimum, by the end of the selection process) will be an essential prerequisite for any area to become a pioneer.'

7.4 The three Norfolk bids will be provided in the format submitted to the Department of Health:

1. West Norfolk
2. North Norfolk
3. Great Yarmouth and Waveney.

7.5 The Board is asked to support each of these bids – which are attached as Appendices A, B and C.

8 Action

8.1
- The Board is asked to comment on the progress and proposed approaches to integration in Norfolk.
- The Board is asked to confirm its support of the three Norfolk bids to the Integration Pioneer programme from:
  a) West Norfolk
  b) North Norfolk
  c) Great Yarmouth and Waveney.
- The Board may wish, through a task and finish group or a one-off meeting, to articulate 3-5 practical deliverables needed to progress integration in service provision and seek Norfolk-wide commitment to put each of them in place within a defined time period.
- The Board may wish to determine further reporting requirements it would like in relation to integration.

Background Papers

Appendices:

1. West Norfolk
2. North Norfolk
3. Great Yarmouth and Waveney.

Officer Contact

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

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

IN TRAN communication for all

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

Appendix A

Expression of Interest in Becoming a Health and Social Care Integration Pioneer

'Creating a transformational and sustainable system for our communities'

'Creating a transformational and sustainable system for our communities'

1. Introduction

1.1 **Our fully integrated model**

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

'We want to create an integrated care organisation (virtual at first) encompassing the activities of all of the local organisations responsible for health, social care and District Council services. This will deliver high quality, person friendly services in a coordinated way, which removes organisational and transactional barriers and costs so that the maximum proportion of funding possible is used for the care of the population. We will care for all sections of our community but we will focus particularly on those most needing care and help and those at risk of becoming so.

All the local organisations including commissioners, providers, such as the James Paget University Hospitals NHS Foundation Trust (JPUH) and East Coast Community Healthcare (ECCH, our local police and patient groups, have a common, united vision and drive to create a system-wide Integrated Care Organisation (ICO) unlike any other in the UK. We have worked hard over recent years to develop the trust and relationships between all stakeholders and know the time is right for us to achieve this goal. We believe we have a unique opportunity as a discrete health economy to realise this ambition of a truly integrated health and social care system which would be an exemplar model for others to copy.

As the Clinical Leader of the Clinical Commissioning Group, I know we can improve care by closer working and better communications between primary, secondary, community and social care. We must use IT as an enabler not a barrier, and create innovative ways of referring such as joint video clinics and release clinical time in so doing. I see the ICO as the vehicle to achieve a real beneficial transformational change for our population. We have a proven track record of delivery and we can deliver this.' ***Dr John Stammers, GP and Chair, NHS Great Yarmouth and Waveney Clinical Commissioning Group***

1.2 **Why it's better for patients and clients**

Integration is beneficial for individual patients, carers and clients. A lack of joined-up care is a huge source of frustration for them, as well as for health and social care professionals. If health, social care and District Councils, working together, can deliver integrated services, this will really improve quality and safety for all those that use these services. Personalisation is at the heart of our approach and we see the learning within *National Voices,* as endorsing this and challenging our ambition to transform outcomes.

1.3 **The integration commissioners**

There are five organisations, two County Councils, two District Councils and an NHS Clinical Commissioning Group, which are responsible for commissioning the majority of services that ensure the health, social care and wellbeing needs of our population are met. We are excited to submit a collective expression of interest to deliver a truly integrated and sustainable health, social care and wellbeing system. Whilst there is a natural affinity and alliance between health and social care, we believe the inclusion of District Councils within our integrated approach is essential. In two tier areas, such as GYW, it is Districts that facilitate the local conditions for sustainable economic growth, job creation and rising health and living standards. Also, social housing tenants are a large element of the group of people most at need of higher levels of support from all agencies.

This is therefore a truly integrated public sector approach, and will operate across all four of our communities in Great Yarmouth and Waveney (GYW). We are clear that the role of education plays a strong part, evidenced by the strong track record GYW has in health prevention work and the successful Troubled Families initiatives locally. We are also mindful of the very significant contribution that private care sector organisations and are therefore engaging with them to ensure their services are woven into this work.

The five commissioning organisations are NHS Great Yarmouth and Waveney CCG (GYW CCG), Norfolk County Council (NCC), Suffolk County Council (SCC), Great Yarmouth Borough Council (GYBC) and Waveney District Council (WDC). GYW CCG has a local operating name of HealthEast.

1.4 **Transforming to an Integrated Care Organisation**

Our transformational change, both in terms of person-focused care and organisational structures, is to establish an Integrated Care Organisation (ICO). This will work across our population of 230,000 which crosses a county boundary, and show how natural systems straddling a county boundary can be fully integrated. GYW is not the only example of this in England and therefore this model will have resonance not only with other systems with an ambition to achieve greater integration, but those operating across local authority boundaries. We believe that the complexity and multiplicity of current organisational structures and financial flows inhibit the optimisation of person centred care, and the best use of our scarce funding.

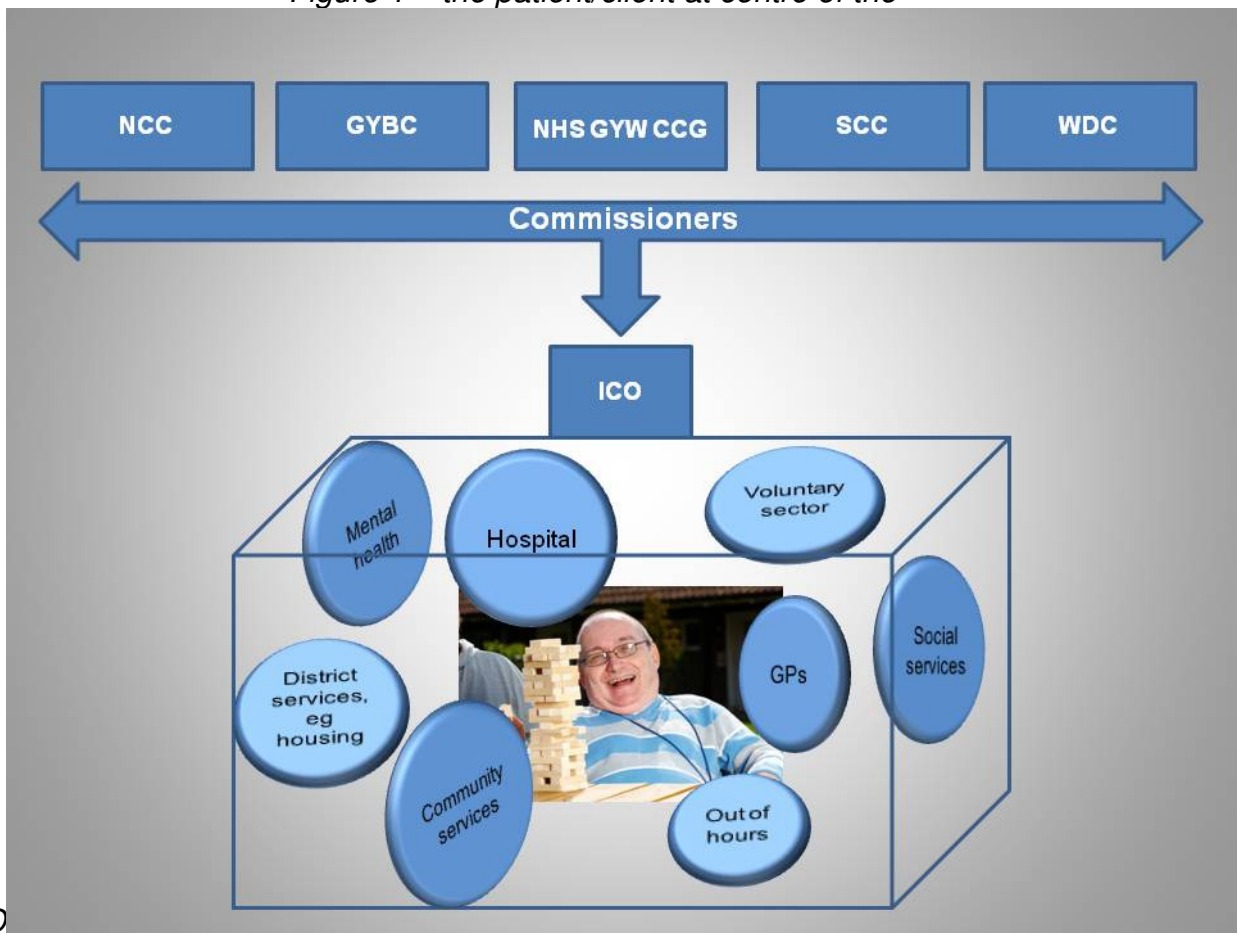
We are excited about this major step change towards integration. It is the next natural step on from our strong track record towards integration within GYW, both culturally and operationally. We see it as ‘the whole toolset in one place’.

The driving force of this change is the GYW System Leadership Partnership (SLP) which is a well established and mature forum, which has been recognised as exemplar practice by Norfolk and Suffolk. Integration was a strong theme flowing through GYW CCG’s application for authorisation, with the CCG being one of the first wave CCGs, fully authorised without conditions. The SLP encompasses senior leaders from health commissioners and providers, both County Councils, the two District Councils, the voluntary sector from Norfolk and Suffolk, Police, Public Health and HealthWatch. The progression towards integration is the 'golden thread' running throughout the SLP's activities and annual work plans. It is underpinned by an operational delivery group, which has already demonstrated improved cohesion by the co-location of health and social care teams.

The estimated annual commissioning budgets of all five organisations which will be combined to provide a total budget are substantial. We have already mitigated some of the effects of traditional commissioning and delivery approaches by our success in establishing integrated and co-located health and social care teams in some communities. We can now show a sufficient scale of coverage in terms of population and spend, and pace in that we plan to establish an interim ‘Op Co’ (Operating Company) during 2014/15 and the ICO within 18 months thereafter.

Figure 1 demonstrates our innovative approach to person centred care, with community design and input to services, and teams working within a single integrated organisation.

Figure 1 – the patient/client at centre of the ICO



1.5 **Why we want to be a Pioneer**

We are highly enthusiastic about the freedoms offered by becoming a Pioneer. This will enable us to test new models of care and funding. Becoming a Pioneer will give us liberty to move away from traditional funding models and allow the five commissioners to operate at a macro level of commissioning, with the main decision making and fine tuning by means of micro commissioning being carried out within the ICO. So we are moving away from the hard edged current delineation between commissioning and provision, for health, social care and the services provided by district councils. We plan also to draw on the contribution that private sector providers can make to this model.

We would very much value the support and help that we could obtain from being a Pioneer, during our journey towards integration. The assistance we would value includes exploring how funding flows should change within our integrated model, developing our ladder of needs approach, how we cost packages of care, new options for combining budgets, removing barriers around interoperability of IT packages and how procurement issues are handled. We would also value input around how we achieve the cultural and behavioural changes needed.

The remainder of this paper is dedicated to explaining the detail of how we will operationalise our integrated approach. It also shows how we meet all six of the criteria. We draw on examples of our strong progress so far towards integration which serve to demonstrate that we already have a track record and we progress from a strong foundation.

2. Current state versus future state and the benefits

Current state	Future state	Benefits
Patients and clients do not have integrated care packages	Single tailored costed personalised plans for frequent	Improved quality of life, improved preventative care

across their spectrum of needs	service users	and reduced emergency activity
Fragmented services and multiple organisations	Integrated and vertically integrated service provided by single team within the ICO, which promotes greater community outreach	Reduced duplication, more predictable activity costs and reduced operational and management costs
Unpredictable tariff based costs for NHS activity	High cost service users covered by pre costed personalised plans	Commissioners have greater control over costs and ICO provider incentivised to provide quality care avoiding emergency activity
Different budgets can lead to cost shifting between organisations or other organisations seeing benefits from another organisation's input	Budgets will be combined and used to maximum effect across our population	Less cost shifting and limited resources are used to maximum effect

Our vision can be summarised as 'Better Care, Better Value, Better Health and Wellbeing'.

3. Costed Personalised Plans

Our prime purpose in setting up an integrated care system is to create personalised plans for care which revolve around all our patients and clients. This will only be achieved by a system where the provider has greater certainty about income, allowing us to foster the incentive of shifting care closer to our patients. At the moment, patients and clients are being moved around the system, between disparate commissioners and care providers, with resultant gaps and duplications in care. This also tends to lead to unnecessary amounts of emergency activity and perverse incentives for providers, to the detriment of patients and the wider system. To this end, we will:

- Provide a holistic health and social care service up and down the 'ladder of needs' for all patients and clients, for both physical and mental health needs. The Op Co and ICO approaches will ensure that the care provided is seamless and not subject to multiple handoffs, duplications or gaps in care due to a number of different organisations delivering care and fragmented care pathways. We will adopt an approach of costed personalised plans for people at high risk of needing unplanned care, to ensure care is optimised and perverse financial incentives are removed;
- Extend our integrated teams, with health (including mental health and dementia teams), social care and district council professionals, in terms of scale and coverage. They will care for all our population, irrespective of what type of need they have. The teams will operate throughout the care pathway, including close interaction with teams based within the acute hospital setting. We will also include a new multiagency generic 'care worker' role we are developing following a successful application for funding by our Local Education and Training Board. These integrated teams will also draw in staff and volunteers from other agencies such as the third sector, as appropriate.

We already have a 'head of steam' in terms of integrating teams. Now we will accelerate towards our vision of an ICO by setting up single management structures for teams, both within our four communities and centrally. The local teams will draw in clinical outreach from JPUH and in-reach from GPs. The GP contribution may be assisted and co-ordination improved by our local GPs' early plans to establish a GP Federation.

Local teams will have different disciplines working within the same integrated team, including community matrons, district nurses, paramedics, social workers and other social care staff. The teams will also include support to services offered by district councils and independent providers, such as homecare, housing management, community alarm etc. The local teams will retain a

community focus, but will be under the central co-ordination and management of the single management within the ICO.

These community based teams will be a true single point of access for GPs or secondary care to put in place costed personalised plans for individual patients and clients. Most local GP practices use EMIS web and the integrated team will use that where it predominates, or use interoperability between health and social care systems as necessary. The Norfolk and Suffolk social care teams are already using Care First, which is also operated within the teams within JPUH and our community hospitals. The innovative Eclipse Live system used by general practice in GYW will also facilitate patient or practitioner enabled collaborative data sharing. We see this as the central thread of how we will link the information streams of different bodies coming together in the ICO. We already have an integrated team in our Shrublands facility in Great Yarmouth. This concept will be rolled out to other areas.

4. How the costed personalised plans will work

Our ICO, with a central management team, will provide integrated services to our entire population in GYW, covering their health, social care and associated district council needs.

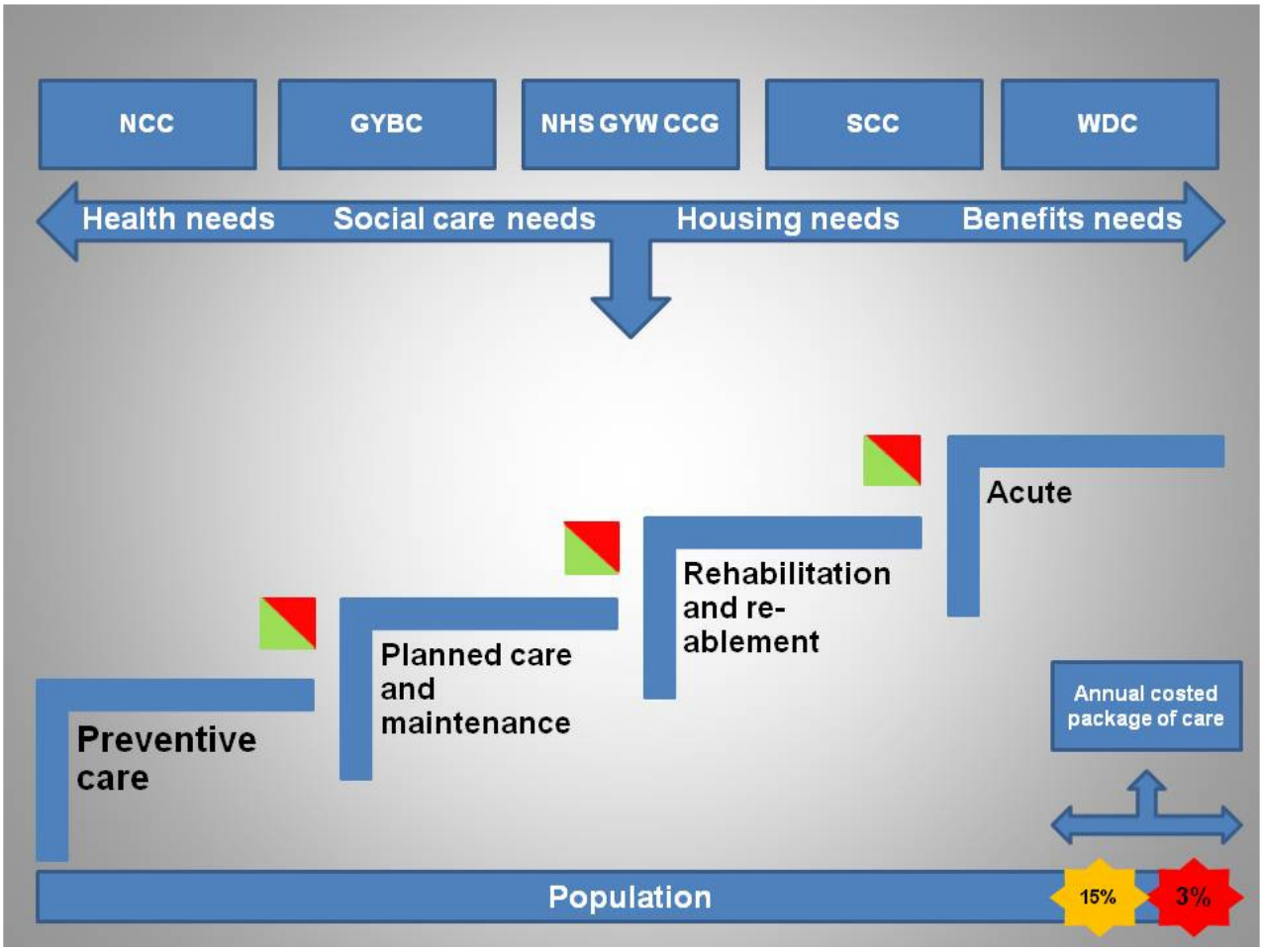
Some of our population will require very focused levels of care, following detailed assessment, in order to fully meet their needs and fully realise the benefits that integrated care can bring.

Figure 2 sets out our ladder of needs approach describing the high risk cohort's needs as a ladder of care, which will be provided by the same integrated team within their community, irrespective of the level of need that the person requires at any one time.

The ladder of needs, which covers health, social care and District Council services, will be used to optimise care for those people at greatest level of risk of requiring unplanned emergency services, and to cost service provision for them. We are calling these costed personalised plans. However, the pathways and disciplines within it will be applicable to our whole population and will be the organising principle for the integrated teams.

Our aim is to move expensive unplanned care to more effective planned and preventative care. The cohort of highest risk patients consists of around 3% of patients at high risk of needing emergency support and heavy users of services, and a further 15% of patients who are moving rapidly to needing the levels of care used by the highest risk 3%. This assumption is subject to further modelling and will be identified using a combination of health and social care utilisation and prescribing data, together with prescriptive risk stratification as appropriate. However, the integrated teams will still offer care to the remainder of our population, which will include a strong emphasis on prevention. For the non high risk cohort, traditional funding models will be used for the time being. This will aid learning around the new funding models for a discrete group of patients, and enable us to adjust if necessary prior to full application once a substantive ICO and funding model have been established.

Figure 2 – our ladder of needs



5. Are we ready to meet the challenge?

Yes we are. One of the key criteria is to demonstrate that we have the capability and expertise to deliver successfully a public sector transformation project at scale and pace. There are major factors already operating within the GYW system to give the judging panel confidence in our ability.
There is a strong relationship between the CCG and the two County Councils with the Norfolk and Suffolk Health and Wellbeing Boards (HWBs). Our overall drive towards delivering care via integrated teams, is in line with the priorities of both HWBs. The HWBs have both given strong support for innovative approaches to integration and are supportive of this bid.
We have providers who predominantly deliver care just to our GYW population (James Paget University Hospital Foundation Trust) and East Coast Community Healthcare (ECCH). We will also work with East of England Ambulance Service Trust, Norfolk and Suffolk Foundation Trust (for mental health services) and Integrated Care 24, (the provider of our successful 111 service). This relatively 'ring fenced' care provides a spring board for our community approach, as all our locally based providers naturally identify with the communities in which they are based, and have a good understanding of the differing needs and approaches within those communities. For example, the focus of communities in deprived urban parts of our patch tend to be different from the values of rural communities spread over wider areas, with a range of affluence and rural deprivation.

We are very pleased to be involved in 'Lowestoft Rising' a strong developmental integration initiative which is sponsored by Suffolk County Council. This is working on all the determinants of how we improve the experiences of the population in Lowestoft, and will include its learning and outputs in our development of the ICO. Lowestoft Rising features in a Pioneer expression of interest being put forward within Suffolk, which is a trailblazer enabling a 'lifespan' approach to generating quality, innovation and improvement. Our two expressions of interest have strong synergies with each other and we whole-heartedly support the Suffolk bid, which has Lowestoft Rising as a central theme.

GYW has long been recognised as a discrete health system with a strong sense of community. In the 2006 'Shifting the Balance of Power' NHS reforms, there was such strong local support for the GYW area that Great Yarmouth and Waveney Primary Care Trust (PCT) was created, despite crossing a county boundary. Great Yarmouth and Waveney Clinical Commissioning Group (known locally as HealthEast) occupies the same footprint as the PCT, as the same rationale for preserving the locality remains intact and gives the benefit of shared learning from the past and continuity.

Great Yarmouth (Norfolk) and Lowestoft (Suffolk) are towns that have more in common with each other, with declining fishing industries and significant deprivation, rather than with the characteristics of their respective counties. The two towns have a history of closely-knit working together, and are only about ten minutes travel time apart from each other.

6. Working for and within our communities

GYW has four distinct communities within its borders, each with different characteristics and needs. These are Great Yarmouth (Norfolk), Gorleston (Norfolk), Lowestoft (Suffolk), and South Waveney (Suffolk).

We are already working closely with each community to encourage them to lead the design of local services that meet their needs – for example allowing for rural isolation, urban poverty, areas with low car ownership etc. Part of this approach, exemplified by the work we have carried out within South Waveney, is to help communities 'live within' equitable distribution of resources, so that one community does not benefit to the detriment of another. This exercise around equitable distribution of resources has already been started by our work on encouraging democratisation and responsibility amongst the member practices of the CCG, and our move towards practice based weighted capitation budgets. It also links closely to other work being carried out by partner agencies to support these communities.

We are very conscious of the unpaid contributions from families and other members of the community, plus the invaluable contribution of our voluntary sector. We will build on the ladder of needs approach, especially in terms on ongoing maintenance and support of patients, so that we can draw in unpaid contributions, but provide essential support and advice to communities.

Our 27 GP practices are key members of our communities, and are a well used and well respected source of help. As indicated earlier, GPs will have an in-reach and outreach role to play in the integrated teams, even though funding streams are separate. We will make sure there is strong communication with GPs about the opportunities within the ladder of needs, so all patients are aware of and able to access services.

GYW has a well advanced carers strategy. This will enable us to harness the views of those closest to our most needy patients and clients, and to draw the valuable unpaid contribution of these carers into our integrated system.

The District Council input is highly relevant to improving the health and wellbeing of our communities. Complex problems of social disadvantage have a fundamental impact on health outcomes and we therefore need to maximise the full range of financial and social support services provided at district level. This will also be essential with the new Welfare Reform changes and to maximise the effect of prevention initiatives.

We are building a new Integrated Centre in a deprived locality within Lowestoft and are engaged in a full public consultation about the future configuration of services in Lowestoft. Our drive towards integration is the underpinning theme of this consultation. Additionally, we hope to build a second phase, which will operate as a health and wellbeing centre for the people of Lowestoft. We have other strong examples of community engagement, such as

our community advocates scheme in Gorleston, now led by Voluntary Norfolk, which has achieved national recognition and is already being rolled out to other areas. The community advocates will have a natural role in the ladder of needs, with their ability to signpost services, and offer informal support.

7. Making the most of our resources and improving quality

Both the NHS and local authorities have major financial challenges, in line with all the others in England. GYW CCG has delivered on QIPP targets year on year, but savings are becoming more difficult to make now that the 'easy wins' transactional savings have been made. Both Norfolk and Suffolk County Councils also have major financial challenges.

The ICO will be commissioned on a macro level by the five commissioners involved. We envisage that this will mean that much of the service transformational work currently carried out by commissioners will transfer into the ICO, who will be responsible for micro- level commissioning. We will build any additional resources for integration into this work through pooling funding into our work.

We plan to determine a 'scale of needs' for each high risk person and cost the personalised plan accordingly. This will include clients in receipt of Continuing Healthcare packages. The scale of needs would have a number of different levels of need, assessed according to the level of input a person might have, in terms of levels of contact with the integrated teams, amount of preventative care they need, amount of planned care, and an estimation of any unavoidable emergency activity. This option will be fully personalised, with great flexibility and is already used in social care settings. The Resource Allocation System currently used by NCC and SCC will be utilised, which can either contribute towards a Personal Health Budget (PHB), or 'Individual Service Funds'. This is a model that could be an alternative to PHBs, where the ICO could offer this package, which might be more cost effective than PHBs. In time, it may be possible to adopt the national assessment and classification system to group people according to their needs and to adopt a common currency of need (as referenced in DH publication *QIPP Long Term Conditions).*

As a later stage of development, we would look to include the wider social care prevention services for clients at less high levels of risk. We will also explore how we fully engage with public health prevention initiatives.

Performance will be assessed by measuring a set of outcomes (linked to the 'Making It Real' narrative) using the outcomes and measures model set out on page 13 of *QIPP Long Term Conditions.* We plan to work with the University of East Anglia to develop a meaningful set of qualitative and quantitative outcome indicators, but we envisage that they will include reduction in admissions to residential and nursing care, and whether personalisation is really making a difference (informed by 'Making it Real' user led organisations).

8. How the Op Co/ICO will work in practice

We will take an evolutionary approach to the ICO model. The paramount principle is to build on work to date in changing cultures and behaviours, with structural change only taking place once we have cultural acceptance of integration. We will work towards creating a suitable operating environment to manage staff and financial resource on behalf of the commissioners and partner organisations. We will model the financial impact of this during 2013/14. During 2014/15, we will operate a virtual ICO in terms of combining budgets and staff teams with a single management, which may be referred to as the 'Op Co'. We will combine budgets to the maximum possible benefit for our community, but plan to move away from traditional pooled budget methods. We would appreciate assistance in working out new approaches. We will operate a pure block contract for people at high risk of requiring unplanned health or social care, in respect of non elective care and some elements of elective care. This has been informed by learning from a King's Fund led study of the

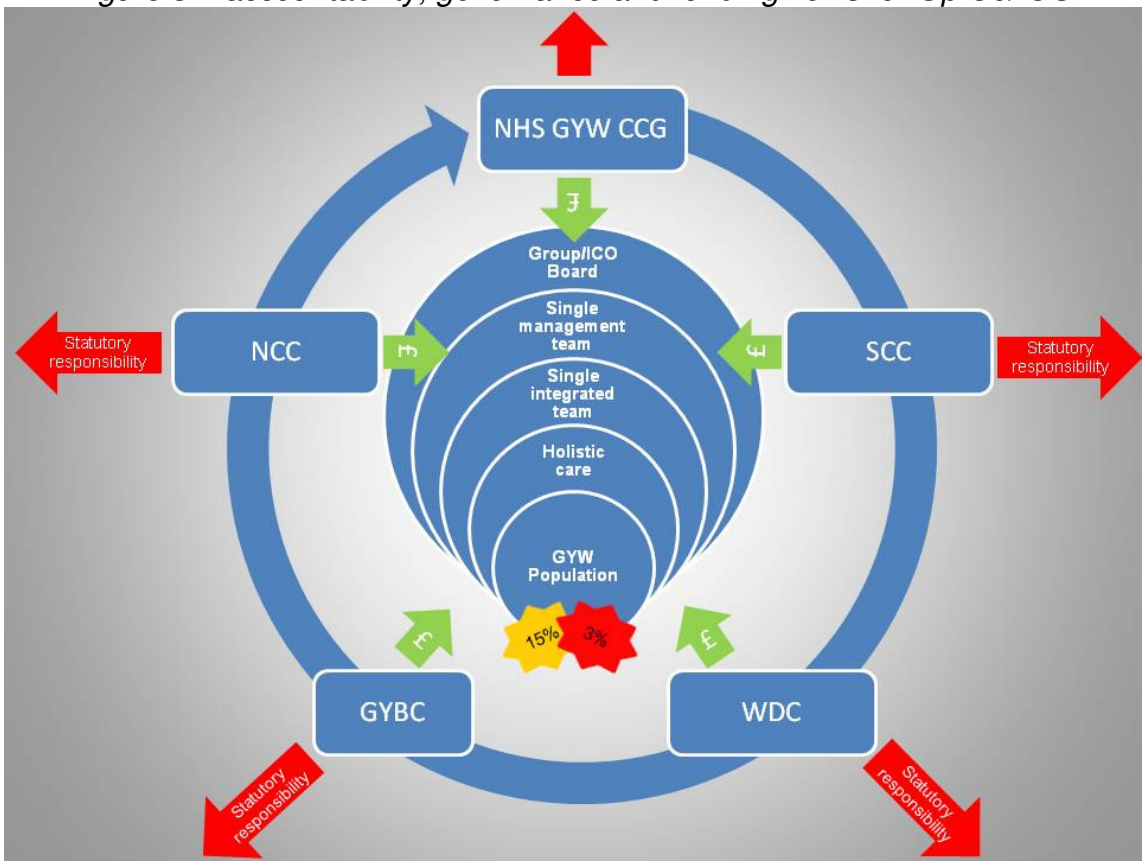
Massachusetts 'Alternative Quality Contract' model. We will move away from Payment by Results tariff for this cohort. There will be clear quality targets and outcomes specified by the commissioners. Locality outcome based commissioning of social care services will work with local care providers to ensure that they are enabled to work in a different relationship with the ICO, maximising their contribution to the integrated approach.

The second stage will be to set up a substantive ICO during 2015/16. Services provided by the ICO will continue to be commissioned by the three health and social care commissioners. Whilst we aim to establish the ICO in 2015/16, we see this as a five year programme of work to engender the necessary person-centred and cultural change.

There will be very significant preparatory work to be carried out to produce change management and implementation plans. Pending the formation of the formal governance structures around the Op Co, we will use our GYW System Leadership Partnership as the senior forum having oversight of progress.

Figure 3 shows the relationships between the commissioners, the funding flows, the high level structure of the ICO and the governance arrangements. This will be replicated, as far as possible, during the Op Co initial phase, although during that time governance arrangements will need to respect the sovereignty of the individual provider organisations, before they move into a fully established ICO.

Figure 3 – accountability, governance and funding flows for Op Co/ICO



9. Workforce implications

There will be wide ranging workforce implications of integration and to this end we have invested in dedicated senior level HR/OD support. We have substantial experience in working together with our partners in system wide workforce strategy and development. We will continue to build on these positive working relationships to build on the opportunities that integration will bring.

We are critically aware that successful integration will depend on how well the organisational implications are examined and remodelled and how far staff are helped to engage, understand and adapt to them. We recognise the many benefits that integration will bring as highlighted throughout, and we will provide opportunities for our staff to be involved and have input in the decisions that affect them. We will also work hard to understand how cultural

barriers to integration resulting from separate methods of professional training, various management styles differing political environments, working arrangements etc can be anticipated. Harmonisation of terms and conditions is another area that will require further investigation and debate with our partners. A major initiative such as the ICO will call for a continuous dialogue not only with our partners but with all of our staff and unions and we will work hard to build on our positive staff and union relationships to deliver this.

10. Harnessing the evidence and academic input

We welcome the clear national drive towards integration, with the evidence supporting it. GYW has been working on the concept of an ICO for a number of years, with an inaugural conference in June 2010, chaired by Professor Chris Ham from the King's Fund. Professor Ham also advised our System Leadership Partnership during its initial months.

The Chief Executive and Clinical Transformation Director from the CCG, together with the Medical Director of JPUH have visited Kaiser Permanante in the USA, and came back inspired by the visit. The learning from this visit has continued to focus our drive towards the ICO model, with a realisation that a vertical integration approach, as proposed within our model, will best meet the needs of our communities.

We plan to work with the University of East Anglia, so UEA can provide academic validation and support in developing new roles, and also to assist us with a short but meaningful set of outcome measures. Additionally, we already have the benefit of some funded support from the King's Fund in working towards cultural change.

We also need to maximise the benefits of digital health. To this end, the CCG's Accountable Officer and Chair (who is a practising GP) are taking part in the 'Making Connections' transatlantic exchange to support the adoption of digital health.

11. Support from partners

We have engaged in an extensive series of discussions with all our partners and stakeholders around the principles of this expression of interest and have received whole-hearted support. We believe that this exemplifies the levels of trust and commitment in GYW, to all working together for the benefit of our population.

12. Conclusion

We hope that the panel will find this expression of interest meets the overarching aim of the call for Pioneer applications, and that our application has demonstrated individualised and personalised care, a radical ambition to move away from traditional commissioning and provider models, changing funding flows and an ability to move at scale and pace. We have more work to do to fully work through the implications of our proposed model and would welcome the support available if we become a Pioneer. We are of course keen to learn from others and to share our learning as we progress with our radical change.

Schedule of partners and stakeholders who support our Pioneer application

Cllr Mark Bee, Leader of Suffolk County Council	Director of Public Health, Norfolk County Council
Peter Aldous, MP	Director of Public Health, Suffolk County Council
Brandon Lewis, MP	Chair of GYW Patient Participation Group Forum
Chief Executives of HealthWatch Norfolk and Suffolk	Voluntary Suffolk and Voluntary Norfolk
NHS East of England Area Team	NHS GYW CCG Council of Members
East of England Ambulance Service NHS Trust	Professor Ian Harvey, UEA
James Paget University Hospitals NHS FT	East Coast Community Healthcare

North Norfolk: A Health & Social Care Integration 'Pioneer'

North Norfolk – A Health & Social Care Integration Pioneer

As a resident of North Norfolk
I am supported to understand and manage:

My Health,

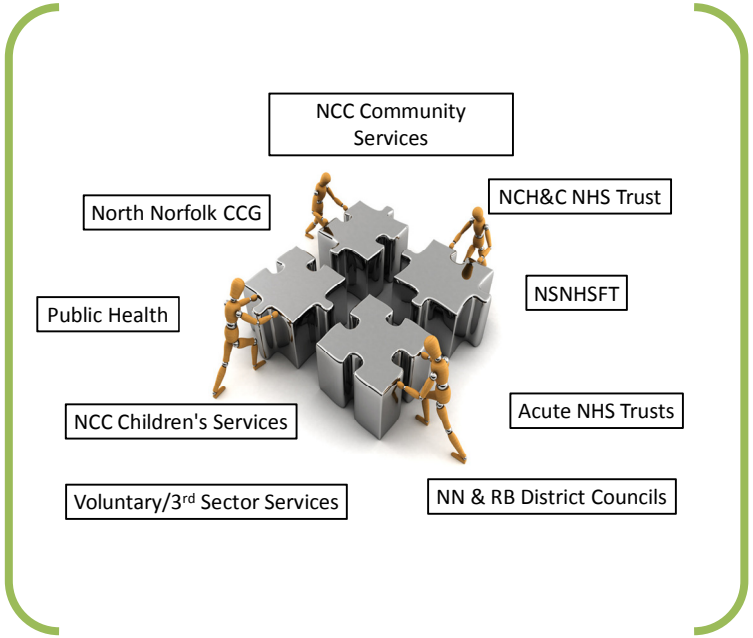
My Care,

My Life,

My Way

A Partnership Approach to Integration:

The expression of interest for North Norfolk to become a Health and Social Care Integration Pioneer is joint application between North Norfolk Clinical Commissioning Group (NNCCG) and Norfolk County Council – Community Services and has been developed as part of the integrated commissioning arrangements that exist between the two organisations. It is additionally supported through existing integrated operational and commissioning programmes of work delivered by the following internal and external partners who are committed to our approach:



Norfolk County Council – Social Care Team (Northern Locality)
Norfolk Community Care & Health NHS Trust (Northern Locality)
Norfolk & Suffolk NHS Foundation Trust
Norfolk County Council – Children's Services
Norfolk County Council - Public Health Team
North Norfolk District Council
Broadland District Council

Key challenges emerging from population demography and epidemiology:

North Norfolk has a population of 167,800 and covers 45 miles of coastline, with 20 General Practices covering the boundaries of North Norfolk and Rural Broadland District Councils. Its unique demographic profile provides challenges in enabling the health, wellbeing and independence of its citizens which can be resolved through integrated solutions in health, social care and housing related support services delivered by key public sector partners.

The 3 key challenges which integrated care and support can address in North Norfolk are:

1. Reducing the health inequalities within the population - whilst North Norfolk covers a population which enjoys relatively good health, the district level population data mask variation at lower super output level

2. Supporting a larger than average ageing population and the percentage of older people with one or more long term conditions, such as diabetes, chronic obstructive pulmonary disease (COPD) and dementia
3. Enabling access to treatment and care in a predominantly rural area, with no major conurbation.

A North Norfolk Vision for Integrated Care and Support:

As a resident of North Norfolk I am supported to understand and manage;
My Health, My Care, My Life, My Way.

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

We see the whole population of North Norfolk, but especially older people and those with long term conditions, having access to a fully integrated primary and community health and social care service, with seamless access to community and specialist care and support when required, that is delivered with compassion and dignity. The following are our key ambitions for integration:

- Fully integrated health and social care delivery teams which fully support the 20 General Practices
- Care and Support services being arranged around patients' GP surgeries with access to a wide range of integrated health, independence and wellbeing related support.
- A single assessment process across health and social care
- Identified key workers who understand individual patient's social as well as medical contexts
- Greater and seamless local access to services with an emphasis on support and information that enables individual self care & management
- Services which are simple to use and can be "switched on" via a single call and assessment by multiple partners
- A universal expectation that all services delivered at or close to home will be delivered with respect, compassion and a personalised approach to care.

An enabler of this vision is the partnership between Norfolk County Council and 'Equal Lives' (a voluntary sector partner), who are signed up to the delivery of *Making it Real (MiR)* in Norfolk, with North Norfolk Health & Social Care leaders committed to driving this forward locally. A reference group has been brought together which includes people with links to community groups, user led organisations and strategic partnerships that have shaped the MiR outcome priorities by which partners will develop their approaches and be monitored against. These priorities are:

- People have individual care and support to live their lives as they wish
- People have access to a pool of people who could support them, advice about how to employ them, and the opportunity to get advice from peers
- People have easy to understand information and support they need in order to remain an independent as possible
- People have opportunities to train, study, work or engage in activities that match their interests, skill and abilities

Platforms for Delivering Integrated Care and Support:

To deliver against our vision for integration we have developed some key platforms, with a breath of partners and key stakeholders, which will provide the foundations upon which we will enable a whole system approach to integration in North Norfolk. These approaches are steered through our 'Integration Board' and are targeted and evidence based, with a robust infrastructure to monitor the impact against key outcomes.

The overarching programme that provides the platforms for our integrated vision is our Integrated Long Term Conditions Programme. The evidence base for which is the QIPP Long Term Conditions programme, a national initiative sponsored by Sir John Oldham. Its aim to deliver a national support and improvement programme enabling local geographic areas to implement evidence based systems for supporting people with LTCs.
We have developed this in North Norfolk to enable coordinated and seamless service provision across Community Health, Mental Health and Social Care. We want people with Long Term Conditions to have effective, timely and high quality integrated care and support interventions which will enable them to be appropriately supported in their own homes and reduce unnecessary hospital admissions.

The programme aim, in its year of implementation (2013/14) is a 6% reduction in emergency admissions for patients with a long term condition against the 12/13 baseline in line with the primary overarching expectation to:

- Reduce Emergency admission for patients with a LTC
- Improve patient experience through self care & self-management
- Embed the principle for people using services of - "No decision about me without me"

This programme of work is intended to directly contribute to Outcome 2 in the NHS *Everyone Counts Outcomes Framework:*

- Enhancing quality of life for people with long term conditions
- Health-related quality of life for people with long-term conditions
- Proportion of people feeling supported to manage their condition
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)

The Five Key Platforms to Integration:

The key platforms that will deliver this programme of work and those that will provide the foundation upon which we will build our infrastructure for enabling whole system health and social care integration are:

1. ***Integrated Risk Stratification:***

Current Position: Predictive Risk Stratification
In consultation with health, social care and mental health professionals we have developed a local Predictive Risk Tool. The tool is designed to identify those patients at an earlier stage in their condition/s to enable preventative, lower cost self-care/self-management interventions to be accessed. The key risk indicators used to identify these people are derived from health (primary care, acute & mental health) and social care data thereby highlighting people who, as a system, we can support to enhance their health, independence and wellbeing, whist preventing the deterioration of their condition and reducing duplication of professional input.

Planned Next Steps: Complex Case Management Risk Stratification
The technical platform for predicatively identifying people also provides us with information on those people who have the most complex needs who are likely to need some level of acute intervention. We are currently looking at this cohort of people as they often have input from multiple health, mental health and social care services. The expectation is that we take a case management approach (already developed) that targets and coordinates support, reduces length of stay in hospital and supports people to live independently for longer, once back at home.

*Integration Pioneer Ambition: Holistic & System Wide Risk Stratificatio*n
Having a clear and targeted approach to supporting different cohorts of people, at the right time, with the most appropriate support within North Norfolk is central to our vision. Therefore ensuring that the information that generates this picture comes from across the whole 'system' of support networks is paramount. To enable this we will look to work further with our other partners within the District Councils, NCC Children's service and our Voluntary Sector Providers, to develop a wider, multi agency, risk profiling approach to holistically identify those people who, with lower level, light touch interventions can maintain their own health, independence and wellbeing.

2. *Integrated Care Teams:*

Fig 1: The Integrated Team Approach

Current Position: Piloting the Approach

We have developed our local Integrated Care Team model with Clinical, Community Nursing, Social Care, and Mental Health leads in North Norfolk who will utilise the stratification data generated by the predictive risk tool. 5 of our 20 practices are currently piloting this approach:

The key principles are:

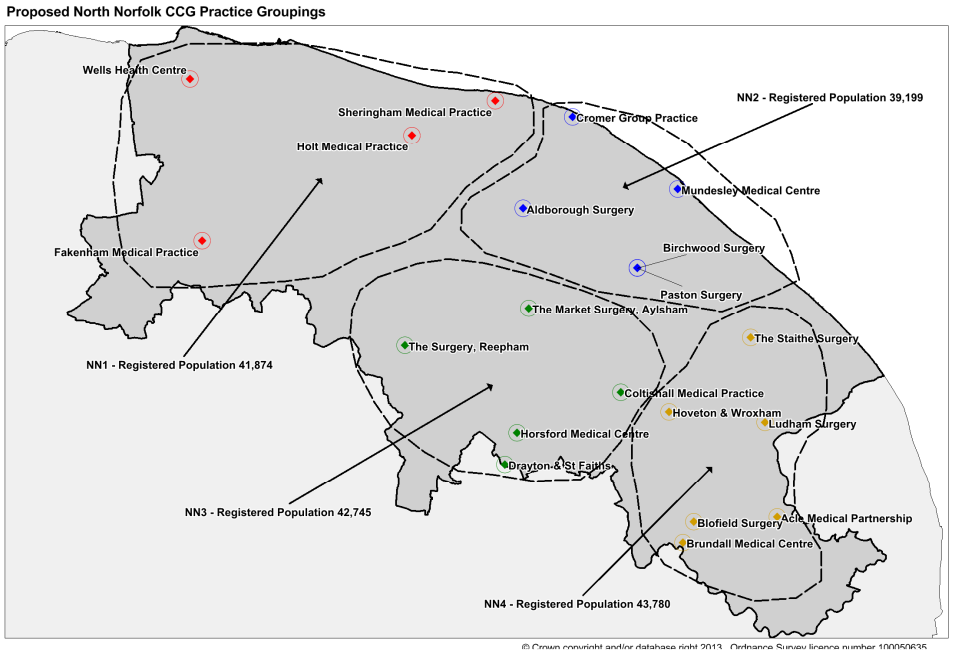
- Each surgery has a named professional from all partners, as part of a MDT approach (see Fig 1), which reviews cohorts of patients identified through the Predictive Risk Tool, or from other key 'risk' groups, such as those on the Gold Standard Framework, to direct and support into the most appropriate service.
- Integrated Care Coordinators are employed to smooth the path to integrated working by enabling the coordination across the partners, accessing records across the system, facilitating the MDT meeting and progressing any resulting actions or referrals.
- The Integrated Teams operate within 4 integrated hubs across North Norfolk providing flexibility and focus within designated geographic areas (See Figure 2).

Next Steps: Full Implementation & Programme Developments

- Full implementation is planned across the 20 practices in September 2013.
- All Practice, Community Health, Social Care and Mental Health leads have signed up to take part in the health coaching programme to facilitate joint professional development and align 'enabling' approaches to care and support across the system.
- Referral pathways to self-care & self-management support options will be finalised and will include, housing, voluntary sector and other health and social care services. It will also bring together other integrated support systems already developed such as local Integrated Housing and Adaptation Teams (with the District Councils) & our Reablement Team.

Fig 2: Integrated Community Hubs:

- We will employ an integrated care coordinator within the Norfolk & Norwich University Hospital, within the Community Liaison Team. They will enable a more responsive join up between the Acute system and our local Integrated Care Teams, facilitating an improved community offer to the individual, thorough intensive case management & reablement thus reducing any delays in discharge and preventing inappropriate hospital re-admission.
- We will develop and implement a programme of work to deliver improved diagnosis of dementia across our Integrated Teams in North Norfolk. This will be achieved by improving access to memory assessments, diagnosis education programmes, targeted screening, assessments and referrals and integrated community support developments.



Integration Pioneer Ambition: Integrating Expert Providers

The 'Help to Live at Home' programme of work Norfolk County Council is developing will radically rethink the role of the voluntary & independent sector in providing interventions that help people to remain independent. Our ambition is to redesign services to enable these provider partners, (such as Domiciliary Care providers) to be a part of our local integrated teams with the ability to provide responsive, assessment and service interventions, independently from our community health and social care teams, which will enable people to stay at home.

3. *Integrated Self-Care & Self-Management:*

Current Position: Developing Alternative Pathways:

The ability to proactively and pre-emptively identify patients with long term conditions (before their condition deteriorates to a point that requires intensive and high cost interventions), requires clear alternative and appropriate lower level provision to be identified.

We are working with partners, committed to our vision for integration, to scope the existing provision that we are currently providing across North Norfolk. We are looking to identify what support options there are, where the gaps are and where the opportunities are for aligning and integrating our approaches to provide seamless and accessible services.

The *North Norfolk and Rural Broadland Strategic Partnership Board*, is the mechanism by which will be managing this approach to local integrated service development and delivery, whist delivering our local health and well-being priorities. The board's membership and strategic aims can be seen below:

North Norfolk and Rural Broadland Strategic Partnership Board

Senior Managers, Commissioners & Representatives:	Strategic Aims
• **Public Health (including Healthy Communities lead)** • **North Norfolk Clinical Commissioning Group** • **Community Services, Adult Social Care - NCC** • **Broadland District Council** • **North Norfolk District Council** • **Children's Services – NCC** • **Mental Health & Drug & Alcohol** • **Probation and Police commissioners**	• Provide strategic oversight to health and wellbeing centred on the NNCCG locality area • Prevent ill health and help people live longer, independent and fulfilled lives • Develop, joined up and aligned services that will positively affect the health and wellbeing of people in North Norfolk • Promote equality by reducing unfair differences in health • Improve the quality, accessibility and integration of health, social care and housing related support services • Deliver efficient and better value services, in partnership where appropriate • Enable individual members to inform, influence, advise and steer their own organisations

Next Steps: Creating a Comprehensive Self-Care & Self Management Offer

We have carried out a stakeholder event that has helped us to identify 3 key areas to align and develop service offers that are reflective of the support either directly provided or commissioned within our Strategic Partnership: The following table highlights these areas and some examples of the associated care and support options.

1. **Education and Support Services**	2. **Telecare and coaching**	3. **Patient Activation – (Patients empowered to manage their care)**
• patient and carer education programmes • medicines management advice and support • advice, advocacy & support services e.g. about diet and exercise	• use of telecare and telehealth to aid remote self-monitoring • psychological interventions (e.g., coaching) • telephone-based health coaching	• systematic training for health and social care professionals in consultation skills that help engage patients. • pain management • people with full access & ownership to their patient/care plan/support plan record

To develop this further we are:

- Holding focus groups with key stakeholders and experts to help understand what current practice and evidence based support should be considered within this programme of work.
- Working in our Strategic Partnership to developed and align longer term plans, commissioning decisions and funding arrangements to meet the health and wellbeing requirements in North Norfolk.

Integration Pioneer Ambition: A Whole System Approach to Integrated Commissioning

The need to create efficiencies and reduce duplication of service provision and create a framework of integrated service offers across the health and care system is a fundamental driver. To facilitate this in North Norfolk we aim to develop a holistic integrated commissioning, procurement and funding framework and strategy, between the North Norfolk & Rural Broadland Strategic Partnership, that expressly facilitates our integrated commissioning ambitions.

1. ***Integrated Approaches to Coproduction and Engagement***

Current Position: A Strong Local Commitment and Infrastructure:
Enabling the residents of North Norfolk to understand and manage 'My Health, My Care, My Life, My Way 'is a key ambition. This reflects our commitment to ensure that people who use services and their carers are at the centre of, and have a key role in shaping the services are that are available to them. In addition facilitating choice and control about what, how, when and where people access support is also a fundamental.

Our commitment in North Norfolk to delivering Making it Real priorities, the development and support of local engagement groups for people who use services and their carers, and the coproduction and performance monitoring of services are all approaches that keep people at the centre of our developments.

Next Steps: Developing and Aligning our Approaches:
We will be developing a reference group of people with Long Term Conditions and their Carers to become part of a reference group who can inform developments particularly with regards to self care and self management approaches.
At a broader level the North Norfolk & Rural Broadland Strategic Partnership will also scope the existing groups and mechanisms by which we engage with the public to clarity approaches and develop a consistency of approach.

Integration Pioneer Ambition: A Whole System Coproduction and Engagement Framework:
The proliferation of user and carer engagement groups across all of the partners provides excellent opportunities for engagement and coproduction, however they are often specific to the service or client area and can perpetuate a fragmented view of the services available to meet people's needs. It can also lead to consultation fatigue when multiple partners are engaging with groups on multiple topics at the same time. To help shape an integrated vision

and engage and coproduce across the system we aim to use the expertise within existing groups, HealthWatch and the Making it Real Reference Group to help shape a North Norfolk Engagement & Coproduction Board who can inform all of our joint decision making and developments.

1. ***Integrated Monitoring and Performance Framework:***

Current Position: A Framework in Development:
The current monitoring and performance framework for our integrated approach to managing Long Term Conditions (LTC) uses the number of Emergency Admissions, for people with a LTC, as the key quantative indicator of the impact of the approach. The qualitative indicator uses a

validated patient questionnaire (LTC6) that identifies whether care planning and supported self-care have been operational and effective. The measures indicate changes in knowledge, beliefs and perceptions which are necessary to sustain change over time.
The framework is also in place to monitor the impact of our work to support those who have the most complex needs, particularly when facilitating timely discharges from an acute setting and preventing re-admittance through intensive case management and reablement.
Next Steps: Expanding the Framework:
It is anticipated that the integrated team and self-care/self-management approach will have additional positive implications for the integrated team partners. We are therefore investigating key indicators that could be built into the monitoring and performance framework that will demonstrate the impact on teams and services provided by Community Health providers, Mental Health and Social Care (e.g. the level of residential care admissions).

Integration Pioneer Ambition: A Whole System Monitoring & Performance Dashboard:
Having a robust understanding of the impact, for all stakeholders, of integrated approaches to the commissioning and delivery of care and support will be an important evidence based upon which to develop and base future decisions. We would therefore aim to develop a system wide performance and monitoring dashboard, for those preventative developments that would have impact for multiple partners. This would not only include health, social care, mental health, housing, health and wellbeing outcome indicators, but also reflect any real term financial benefits to the health and social care system to this preventative approach.

North Norfolk – A Health & Social Care Integration Pioneer:

As a Health & Social Care Integration Pioneer, North Norfolk will be provided with the opportunity to develop and share our learning of integration, that has, and will continue to be, grounded on a strong foundation of evidence based good practice. This has been achieved, at scale and pace, through our experience of delivering, for example, the QIPP LTC Programme, Integrated Care Organisations pilot, Making it Real and our Integrated Health & Social Care Commissioning Team.

North Norfolk's 5 *Integration Pioneer Ambitions* outlined in the paper will be the focus upon which we would seek support from national partners and provide learning to the wider system, as summarised below:

1	*2*	*3*	*4*	*5*
Holistic & System Wide Risk Stratification	***Integrating Expert Providers***	***A Whole System Approach to Integrated Commissioning***	***A Whole System Coproduction & Engagement Framework***	***A Whole System Monitoring & Performance Dashboard***

We have a vision and a programme of work that is and will be developed and delivered by committed partners across the North Norfolk health and care system. We also have demographic challenges, in terms of having one highest ageing populations & prevalence of people with one or more

long term conditions, with a high level of rurality, which provides us with a unique opportunity to demonstrate the positive impact of an integrated approach.

As a health and social care system in North Norfolk, there is a need for us to achieve efficiencies in our approaches, deliver value for money and quality services in innovative and radical new ways. This is not an option but a challenge we can meet as an integrated system.

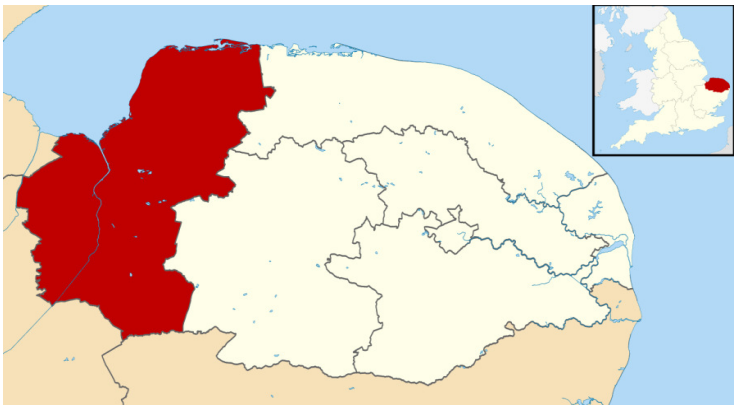
In North Norfolk we have a commitment to keeping people who use services, families and their carers at the centre of and part of all of our developments ensuring we never lose sight of the primary purpose of all of our work and drive for integration, namely;

As a resident of North Norfolk I am supported to understand and manage;
My Health, My Care, My Life, My Way.

Lead Contact Details:
John Everson
Head of Integrated Commissioning - North Norfolk
Community Health and Social Care
North Norfolk CCG & NCC Community Services
1 Mill Close | Cawston Road|Alysham|Norfolk|NR116LZ
Mob: 07825055494
Email Address: j.everson@nhs.net

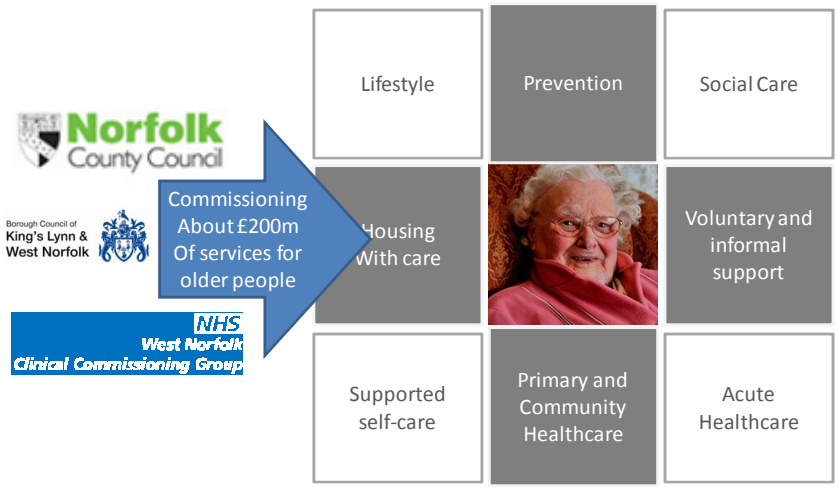
Expression of Interest

Integration Pioneers Network



On behalf of the West Norfolk Health and Social Care Alliance comprising:

- Norfolk County Council Adult Social Services
- Borough Council of King's Lynn and West Norfolk
- West Norfolk Clinical Commissioning Group
- Norfolk Community Health and Care NHS Trust
- Norfolk and Suffolk NHS Foundation Trust (Mental Health)
- The Queen Elizabeth Hospital King's Lynn
- West Norfolk Voluntary and Community Action
- Freebridge Community Housing
- The College of West Anglia
- Norfolk Independent Care



A joint submission of the CCG and Local Authority on behalf of the wider Alliance

Principal Contacts for this expression of interest:

Sue Crossman, West Norfolk CCG sue.crossman@nhs.net 07799 054112

Harold Bodmer, Norfolk County Council harold.bodmer@norfolk.gov.uk 01603 223175

The Problem

In West Norfolk we have a widely-scattered and rapidly ageing population of 150,000 people with pockets of deprivation. We have limited resources to serve them, spread across multiple suppliers in the NHS, social care, local authority and voluntary sectors. Patients and carers have a fragmentary understanding of a fragmented system and the health and care economy depends, to a greater extent than in many urban areas, on the goodwill of volunteers. But the largest problem is the lack of integration and information sharing.

As part of our integrated care pilot, we engaged with local older people and they told us very clearly that they:

- Wanted to tell their story once
- Saw their GP practice as their single point of contact
- Expected us to share information and be co-ordinated
- Weren't concerned which organisation provided which service.

This aligns closely with the National Voices statements. We have compiled this "patient story" – an amalgam of several real-life examples - to show the typical kinds of things which go wrong in our system:

To whom it may concern:

I wanted to share with your CCG the poor experience we have recently had of health and social care in your locality. My wife Ella is 86 years old and suffers from COPD and we live together in a bungalow we own in a rural West Norfolk village. Neither of us drives anymore, due to poor health and I also suffer from diabetes and had a very minor stroke 2 years ago. We are both still physically mobile and able to live independently but obviously we need a considerable amount of health service treatments, which necessitates attending our local GP and also the hospital.

During a recent admission to hospital for treatment for her COPD which had worsened, my wife became quite confused and disorientated and whilst on the ward she was assessed by a therapist who said the result suggests she has dementia and her GP would be informed. Her discharge from hospital was complicated by the fact that she had an infected leg ulcer which needed daily dressings and so a district nurse was booked to call daily. Over the course of the next week we had no less than **9** different people visit her, including a district nurse to do her leg ulcer, a different district nurse to give her an iron injection, a 'DIST' team worker, a carer support volunteer, a lady from the Alzheimer Society, a Social Worker to assess her personal care needs, a community mental health nurse, someone from an agency that fits alarm pressure pads, someone to talk to us about benefits. We found this whole experience utterly exhausting and in between, had to fit in visits to the surgery and a follow-up out-patients appointment in the COPD clinic at the hospital.

I cannot fault the actual care my wife received, however, the lack of any communication or coordination between the myriad of professionals who attended her was appalling. Many of them asked for exactly the same information over and over again, they talked about options we did not understand and offered us things we didn't think we needed. Yet none of them noticed that my wife's physical and mental health was deteriorating. What we actually needed was someone to help my wife with her oxygen as she gets muddled and keeps taking it off and also to give her a wash in the morning but we were not clear at all who to ask for this as we were told we did not qualify for social care. We are still not clear which person does what and who we should contact if we need help.

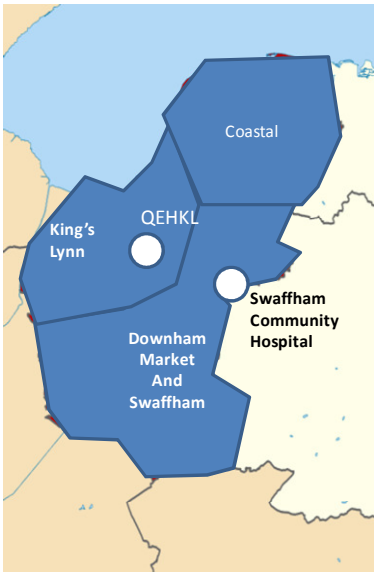
I would urge you to take a hard look at the way these services are provided in your area as this experience has left us both extremely anxious and not sure where to turn next. My wife is currently in a nursing home being treated for cellulitis from the leg ulcer and I am very worried about how I will cope when she comes home.

Yours Sincerely,
Mr Fred Robertson

Existing base of integration

West Norfolk benefited from its engagement as part of the Norfolk Integrated Care Organisation pilot and has continued to build on the framework which this established and to further innovate.

- Norfolk County Council and NHS West Norfolk Clinical Commissioning Group established an integrated commissioning team for community health and care services from the inception of the CCG. This gives us the mechanism for commissioning integration.



- Community health and social care teams now operate from three integrated locality hubs, hold multi-disciplinary team meetings and have an integrated management structure. A number of jointly appointed posts facilitate information sharing and cross-organisational case management.

- Our local housing association is further developing new models of care provision provided by equivalent associations in Holland which they can provide directly for communities .

- We have established our "Prevention First" partnership between the District Council, voluntary organisations, the CCG and County Council to bring together elements commissioned through the partners to create connected and targeted prevention for older people. Our innovative District Council has led the implementation of the first stage of this and West Norfolk Voluntary and Community Action is supporting the establishment of network of a community-based support service underpinned by a local database of needs and resources. The introduction of a structured time banking scheme has already resulted in 750 new volunteers coming forward in the area.

We have a firm foundation to take integrated services to the next level by involving more organisations in a broader Alliance. The system thus has a very strong record of integrated work and is therefore excellently placed to move to an ambitious programme of whole scale integrated working.

The integration pioneer initiative comes at a time when we are ready to take our discrete initiatives to the next level and create a full-scale Health and Social Care Alliance including all provider entities in the area, working under integrated commissioning, with pooled budgets and a common understanding of the empowerment of staff from all agencies to provide the right care at the right time in the right place.

The local goodwill and experience of joint working is there. We have some radical ideas about the empowerment of volunteers and carers but to take this to the next level we need specialist input on some of the knottier problems such as how to re-engineer funding flows and how to safely handle information governance across boundaries. We are passionate about improving the outcomes for service users and their carers and have drafted this "patient story" to encapsulate our aspirations for our new approach:

Moving to a larger scale

Our proposal for the Integration Pioneer Initiative is to move from our existing modest but proven integration to large-scale, whole-system, collaborative change in the whole West Norfolk health and social care system. At the heart of this work is the experience of patients/ citizens and we will ensure that we build in effective feedback and consultation throughout. We are building on a very firm foundation of integrated work and our plan is based on the delivery of an integrated approach in local communities, making maximum use of local voluntary and informal support systems wherever possible. Through our partnerships and our innovative work in prevention we are well placed to strengthen local community initiatives and networks to help people remain independent at home and this is central to our approach.

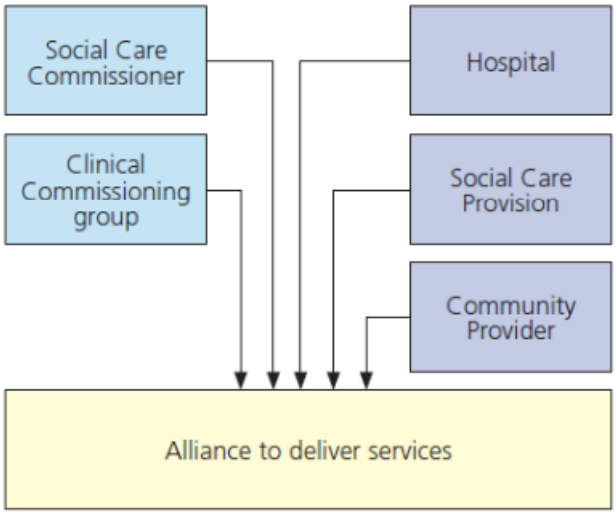


Illustration of the Alliance Contracting Model
Source: Enabling Integrated Care NHS East and Midlands 2013

However, we are aware of the cultural and organisational barriers to change, particularly those that arise from the tension between the duties of commissioners and independent and competitive providers.

We have therefore set up a West Norfolk Health and Social Care Alliance to encompass both groups (membership details can be found in the Appendix) and we now need to look at new contracting models to optimise the relationship between them

One possibility we intend to pursue is the 'alliance contracting' model[1] and the existing local multi-agency safeguarding hub (MASH) concept used successfully in children's safeguarding services. In this model agencies work together to a common set of principles and working practices in a system that ensures ease of communication between practitioners in different organisations.

The main feature of the new model must be that it allows practitioners to use their judgement to make the right decision for patients there and then, instead of handing over to another agency which creates a delay and a repetition of process. We are therefore intent on ensuring that our staff feel empowered to a new way of working.

We have strong engagement from independent care providers to work with us in innovative ways, which will allow them a core role in the integrated team, for example local domiciliary care providers commissioned to an outcomes model, embedded as part of the team, undertaking new responsibilities and commissioned to work in strong alliance with local communities.

This will require new 'permissions' that transcend organisational boundaries and challenge current financial incentives and regulations. We believe this is essential in order to have a really positive impact on patient experience and we would welcome the opportunity to lead the way with this innovative approach, advising the centre about how best to achieve it. We recognise that transformation of this scale will require very significant cultural change and for this reason we have engaged The Kings Fund to undertake whole system work with

[1] Enabling Integrated Care (2013) NHS Midlands and East

practitioners and front line staff from all the partners. We also recognise that this is not a short term piece of work and are all signed up to a five year change programme.

Clearly the recent announcement of new funding to jointly commission social care to support health services strongly aligns with this approach where existing integrated commissioning arrangements are geared to transcend the traditional silos.

Dear Sue,
I would like to commend the local 'Health and Social Care Alliance' in West Norfolk and share with you the experience of my wife Ella and I.

My wife has chronic COPD and is usually well supported by her GP and community matron. However, recently she had to be admitted to hospital for an operation and during her admission her COPD got much worse so we were quite worried about what extra care she might need once she came home again. Whilst in hospital, my wife was visited by a community key worker who did a full assessment of what she would need once discharged home. This included a practical assessment of how much assistance she might need to wash and dress, take her medication and enjoy social activities. The key worker also asked how I would manage looking after my wife and whether it would be helpful to have early contact with a carer to give me some help. She explained that we would not qualify for Social Services support due to our level of income but provided us with a choice of local reputable agencies that she could help us to contact. Before Ella was discharged, the key worker completed an attendance allowance application, arranged installation of grab rails in the bathroom and made contact with our GP and the community matron who would be looking after Ella once home. This meant that the community matron was able to ensure that an oxygen supply was set up for us and a revised self-management plan was agreed for Ella's COPD care, with a follow-up appointment in the community COPD clinic a week later in the GP surgery.

The community matron visited daily for the first week to do Ella's dressings, injections and check her inhaler techniques and oxygen. Now that Ella's condition has stabilised again, the community matron no longer visits but we know what symptoms to watch out for and can ring her at any time if we are worried. We had a slight set-back recently when Ella developed cellulitis in her leg at a weekend, but I rang 111 and the doctor visited us at home, knew all about my wife and admitted her to a community bed for 2 days while intravenous antibiotics were set up and she then had the remaining doses at home. I had assumed she would have to go into hospital so imagine my delight, and hers, when she was able to stay in the community. Given our circumstances I was relieved that we were given a night sitter for that first night back at home, when we were still anxious about her condition. The next morning, she had an urgent appointment to see the geriatrician in the community and she assured us both that the condition could be continued to be managed at home.
The key worker continues to visit once a fortnight to check how we are coping. Last week she arranged for us to meet with a local care agency to discuss how to begin a bit of extra help changing the beds and helping Ella to bathe. Ella has been getting more confused and forgetful lately and the key worker was able to provide us with really practical advice about how to manage that, what to expect and reassured us that she will arrange help from the mental health team when we feel we will need it. She also gave us literature from the Alzheimer Society and local carer support volunteers who can provide more help when we need it.
The help we have received from both the matron and the key worker has made us feel confident and safe because we will not have to worry about how to find information on things and who to ring. Although the help we need comes from a range of different places, the fact that our key worker knows how to put it all together for us makes our life so much easier and this makes us more relaxed and able to enjoy each other's company.
Yours Sincerely
Fred Robertson

The Principles

Partners within the system will work to the following principles:

- Patient / citizen voice is central to the partnership through local steering groups made up of older people's organisations/ forums.
- Promotion of independence, choice and quality of life for individuals is central of all of our work.
- We are all committed at the highest level to the removal of barriers that stand in the way of achieving our objectives.

- Our aim is to support informal/ voluntary care systems in local communities wherever possible
- People have one care plan and we share information safely so that they don't have to navigate their way through our services. This will be a major focus of our activities in order to achieve a system which satisfies the service user and carer expectations set out in National Voices and locally
- People have easy access to their key professional
- We never duplicate services and professional input/ contact with individuals
- We have maximum flexibility about roles and organisational boundaries. For example volunteers and home care staff will be trained to set up simple care packages without recourse to complex assessment and cross referral processes.
- Our services are accessible where people are and linked into primary care in local communities
- Data will be shared appropriately across the partner agencies to ensure safe delivery of services.
- We will ensure that budgets can be pooled or transferred to ensure that they follow patients' needs. The recent announcement about pooling of budgets will support this.

Illustration of the information sharing issues based on National Voices patient narratives

How will we make this happen?

We have identified and are implementing elements which are essential to achieving this change:

- We have achieved sign up at senior level through the partner organisations (as listed in Appendix) and commitment to a five year programme to develop a very different way of working
- We will implement new approaches to commissioning of both NHS and Social Care services, based on outcomes and incentivising an enabling and preventative approaches. For example, we are developing outcome based commissioning of home care on a locality basis, based on a flexible use of home care to keep people independent and engaged with their local community assets
- Local integrated teams which are already linked to primary care will be extended and will include not only community health care and social care staff, but also housing officers, private sector homecare providers and key voluntary sector colleagues. Maximum flexibility between roles is key and assumptions about traditional professional roles will be challenged. For example home care providers who may have most knowledge of an older person with significant care needs will be able to play a key part in assessment or undertake the assessment in total, thus avoiding duplication.

- We will target a change in funding based on reducing the number of inappropriate admissions to the Acute Hospital and significantly speeding up discharge. Over time this will result in a radical re-design of health and social care services in West Norfolk.

- We will ensure that this approach is underpinned by personalisation of health and social care and builds on Norfolk County Council's strong track record of innovating through personal budgets.

- We have strong commitment from independent sector social care providers who see transforming their role as key to this transformation. We will generate new partnerships between independent providers and both local communities and statutory services.

- We are committed to creating fresh approaches to professional roles and blurring the boundaries between paid staff members and volunteers.

- We will need clear processes and some radical innovation around data sharing and confidentiality, and the technical systems in place to support this. In this regard we are exploring the use of smart-card systems for identity, consented data sharing and transaction logging and have local smart card innovations we can work with.

- We are committed to a very different approach to whole sector partnership, seeing the private care sector, the social housing sector and the voluntary sector as essential core members of the multi-disciplinary team.

- Managing the local resources in a radically different way will be a consequence and enabler. Pooling of local budgets is central to this approach.

Next Steps

Having created the West Norfolk Health and Care Alliance we will build on existing elements of integrated services noted above to move towards a full Alliance Contracting model.

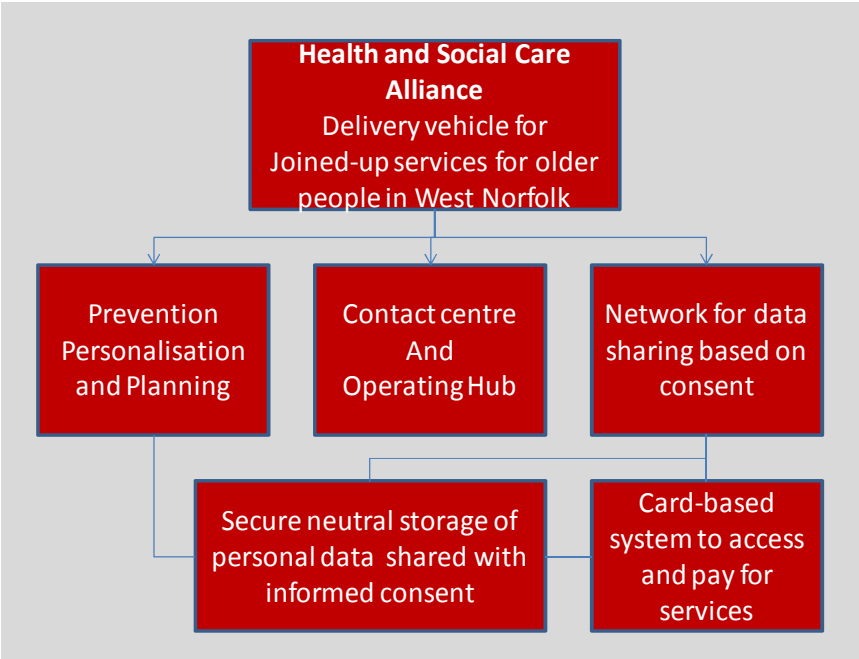
Illustration of the care planning issues based on National Voices patient narratives

If we are chosen to become an integration pioneer we will focus immediately on our largest challenge, which will be to deliver the seamless working which patients and carers have articulated in National Voices, particularly around care planning, supported self-care and personal budgets.

Our model of an Alliance Contracting vehicle will require significant work on the systems and shared rules which will underlie joint working between staff of multiple organisations.

We will draw on both local expertise in systems and information management and will want to use the management support which can be provided by the Integration Pioneer Network

We envisage that the end result of the programme will be to have a formally constituted alliance contracting vehicle underpinned by excellent systems for appropriate data sharing as illustrated here:



The Norfolk Health and Wellbeing Board, which strongly supports innovative approaches to integration, is aware of this bid which aligns with current strategy. The Board will be giving this pioneer bid full consideration at its meeting on 10th July.

Resources sought
In terms of the resources offered by the Integration Pioneers network we would anticipate the following:

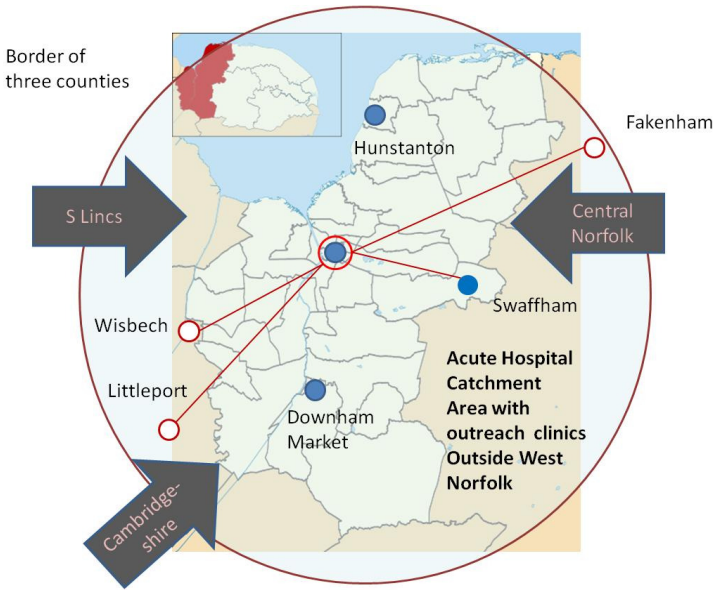
Changing the strategic/executive level culture	We are already working with the King's Fund on front line staff development and will ensure shared learning from this initiative into the Alliance.
Developing local payment systems	We would like to explore some radical new ways of handling health and care transactions using personal smart-cards, possibly based on the older person's Bus Pass or similar cards. We can call upon local expertise in this area but we would like to take advantage of national expertise in this area
Understanding the framework of rules on choice, competition and procurement	We would like to avoid our Alliance becoming a closed cartel and would like advice on how to establish a truly open alliance which can include private sector, voluntary sector and public sector staff
Workforce flexibility	We do envisage needing employment law advice as we develop the Alliance especially in support of the development of shared roles and role flexibility.
Public and professional opinion and engagement	We have a strong tradition of public and patient engagement in West Norfolk and do not anticipate needing help with this aspect.

Analysis and evidence	We intend to work with the University of East Anglia, one of the leading universities in the country for Health Economics expertise

Why West Norfolk?

West Norfolk is a distinct healthcare economy and system with a single Clinical Commissioning Group coterminous with Kings Lynn Borough Council.

At its centre is The Queen Elizabeth Hospital, King's Lynn, which serves the West Norfolk CCG area and some populations from neighbouring Cambridgeshire, Lincolnshire and Central Norfolk.



This overlap with other CCG areas will allow the possibility to compare the outcomes and patient satisfaction of services delivered using our new model (in West Norfolk) and those outside our Alliance (in North Cambridgeshire and South Lincolnshire before moving to more complete integration across borders.

The West Norfolk area has a number of specific challenges which inhibit the delivery of high quality service in the absence of integration which this project seeks to address, including:

- Coastal and Urban Deprivation
- Limited choice of/access to services
- Voluntary services stretched
- High levels of disability
- Rapidly increasing age profile
- Rural isolation, fuel and transport poverty
- Insufficient information about services available to older people who are often fearful of change.

Summary:
West Norfolk is a discrete health and care system set in a community which is dispersed and has significant areas of deprivation. We have benefited from our participation in the Integrated Care Organisation pilot and our continuing development of local integrated health and care commissioning and community provision.

We are now ambitious to work in a radically different framework and have established a model where District Council, voluntary and independent sector providers are now seen as crucial partners. We will connect older people with their communities, their specialist health and care services and their local care providers in a radically new way. This model will ensure that practitioners drive what's right for patients using new permissions, transcending organisational boundaries, challenging the current financial incentives and assumptions. It will release the innovation to transform the outcomes for people in West Norfolk.

Appendix:

West Norfolk Health and Social Care Alliance – member details

Sue Crossman, Chief Officer,
West Norfolk CCG
King's Court, Chapel Street,
King's Lynn, PE30 1EX
Tel: 01553 666901
Mob: 07799 054112
Sue.crossman@nhs.net

Harold Bodmer, Director of Community Services
Norfolk County Council
Room 608, County Hall
Martineau Lane
Norwich, NR1 2SQ
Tel: 01603 223175
Harold.bodmer@norfolk.gov.uk

Ray Harding, Chief Executive
Borough Council of King's Lynn and West Norfolk
Kings Court, Chapel Street
King's Lynn, PE30 1EX
Tel: 01553 616245
Ray.harding@west-norfolk.gov.uk

Heather Farley, Chief Executive
West Norfolk Voluntary and Community Action
2 Regis Place, Bergen Way,
King's Lynn, PE30 2JN
Tel: 01553 760568
heather@westnorfolkvca.org

Patricia Wright, Chief Executive
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust,
Gayton Road,
King's Lynn, PE30 4ET
Tel: 01553 613613
Patricia.wright@qehkl.nhs.uk

Michael Scott, Chief Executive
Norfolk Community Health and Care NHS Trust
Elliot House, 130 Ber Street,
Norwich,
Norfolk, NR1 3FR
Tel: 01603 697300
Michael.scott@nchc.nhs.uk

Dennis Bacon
Chair Norfolk Independent care
Progress House, Plantation Park
Blofield
Norwich NR13 4PL
Tel: 01603 712250
Tony Hall, Chief Executive
Freebridge Community Housing
Juniper House, Austin Street,
Kings Lynn, PE30 1DZ
Tel: 03332 404 444
Tony.hall@freebridge.org.uk

Aidan Thomas, Chief Executive
Norfolk and Suffolk NHS Foundation Trust
Hellesdon Hospital
Drayton High Road
Norwich NR6 5BE
Tel: 01603 421421
aidan.thomas@nsft.nhs.uk

David Pomfret, Principal
The College of West Anglia
Tennyson Ave
Kings Lynn, PE30 2QW
dpomfret@col-westanglia.ac.uk

Report to Norfolk Health and Wellbeing Board
10 July 2013
Item 11

Accountability framework – outline of performance and quality measures

Cover Sheet

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

- The Board needs to decide if the proposed principles, scope and approach will enable it to both drive and evaluate progress in achieving its statutory responsibilities and its strategic priorities.

Key questions for discussion

1. Are the proposed principles right?
2. Is the scope too narrow or too wide?
3. Is the approach to the accountability framework proportionate?

Actions/Decisions needed

- The Board needs to agree or amend the proposed principles, scope and approach.

Report to Norfolk Health and Wellbeing Board
10 July 2013
Item 11

Accountability framework – outline of performance and quality measures

Report of Head of Planning, Performance and Partnerships

Summary
This paper draws together thinking on possible means for the performance monitoring of the work of the Health and Wellbeing Board over the next three years. The key points from workshops and other meetings are highlighted and a proposed approach is set out. The specification of a performance monitoring framework for the JHWS 2014/17 will be dependent upon the priorities identified as well as the underlying principles and assumptions. Therefore, this report needs to be read in conjunction with those on the approaches to the development of the JSNA and the JHWS.

Action
The H&WB is asked to review and comment on the content of the report, specifically the recommendation:

To adopt a performance monitoring framework that is light touch and yet able to provide a good understanding of how the Board is functioning, what impact it is having on the health and wellbeing of the people of Norfolk, what progress it is making with the implementation of a JHWS 2014/17, and a sense of emergent issues around the safety of services commissioned and provided in the health and social care system. This would include:

1. An annual appraisal process of how the Board works using a series of structured questions, similar to those in the LGA tool
2. Monitoring either one or a set of global indicator(s) of the health and wellbeing of the people of Norfolk
3. A light touch way of reporting on progress against the strategy priorities for 13/14 and 14/17, using qualitative and quantitative data
4. A regular slot on the agenda of the Board to enable key issues from the Quality Surveillance Networks to be shared.

1. Background

1.1 At the last meeting of the shadow Health and Wellbeing Board on 17 April 2013, Board members agreed that a piece of work be undertaken to “to determine what performance and quality measures could be used by the HWB to monitor both performance in key areas of health and wellbeing and the work of the Board itself”.

1.2 In response to this request, a workshop was held on 5 June 2013 which was attended by 18 representatives of the Health and Wellbeing Board, either Board members or people delegated to attend on their behalf (see Appendix 1). The key issues arising from these facilitated discussions (see Appendix 2) informed the first draft of this report, which was then further validated by a subsequent small working group on 19 June 2013.

2. Statutory responsibilities

2.1 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 (JSNA), including a Pharmaceutical Needs Assessment (PNA) and Joint Health and Wellbeing Strategy (JHWS)
- 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 Joint 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 the JHWS.

2.2 These then inform what type of measures that the Board will need to have in place as a minimum. The Board will need to be able to:

- demonstrate progress with integration
- assess the commitment of the CCGs to deliver key aspects of the JHWS
- assess the role that the CCGs have played in the development of both the JHWS and the JSNA

3. H&WB Operating Framework

3.1 At the July 2012 meeting of the shadow Health and Wellbeing Board, an Operating Framework for the Board was agreed that included accountability. The relevant section from the report is appended to this report, Appendix 3. It clearly states a number of approaches to accountability, as summarised below:

- Collective and shared responsibility – to maintain a strategic overview of the health and social care 'system', and hold each other to account for joint agreed actions
- 'Soft' account ability - that emerges from mechanisms of shared culture, common purpose and trust
- Local accountability – to the people of Norfolk, partly through the democratic process.
- Service user voice - local healthwatch playing a key role in articulating the concerns and views of patients, service users and the wider population.

4. Workshop on accountability

4.1 The high level summary of key points from the workshop that was held on 5 June 2013 is appended to this document. What follows is a pulling together of these key points to determine the approach to and scope of performance monitoring by the Board.

Working assumptions

4.2 **Proportionality** – ensure that any reporting is proportionate, draws on the existing regulatory and performance reporting regimes and does not create an unnecessary additional burden. Performance monitoring is, therefore, to be undertaken upon the basis of a minimum data set that is required to enable the Board to understand its impact and react to any concerns.

4.3 **Transparency** - evidence that the work of the Board is making a tangible difference in such a way that it is easy for people to understand and so provide a means for holding the Board to account.

4.4 **Clarity** – simply and clearly articulate what it is that the Board is trying to do, by when, whether it is succeeding and what the impact is.

4.5 **Emphasis on areas of shared responsibility** – the Board is a collective that by coming together add value to what could otherwise be achieved when working in isolation. This collective or network has a shared responsibility to identify key health and wellbeing issues that need to be resolved, to respond to them and then be held responsible for the work that has been done.

4.6 **Experiential data and intelligence** – use a range of sources to enable the voice of patients, service users and the general population to be heard.

4.7 **Quality** – issues around the quality of health and social care services are picked up elsewhere is the system and do not need to be directly addressed by the Board.

4.8 **Scrutiny** – this formal role is undertaken by the NCC Health Overview and Scrutiny Committee (HOSC) and so is not in the remit of the Board. The Board has the ability to refer issues of concern to HOSC for formal scrutiny and vice versa.

Proposed scope and approach

4.9 An outline of the proposed scope and approach of performance monitoring by the Board is given below.

Proposed Scope	Proposed approach
The accountability framework will have, as its prime area of focus, the **achievement of the Board's statutory responsibilities**, including, in particular: • The Board's priorities and objectives as set out in the Joint Health and Wellbeing Strategy • The maintenance and development of a fit for purpose Joint Strategic Needs Assessment • Making progress on integration	1. A light touch way of reviewing progress on the 2013/14 strategy priorities would be to undertake an **end of year assessment** of where the **activity of Board members has made a difference.** This would balance qualitative data from services users with quantitative data from existing outcomes frameworks. For the 14/17 strategy, a similar approach would be adopted, with qualitative and quantitative data provided except on a 1/4ly basis. This would then be substantiated by an end of year report to coincide with an annual review of the JSNA. 2. Undertake an **annual review of** the JSNA's **effectiveness**. The approach to this will need to be developed with reference what the 14/17 strategy sets out to achieve on integration and to the national indicators on integration that will be made available later this year.
System effectiveness - maintain an overview of the effectiveness – to understand how well: • The system is performing as a whole; and • The Health and Wellbeing board itself is working	1. **Select and monitor one or a set of global indicator**(s) of the health and wellbeing of the people of Norfolk. For example, disability-free life expectancy. 2. Evaluate the effectiveness of the Board through an **annual appraisal process or health check of the Board.** For example this could be done by using a series of structured questions similar to those adopted by the Local Government Association as part of its assessment of the development of Health and Wellbeing Boards. ('A new development tool for health and wellbeing boards', LGA 2012). The tool covers 17 key issues, grouped into the areas of: Strategy, purpose, vision; Leadership, values, relationships, ways of working; Governance; Roles and contributions; Measures and accountabilities.
Quality – issues around the quality of health and social care services are picked up elsewhere in the system and do not need to be directly addressed by the Board.	Mechanisms are in place, through the national Quality Surveillance Group network, to ensure that early intelligence on significant failings in standards of care can be addressed. It is proposed therefore that a **slot is included on the agenda of the Board** to enable key issues including from NHS England/Quality Surveillance Networks to be shared brought to the attention of the Board.

5. Action

5.1 The Norfolk Health and Wellbeing Board is asked to review and comment on the content of the report, specifically the recommendation:

To adopt a performance monitoring framework that is light touch and yet able to provide a good understanding of how the Board is functioning, what impact it is having on the health and wellbeing of the people of Norfolk, what progress it is making with the implementation of a JHWS 2014/17; and a sense of emergent issues around the safety of services commissioned and provided in the health and social care system. This would include:

- An annual appraisal process of how the Board works using a series of structured questions, similar to those in the LGA tool
- Monitoring either one or a set of global indicator(s) of the health and wellbeing of the people of Norfolk
- A light touch way of reporting on progress against the strategy priorities for 13/14 and 14/17, using qualitative and quantitative data
- A regular slot on the agenda of the Board to enable key issues from the Quality Surveillance Networks to be shared.

5.2 The Board may wish to consider setting up a working group to lead on the development of the performance monitoring framework over the next 8 months or ask an existing group to take on that responsibility.

Officer Contact

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

Name	Tel	Email
Daniel Harry	01603 222568	daniel.harry@norfolk.gov.uk
Debbie Bartlett	01603 222475	debbie.bartlett@norfolk.gov.uk

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

Appendix 1

Attendance at workshop – 5 June 2013

Name	Organisation
Claire Collen	Voluntary Norfolk
Chris Price	Norwich CCG
Joyce Hopwood	Norfolk Older People's Strategic Partnership
Yvonne Bendle	Councillor, South Norfolk District Council
Lucy Macleod	NCC, Public Health
Debbie Bartlett	NCC, Planning, Performance and Partnerships
Sonia Shuter	North Norfolk DC
Augustine Pereira	NCC, Public Health
Joanna Hannam	NCC, Communications
Tracy Dowling	East Anglia Area Team, NHS England
Dr Ian Mack	West Norfolk Clinical Commissioning Group.
Richard Draper	Benjamin Foundation
Ralph Jackman	Norfolk Constabulary
Jenny McKibben	Deputy Police and Crime Commissioner
Anne Gibson	NCC, Acting Managing Director
Martyn Swann	South Norfolk District Council
Victoria Jackson	Borough Council of King's Lynn & West Norfolk
Jon Bryson	South Norfolk, Clinical Commissioning Group
Tim Eyres	NCC, Children's Services
Sarah Spall	NCC, Children's Services
Ann Baker	Norfolk Older People's Strategic Partnership
Roger Foulger	Councillor, Broadland DC

In attendance:

Linda Bainton, NCC, Planning, Performance & Partnerships (PPP)
Daniel Harry, NCC, PPP
Judy Lomas, NCC, Norfolk Insight
Jo Webb, NCC

Appendix 2

Key messages from workshop – 5 June 2013

Roles and responsibilities

- Quality is not the direct concern of the Board as this is picked up elsewhere and early warnings and/or intelligence can be shared with the Board so that there are no surprises.
- Not about scrutiny as that is undertaken by the NCC Health Overview and Scrutiny committee
- Fulfil a need to demonstrate that the Board has made a difference and can be held accountable
- Provide some understanding of progress with integration – pooled, aligned, budgets, teams, personal experience, mapping pathways, client interaction web, etc. Quality is not a separate issue here, it is integral to how we assess our progress with integration
- A check for the levels of engagement
- Establish a sub-group to look at accountability and performance.

Proportionality

- Risk that the focus on challenge and accountability stifles innovation and doing different
- Focus in on progress with priorities that have been identified, initially in the 2013/14 strategy.

Measures

- Periodic reporting back on data, actions taken and user involvement to enable a judgement to be made about the work of the Board
- Global indicator(s) of the health and wellbeing of the people of Norfolk - as well as the 'local' impact of the work of the Board
- Longitudinal studies of how individuals progress through the health and social care system and the outcomes they achieve
- Annual appraisal or healthcheck of Board - using formal meetings with Board members to assess individual agency contributions and collaborations
- JSNA as a baseline, the Strategy articulating what improvement looks like, and then using changes in JSNA to test results
- Greater use of qualitative case studies and the experience of living in Norfolk and/or accessing health and social care - concept of a 'collection of voices'

Appendix 3

Extract from the H&WB's Operating Framework

From the Report to the Shadow H&WB, 18 July 2012 (Item No: 5)

Section 4

4. Accountability

4.1 Members of this Shadow Board are formally accountable to different parts of the system. However, there is a collective and shared responsibility for maintaining a strategic overview of the health and social care 'system', and holding each other to account for joint agreed actions.

4.2 Critical to working effectively will be 'soft' account ability mechanisms of shared culture, common purpose and trust. The Shadow year will be an important time to build understanding of different constraints and pressures, and how sometimes these might conflict.

4.3 As well as the governance of individual members, the Board itself will be held to account both nationally and to the local population. As a statutory committee of the County Council, the Board will be accountable to the Full Council and ultimately through this, to the public.

4.4 The local healthwatch organisation – to be represented on the Board – will play a key role in representing the views of patients, service users and the wider population.

In-Year Monitoring of Health & Wellbeing Priorities

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, 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

1. Are the commissioning plans aligned with the priorities in the Joint Health and Wellbeing Strategy and is it contributing to delivery of those priorities?

2. What else could partners round the table could be doing to help drive improvements in priority areas identified locally?

Actions/Decisions needed

The Board needs to:

- Consider and comment on the information provided in the reports and presentations from the CCGs, including the alignment with the JH&WBS and progress being made, and
- Respond to any specific requests for endorsement within the CCGs submissions
- Decide if there are any actions that the Board, or individual partners round the table, could be taking to help drive improvements in priority areas identified locally

In-Year Monitoring of Health & Wellbeing Priorities

Report by Norfolk's Clinical Commissioning Groups and the
Head of Planning, Performance and Partnerships, NCC

Summary
The Health & Wellbeing Board's forward plan includes an item on 'In-year monitoring on Health & Wellbeing priorities' to be considered at its meeting in July. It was proposed that each of the CCGs lead a discussion on progress against their commissioning priorities, with an emphasis on how they are contributing to the priorities of the Joint Health and Wellbeing Strategy.

This report brings together the submissions from each of the CCGs and includes information on their annual 'Plan on a Page', their 3 local priorities identified for the purpose of the national 'Quality Premium' and their Prospectuses for residents and patients.

Action
The Health & Wellbeing Board is asked to consider the information provided in the report and in the CCGs presentations at the meeting and:

- Consider the contribution to delivering the priorities of the Joint Health and Wellbeing Strategy
- Respond to any specific requests for endorsement within the CCGs submissions
- Consider the progress being made and whether there are any actions that the Board, or individual partners round the table, could be taking to help drive improvements in priority areas identified locally

1. Background

1.1 At its meeting in April 2013, the Health & Wellbeing Board agreed a Forward Work Programme for the year and it includes an item on 'In-year monitoring on Health & Wellbeing priorities' to be considered at its meeting in July. The Board's forward plan proposed that at this meeting each of the CCGs lead a discussion on progress against their commissioning priorities, with particular emphasis on how they contribute to the priorities of the Joint Health and Wellbeing Strategy.

1.2 In setting priorities for Norfolk as a whole, it is acknowledged that there are local variations in the levels of need and each priority will have a different 'play' in local areas. This has an impact on the order in which different areas tackle countywide priorities and CCGs' annual planning highlights both the alignment with the work of the Board and the local variations in focus.

2. CCGs Annual Planning

2.1 As part of the annual planning round, all CCGs are required to produce a **'Plan on a Page'** which follow a common set of headings and demonstrate key health and health care commissioning priorities.

2.2 CCG's are also asked to **identify three local priorities** against which it will make progress during the year. These priorities will be taken into account when determining if the CCG should be rewarded through the Quality Premium. (The Government has introduced a 'quality premium' which is intended to reward CCGs for improvements in the quality of the services that they commission and for

associated improvements in health outcomes and reducing inequalities). These three local measures should align with the local priorities identified in the Joint Health & Wellbeing Strategy (JH&WBS).

2.3 These 3 local priorities are agreed between individual CCGs and the area teams of the NHS England, and the expectation is that this follows consideration with Health and Wellbeing Boards as well as key stakeholders, especially patients and local community representatives. However, the national deadline for agreeing these 3 local priorities for 2013-14 has already passed but this process has been set earlier in the cycle in the H&WB Forward Plan for 2014-15 in order for it to be fully meaningful for all concerned.

2.4 In addition, all CCGs are required to publish a **Prospectus** – a short guide which explains to their local community what the CCG is and the ambitions it has for its local population's health services. Each CCG's prospectus is expected to be locally determined to reflect the needs of the people served - it should reflect what the CCG, in discussion with key stakeholders, believes will meet their population's needs and wishes.

2. Norfolk CCGs local priorities, planning and progress

2.1 For the purposes of today's discussion, each of Norfolk's CCG were invited to:

- Identify their 3 x local priorities, as informed by the JH&WBS
- Feedback progress being made against them
- Share their Plan on a Page and their Prospectus

2.2 The information from the CCGs is provided is in Appendix A and there will be presentations of some of the material on the day. At the meeting each CCG will lead discussion of progress against their commissioning priorities, with particular emphasis on how they contribute to the priorities of the JH&WBS.

3. Action

3.1 **Action**

The Health & Wellbeing Board is asked to consider the information provided in the report and in the CCGs presentations at the meeting and:

- Consider the contribution to delivering the priorities of the Joint Health and Wellbeing Strategy
- Respond to any specific requests for endorsement within the CCGs submissions
- Consider the progress being made and whether there are any actions that the Board, or individual partners round the table, could be taking to help drive improvements in priority areas identified locally

Officer Contact

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

Name	Tel	Email
Debbie Bartlett	01603 222475	debbie.bartlett@norfolk.gov.uk

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

Appendix A

North Norfolk CCG

Report to Norfolk Shadow Health and Wellbeing Board
Development of the Health Improvement Strategy for North Norfolk and Rural Broadland

Dr Anoop Dhesi, North Norfolk CCG,

Summary
This paper sets out progress made in the development of the Health Improvement Strategy and Action Plan for North Norfolk and Rural Broadland flowing from the Health and Wellbeing Board's emergent priorities.
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Recommendation
The Board is asked to note the report.

1. Background and Purpose of Report
1.1 In the North Norfolk Clinical Commissioning Group (CCG) area there is an appetite from both the District Councils and the CCG to drive forward a local programme of action based on the locally defined priorities. The purpose of this report is to update the Board on the progress made to date with this agenda.

2. Introduction
2.1 Following the identification of the eleven emergent priorities for the Health and Wellbeing Strategy, North Norfolk CCG took these as the basis for a discussion with stakeholders, including both the District Councils in the area. As a result the North Norfolk and Rural Broadland Strategic Partnership Board was established. This board is the mechanism by which we are jointly developing approaches to meet the local health and well-being priorities. The membership of this Board includes senior managers and commissioners from:

- Public Health (including Healthy Communities lead)
- North Norfolk Clinical Commissioning Group
- Community Services, Adult Social Care - Norfolk County Council
- Broadland District Council
- North Norfolk District Council
- Children's Services – Norfolk County Council
- Mental Health & Drug & Alcohol commissioners when required
- Probation and police commissioners when required

2.2 The Board has now met on five occasions, the Terms of Reference have been finalised and agreed and the existing North Norfolk Health Improvement Forum has been identified as the group responsible for operational delivery. The Board's strategic aims are to:

- Provide strategic oversight to health and wellbeing centred on the NNCCG locality area (NN and parts of Broadland)
- Prevent ill health and help people live longer, independent and fulfilled lives
- Develop, joined up and aligned services that will positively affect the health and wellbeing of people in North Norfolk
- Promote equality by reducing unfair differences in health

- Improve the quality, accessibility and integration of health, social care and housing related support services
- Deliver efficient and better value services, in partnership where appropriate
- Work together to enable individual members to inform, influence, advise and steer strategic and other groups within individual member organisations.

The Boards key objectives are:

- To provide strong local leadership for improvement in health and well-being
- To deliver efficiencies by reducing duplication of provision and developing integrated/aligned approaches
- To support and direct the work of the North Norfolk Health Improvement Forum
- To monitor health improvement work across the North Norfolk CCG area
- To support the involvement of service users in developing local health improvement strategy
- To develop work across organisational boundaries to promote health and well-being, including further development of joint financial arrangements where appropriate
- To take an overview of partnership work undertaken to deliver the agreed Health and Wellbeing outcomes
- To monitor key indicators for the Health and Wellbeing outcomes
- To work together to remove potential barriers to effective joint working
- To assist in the solving of strategic issues which prevent or slow achievement of agreed outcomes.

The Board will;

- Localise the Health and Wellbeing Board emergent themes
- Liaise with North Norfolk Health Improvement forum
- Agree strategic priorities based on evidence of need
- Work to understand what makes a difference by considering evidence and listening to, and learning from, people
- Build on, rather than reinvent, good practice
- Consider exploring opportunities to align budgets where appropriate
- Focus on outcomes
- Agree clear, realistic but challenging metrics to measure progress in each area.

3. Local Priorities

3.1 Based on a discussion of the available data for the CCG area, feedback from other local partners, patients and carers at CCG engagement events and the experience of the various Group members, the Board has agreed three areas for action which amalgamate six of the Health and Wellbeing Board's emergent priorities. These are:

- **Physical Activity, Healthy Eating and Weight Management**; nearly 94,000 adults in the CCG area (67%) are estimated to be overweight or obese and adult participation in sport is lower than in other CCG areas. There are considerable differences in National Child Measurement Programme outcomes between the best and the worst MSOA in the CCG area. This is an issue which is important in both the North Norfolk and the Broadland District Council areas.

- **Supporting independence at home, better supporting people with long term conditions, and addressing the needs of adult and young carers.** This encompasses four areas from the emergent priorities;
    - Unplanned/emergency care and admissions and preventing re-admission of people to hospital and/or health and social care services, post-intervention
    - Supporting Frail People Living Independently
    - Carers of older people and people with long term conditions
    - Young carers – identify and support young carers and their families.

The North Norfolk and Rural Broadland area has the highest proportion of older people in the County with high levels of fuel poverty in parts and a relatively high level of excess winter deaths all of which are associated with unplanned or emergency admissions. Levels of age related conditions such as dementia are projected to rise and there is considerable geographical variability in people over 65 admitted to hospital with fractures. Clearly the role of carers, young and old is a key one in improving outcomes for older people and those with long term conditions and their needs are therefore a priority. This area of work was agreed to be one where cross agency working would be beneficial and add value to the efforts of individual partners.

- **Creation of good developmental and learning outcomes for children and young people;** Child poverty has worsened in both of the Districts since 2011 and roughly one in ten children in the CCG area now lives in poverty. GSCE attainment has worsened in North Norfolk, but improved in Broadland. At foundation stage, there is considerable variation across the area with parts of North Norfolk having the worst attainment in the County. Childrens' development and achievement relates closely to their future health and life outcomes and this area has therefore been agreed as a partnership priority.

3.2 The areas listed above are seen as an initial approach to localising the Health and Wellbeing Board emergent themes. Clearly there is no implication that the other areas are not important, but that these workstreams fit well with demographics and expressed need in the CCG area and provide a good starting point for joint activity. There is agreement that the prioritisation process will be reviewed on a regular basis to check whether sufficient progress is being made in the areas prioritised, whether the higher priority areas still make sense in the light of needs and demographics and whether the balance of priority needs to be changed in the light of performance in the five lower priority areas.

3.3 A report on the priority workstreams and the establishment of the North Norfolk and Rural Broadland Strategic Partnership Board has been put before the CCG Council of Members and existing activity in the workstream areas has been mapped.

4. Next Steps

4.1 The Board will monitor progress of in the identified priority areas and will continue to explore opportunities to align, integrate and develop services locally that will meet the health and wellbeing priorities.

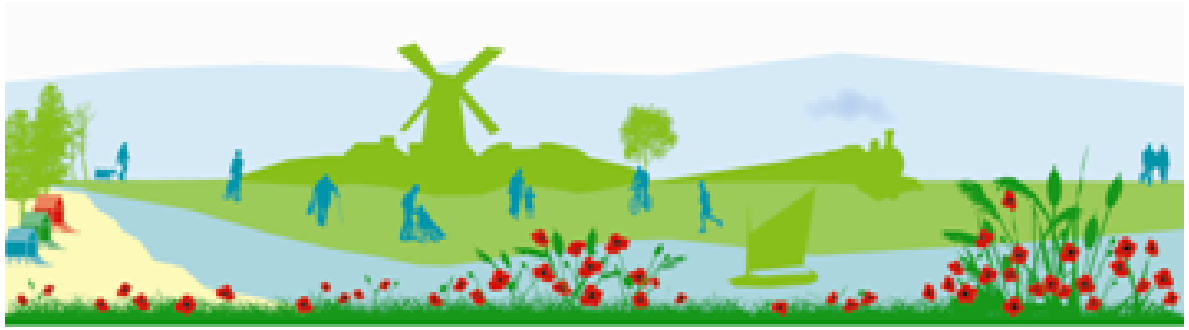
5. Recommendations

5.1 The report is for noting, though the North Norfolk and Rural Broadland Strategic Partnership Board would welcome any comments from the Board.

NHS
North Norfolk
Clinical Commissioning Group

North Norfolk Clinical Commissioning Group Health and Wellbeing Board

July 10th 2013



Plan on a page

North Norfolk CCG (NNCCG)
Plan on a page 2013/14

NHS
North Norfolk
Clinical Commissioning Group

Working together for excellent healthcare in North Norfolk and rural Broadland. Delivering seamless health and social care for our patients by 2016

Our Five Priority Areas:

Older People

- Seamless health and social care delivery
- Care that is focused on the patient's needs not built around the different agencies' offers
- Identifying people who are at risk earlier to ensure we get the right help to them quicker
- Supporting carers and families so they can assist in maintaining older peoples' independence

In 13/14 we will improve efficiency by working in partnership with the local authority to redesign how we purchase care home placements.

Mental Health

- Ensuring effective and safe implementation of the Norfolk and Suffolk Foundation Trust Mental Health Strategy
- Have better access to screening for dementia so that patients and their carers are given earlier treatment options
- Improve access to various therapies for people with depression and anxiety

In 2013/14 we will increase the rate of dementia diagnosis by 8% (compared to 2012/13) and for those diagnosed increase the availability of carer support.

Planned Care

- Improve access to elective services and make sure all NN CCG patients have access to the same care, in particularly orthopaedics
- Make sure that we apply consistent thresholds to referrals for all NN CCG patients.
- Increase patient choice through innovative service redesign and introduction of new providers

In 13/14 we will work with other Norfolk CCGs and the NNUH to improve the Oxford Knee Score (OKS) health gain score by 6%.

Unplanned Care

- Identify people who are at risk and ensure services are in place to stop them from being admitted to hospital unnecessarily
- Reform the emergency care system so that it works better in a rural area
- Improve the quality of care for Stroke patients and their carers so that they have better outcomes

In 13/14 we plan to prevent 500 people (against forecast) from having an unplanned admission to hospital by better supporting them at home, which could save the local health economy approximately £1m.

Children

- Support Young Carers so they can continue to care but don't miss out on other opportunities in life
- Conduct a review of child epilepsy related admissions and implement changes in practice as appropriate
- Encourage children to be more active and maintain a healthy weight

In 13/14 we will continue work in collaboration with both North Norfolk and Broadland District Council to deliver services that support younger people to live a healthy and active lifestyle.

We will deliver:

The NHS Constitution for the people of North Norfolk and rural Broadland
The NHS Outcomes Framework
The Social Care Outcomes Framework

Public Health Outcomes Framework
Innovation by turning good ideas into services to benefit patients
Services closer to home where appropriate

Key Risks:

- An ageing population who are living longer often with more than one Long-Term Condition
- Rising Continuing Care costs and uncertainties
- Rising emergency admissions
- Being able to make the efficiency savings needed

We will manage these risks by:

- Working with local clinicians to design local services
- Regular on-going engagement with patients and stakeholders
- Designing evidence-based and needs driven services
- Commissioning for quality and efficiency
- Developing employees potential to innovate and deliver

Foundations built on Quality and Patient Safety: Patient Centred – Care that is safe – Clinical excellence – Caring and compassionate staff and service

Priorities

- ✓ **Physical Activity, Healthy Eating and Weight Management**
- ✓ **Supporting independence at home, better supporting people with long term conditions, and addressing the needs of adult and young carers.**
  - Unplanned/emergency care and admissions and preventing re-admission of people to hospital and/or health and social care services, post-intervention
  - Supporting Frail People Living Independently
  - Carers of older people and people with long term conditions
  - Young carers – identify and support young carers and their families.
- ✓ **Creation of good developmental and learning outcomes for children and young people**

Delivering the priorities

- Exercise referral scheme
- Long term conditions Programme
  - NN Integrated care teams
  - Self-care and self-management (focus groups)
  - Predictive Risk Management
- Living well with Dementia project

Norwich CCG

NHS
Norwich
Clinical Commissioning Group

Subject:	NHS Norwich CCG – In-Year Monitoring
Presented By:	Dr Chris Price, Chair NHS Norwich CCG
Submitted To:	Norfolk Health & Wellbeing Board 10th July 2013
Purpose of Paper:	Information

Summary:

As requested, NHS Norwich CCG has provided the following documents:

- 2013/14 Plan on a Page
- 2013/14 Local Measures – CCG Quality Premium
- 2013/14 CCG Prospectus
- 2013/14 Summary Operating Plan

These documents have been submitted as part of the NHS England Operating Framework, and have been approved by NHS England as required.

All projects as set out in these documents are currently on track for delivery during 2013/14 fiscal year.

Recommendation:

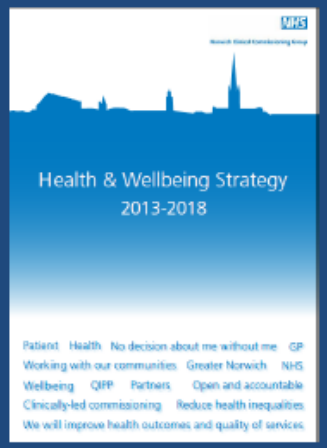
The Board is asked to note the contents of the 2013/14 CCG Planning Documents

OUR VISION

We will improve health outcomes and quality of services year on year for all the people of Norwich

OUR 4 STRATEGIC GOALS

1. **Continuously improve and assure the quality and safety of healthcare**
2. **Continuously improve the health and wellbeing of the population**
3. **Reduce health inequalities—the health gap between different communities**
4. **Manage our resources responsibly and ethically, and deliver value for money for the taxpayer.**



The NHS Norwich CCG Health and Wellbeing Strategy can be found at www.norwichccg.nhs.uk

Strategic Plan on a Page for 2013-2014

NHS
Norwich
Clinical Commissioning Group

KEY TRANSFORMATIONAL AREAS (QIPP)

Healthy Norwich

Partnership with Norwich City Council and Norfolk County Council (Public Health) to develop joint strategies, campaigns, and new services for:

- Physical activity in children and adults
- Child and adult immunisations and health screening
- Weight management
- Drug and Alcohol misuse, and smoking cessation

Urgent Care

- Improving the performance and safety of the unplanned care system in Central Norfolk (Project Domino)
- Reducing unplanned admissions of older people through risk stratification, support for care homes, and extended community nursing.

Planned Care

Pathway reviews and service redesign for dermatology, trauma and orthopaedics, audiology, physiotherapy, dementia, and palliative care

Prescribing

Primary care medicines formularies for Primary Care, and medication reviews in care homes to improve the care of patients with long term conditions, and reduce waste.

Continuing Healthcare

Improving the system for assessing and arranging care packages for patients, including the further extension of personal health budgets.

Quality & Safety

- Rollout of Friends and Family Test as a headline measure of user satisfaction
- Development of feedback tools for patients and health professionals to assure the quality and safety of care

KEY RISKS

1. CHC Restitution claims and inherited financial deficit create financial imbalance.
2. Transformation projects do not deliver as expected
3. Providers do not deliver to quality and finance requirements
4. Population and service demand changes exceed planning assumptions

RISK MITIGATION

1. Development of financial risk mitigation and contingency plans
2. In-year monitoring of delivery of transformation plans, and review against projected impact
3. Further development of Provider assurance systems and relationships

2013/14 Quality Premium
Local Measures

Patient & Clinician – Feedback Systems

Domain of CCG Outcomes Indicator Set	4. Ensuring that people have a positive experience of care 5. Treating and caring for people in a safe environment and protecting them from avoidable harm
Quality Premium Measure	1. Rollout of Patient Opinion 2. Rollout of SickAdvisor® 3. Improvement in patient satisfaction as measured by Patient Opinon reporting tools.
Rationale	We are negotiating with main providers to embed 'Patient Opinion' into their quality systems from April 2013. Patient Opinion is a web-based feedback tool where patients give feedback on the care they received, and providers are able to respond. We would ask practices to actively promote Patient Opinion in their patient areas, and promoting its use during contact with patients. We will soon be launching Sick Advisor®, a Norwich CCG designed web-based tool which enables health professionals in Norwich to highlight positive experiences, issues, and concerns relating to care provided to their patients – either reported by the patient, or experienced by the health professional in their dealings with providers. Both of these measures will provide us with detailed soft intelligence about the quality and safety of local services, ensuring that systematic failures of care and caring do not occur in Norwich. The use of these systems to drive service improvement should deliver an improvement in patient satisfaction with services.
Value	12.5% of Quality Premium
Threshold	To earn this portion of the quality premium, there will need to be 1. Assurance that Patient Opinion is being actively promoted by Primary Care to all patients 2. Assurance that SickAdvisor® has been installed on all GP Practice systems, and that Primary Care clinical staff have been trained in its use. 3. Improvement in patient satisfaction with local health services in Q4 in comparison with a Q1 baseline measure.

DRAFT

Upstream Project – Older People and Carers of all Ages

Domain of CCG Outcomes Indicator Set	1. Preventing people from dying prematurely
Quality Premium Measure	1. Establishment of Voluntary Sector Services and Portals 2. Rollout of Referral Scheme 3. Reduction in acute health need in patients accessing the service over the second half of the year in comparison with an appropriate control group
Rationale	Projects in other parts of the UK have indicated that the Voluntary Sector can have real impact in helping people stay independent and well with a variety of interventions, such as: • Conducting benefits checks and helping people claim for benefits to which they might be entitled • Providing short respite support for carers, or assistance with shopping and other day-to-day household activities • Providing access to social activities to reduce social isolation and the associated risks to physical and mental wellbeing The Upstream Project would enable GPs to refer patients to a Voluntary Sector organisation – such as AgeUK or the Carers Forum – for a variety of services, including benefits checks and the provision of social activities. Volunteers would also act to provide an additional route of signposting back to the GP where they believe a patient may be in need of medical care, or access City Council services for Housing support, finance and debt support, or assistance with managing fuel poverty.
Value	12.5% of Quality Premium
Threshold	To earn this portion of the quality premium, there will need to be 1. Evidence of service agreements with a minimum of one voluntary sector organisation which supports older people, and one which supports carers, to provide a referral scheme for primary care to refer patients into their service, and for a range of services to be delivered within defined timescales 2. Assurance that Primary Care Health Professionals and aware and are appropriately accessing these services on behalf of their patients. 3. Reduction in the use of acute medical services over the second half of the year compared with an appropriate control group.

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Reducing the Incidence of Pressure Ulcers in Primary Care

Domain of CCG Outcomes Indicator Set	5. Treating and caring for people in a safe environment and protecting them from avoidable harm
Quality Premium Measure	Practices to provide evidence that they have: 1. Obtained, reviewed and internally discussed the current PU NICE guidance with all clinical staff within the practice 2. Reviewed and logged all patients at high risk of developing PU 3. Reduction in patients admitted to hospital with a pre-existing PU, who are primarily under the care of General Practice.
Rationale	Following the recent death of a 51 year old Norwich lady from sepsis (secondary to the development of a pressure ulcer), it has become apparent that some patients may be at risk of developing pressure ulcers whilst under the care of Primary Health Care. This quality measure seeks to address the recommendations of the Coroner's report. Significant progress has been made with the SHA ambition to eliminate new pressure ulcers in the secondary and community sectors; this work has not yet fully extended to Primary Care. The identification and management of patients at high risk may further contribute to the reduction of new pressure ulcers in the community.
Value	12.5% of Quality Premium
Threshold	To earn this portion of the quality premium, there will need to be: 1. Assurance that all clinical staff in primary care have reviewed current NICE PU guidance, and have considered any appropriate changes in operations, systems, or clinical practice. 2. Evidence that all General Practices have established and are maintaining a register of patients considered at high risk of developing a PU, and have taken action – including referral to community nursing services – where appropriate. 3. A reduction – compared to 2012/13 in the levels of patients with a PU on admission to hospital, where patients are primarily under the care of General Practice.

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NHS
Norwich Clinical Commissioning Group

NHS Norwich CCG 2013/14 Prospectus

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Patient Health Wellbeing Open and accountable
NHS QIPP Partners
Reduce health inequalities No decision about me without me
Clinically-led commissioning GP
We will improve health outcomes and quality of services

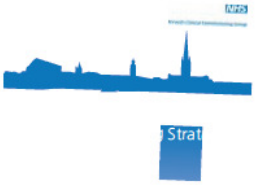
1 About NHS Norwich Clinical Commissioning Group

NHS Norwich Clinical Commissioning Group (CCG) is a new organisation, led by local doctors and nurses. We are responsible for spending the local health budget to secure the services we need to help keep people well and to ensure they receive prompt, high quality and appropriate care when they experience illness or injury.

This prospectus sets out the key information about our plans for our first year of operation and our long-term goals for the next five years.

2 Our Strategy for Improving Health & Wellbeing in Norwich

i. Our Vision



We will improve health outcomes and quality of services, year on year, for all the people of Norwich

ii Our 4 Strategic Goals

1. Continuously improve and assure the quality and safety of healthcare
2. Continuously improve the health and wellbeing of the population
3. Reduce health inequalities—the health gap between different communities
4. Manage our resources responsibly and ethically, and deliver value for money for the taxpayer.

You can read more in our Health and Wellbeing Strategy for 2013-2018

There is also more information about what we want to achieve this year in our Plan on a Page

iii Our Key Areas of Work in Year 1

Healthy Norwich

We are working in partnership with Norwich City Council and Norfolk County Council (Public Health) to develop joint strategies, campaigns, and new services for:

- Physical activity in children and adults
- Child and adult immunisations and health screening
- Weight management
- Drug and Alcohol misuse, and smoking cessation

Children and Families

We are committed to providing care closer to home: If children need to go to hospital then we want to see them discharged safely and helped to return home as soon as possible. To do this are working with our acute and community providers to develop a Children's Community Nursing service.
We are also working to find ways of helping people with epilepsy, diabetes and asthma manage their conditions safely at home. This will improve the quality of their lives and also avoid sudden health crises which would otherwise mean an emergency admission to hospital.

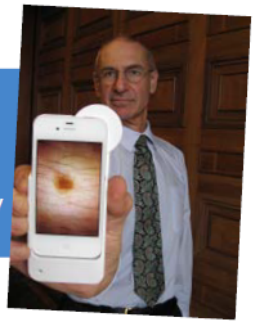
Urgent Care

We are committed to improving the urgent and emergency care system in Central Norfolk through a major project known as Operation Domino. This project involves every part of the healthcare system, across Central Norfolk, working together to deliver fast, safe and effective care for now and the future.

Planned Care

We are reviewing, simplifying, and improving the models of care for dermatology, trauma and orthopaedics, audiology, physiotherapy, dementia, and palliative care.

We are are trialling a new, easier way to help GPs diagnose skin problems, using a dermascope and smartphone, called TELEDerm. Five GP Practices in Norwich are taking part. Dermatology is our fourth largest referral area and we hope this will reduce unnecessary referrals to the hospital.



Prescribing

GP Practices will be invited to work alongside our specialist prescribing team to undertake 'enhanced medication and patient reviews' for patients in care homes. They will be looking to ensure our patients have the right drugs to keep them as safe and well as possible. The prescribing team will also be looking to standardise medication for patients with long term conditions and look for any opportunities to reduce the amount of waste - for example medicines which are prescribed but not used.

Supporting Frail, Older People to Live Independently

We will continue to develop services in the community such as 'Case Management' to ensure that people are being looked after to prevent admission in the future. We will aim for multi-disciplinary assessment and care planning, supported by an Integrated Care Coordinator. We will work with voluntary groups to support the health and wellbeing of older people.

Improving Access to Primary Mental Health Care

We are planning to develop services in preparation for procurement in 2014/15.

Continuing Healthcare

NHS Continuing Healthcare (CHC) is a package of care funded entirely by the NHS, which meets both the health and social care needs of people with significant and enduring health and personal care needs. We will be improving the system for assessing and arranging care packages for patients, including the further extension of personal health budgets.

Quality and Safety

We will be launching national and local tools to get better information about patient experiences of local healthcare. The 'Friends and Family Test' will be used as a headline measure of patient satisfaction. We will also be launching 'Patient Opinion' this year – a web-based system for patients to share their experiences of local health services.

3 What you can expect from local health services

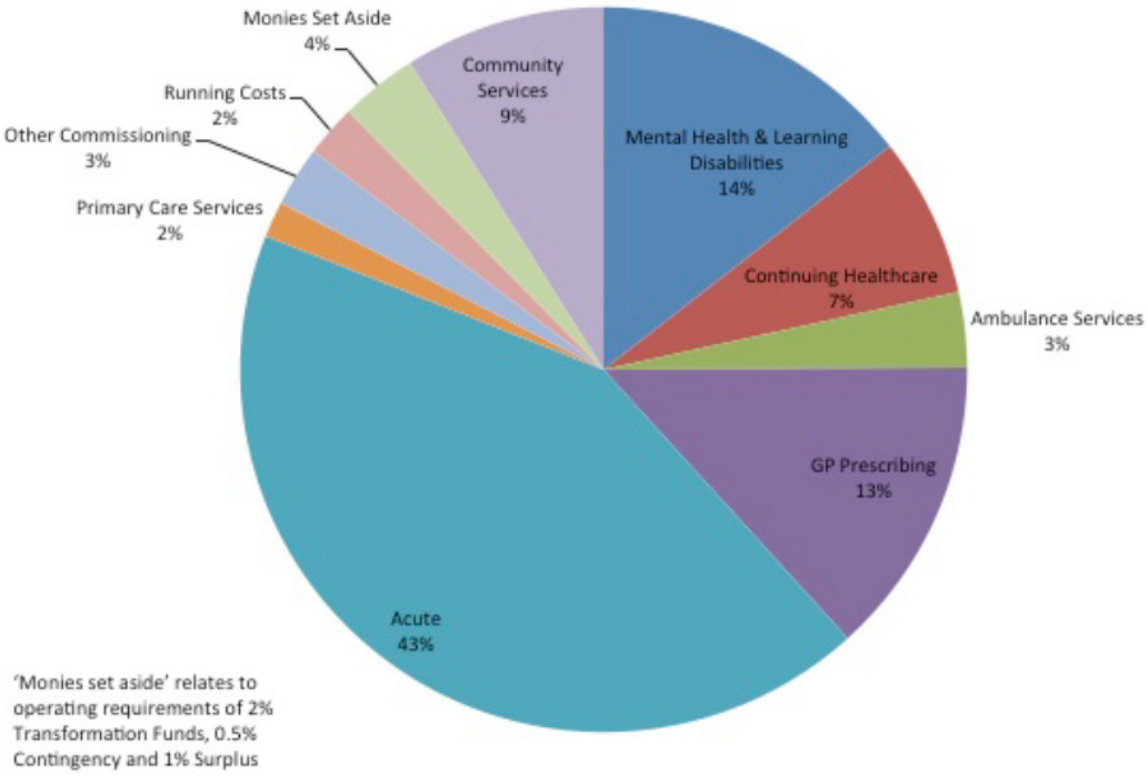
It is our priority to help you and your family live longer healthier lives by making sure you get the very best services, where and when you want them. We will ensure that the rights you are afforded in the NHS Constitution are adhered to by providers of health care.

The quality and safety of patient care is paramount. We have a Quality Committee to provide assurance on the quality of services that we commission. It also promotes a culture of continuous improvement and innovation in the safety of services, clinical effectiveness, and patient experience.

Our Health and Wellbeing Strategy was developed in partnership with Norwich City Council and other stakeholders and we will work together to provide more joined up health and social services.

4 How we spend the local NHS budget

Our budget for 2013/14 is nearly £216million. This chart shows how we plan to spend it for the benefit of our patients



4 How you can get involved

We know that our planning and decision-making is considerably stronger when we work with patients, stakeholders and partners, including HealthWatch. We believe the resulting services are better for it. We also need to make sure that providers of health care involve the public consistently and effectively. To be able to do this we have developed a Communications and Engagement Strategy

You can contact us by email
Write to us: Room 202
City Hall
St Peters Street
Norwich
NR2 1NH
Phone us: 01603 613325
www.NorwichCCG.nhs.uk

NHS

Norwich Clinical Commissioning Group

2013/14 Project Plan

Health Needs Assessment	Population Group	Healthy Norwich	Urgent Care	Planned Care	Prescribing
High Levels unplanned acute care	Children and Young People	Campaign: increase physical activity in children	Reduce admissions for epilepsy, diabetes and asthma (enhanced management in primary and community care)	Enhanced primary care mental health support for young people	Service: development of paediatric community services including IV therapy
		Campaign: increase uptake of childhood immunisations			
		Campaign & joint strategy: drug and alcohol misuse	Review: paediatric unplanned care pathway	Review & redesign: ADHD pathway	
Large Population of Young People	All Adults	Campaign & Service: weight management	Mental health support for patients with Long Term Conditions	Peer review of GP referrals in key specialties	Toolkit: CCG Primary Care drugs formulary for LTCs
		Campaign & service: increase physical activity in adults		Redesign of trauma & orthopaedics pathway	
Unhealthy Lifestyles		Campaign: improve outcomes and reduce variation in mortality from cancer and heart disease	Review: stroke service reconfiguration, redesign and contracting	Service development: Community Audiology Services	Toolkit: CCG Prescribing incentive scheme
Income Deprived Families		Campaign & Service: reduce number on lung cancer register (smoking cessation)	Toolkit: admissions avoidance through population risk stratification	Service review: Local Enhanced Services in Primary Care	
		Campaign: increase update of screening services	Toolkit: readmission avoidance through risk stratification at discharge	Primary Care dermatology diagnostics	Toolkit: further implementation of 'Scriptswitch' to increase use of generic medications
High Levels of Mental ill-Health		Service review: Sexual health services	Redesign of unplanned care system (Project Domino)	Re-procurement of community physiotherapy	
Isolated & Income Deprived Older People	Older People	Campaign: reducing winter deaths	Review of Falls Pathway and current services for prevention and management	Education and support for palliative and end of life care	Medication reviews for patients in care homes
		Voluntary sector upstream projects (maintaining independence)	Integrated case management extension to 7 days	Evaluate and develop existing services for identifying and supporting patients with dementia	
			Integrated case management: acute liaison		

Continuing Healthcare	System Efficiencies	Quality, Safety & User Experience
Fundamental redesign of model of care for continuing healthcare: placement without prejudice; standardisation of packages, tariffs and prices; quality assurance scheme	Review of IAPT and Community Mental Health Services	Launch of 'SickAdvisor' Initiative for Health Professional s
	Prior Approval scheme extension	Monitoring and Continuous Reduction in HCAIs
	Care package validation	Outcome measures for MH interventions
	Day case / outpatient tariff review	Rollout of Friends & Family Test for main NHS Providers
Accelerate rollout of personal health budgets for CHC	Review of Non-GP referrals	Implementation of 'Patient Opinion' Service in Main Providers
	Review of A&E follow-up clinics	
	Re-pricing of community clinic services	

CCG Outcomes Indicators

1. Preventing people from dying prematurely
2. Enhanced Quality for Life: long Term Conditions
3. Recovery from Episodes of Ill-Health or Injury
4. Ensuring People Have a Positive Experience of Care
5. Providing a Safe Environment for Treatment and Care

NHS
Great Yarmouth and Waveney
Clinical Commissioning Group
HealthEast

Title of Paper	In-year monitoring on Health and Wellbeing priorities- NHS Great Yarmouth and Waveney Clinical Commissioning Group (locally know as HealthEast)
What the Board is being asked to decide or approve	The Board is asked to: • Note our local health priorities • Approve HealthEast's prospectus • Note our Plan on a Page.
Executive Summary	**1. Local health priorities for HealthEast** In 2013/14 our health priorities are: • Ensuring high quality, safe services for our patients • Integration of services between health, social care and district councils • Focusing on the major causes of ill health in our communities – respiratory illness, diabetes and people who are elderly and frail • Strengthening our GP practices • Improving emergency care and reducing hospital admissions • Being transformational and innovative in the services we buy, focusing on better care for people with long term conditions • Delivering modern 21st century health care in settings that are comfortable and clinically appropriate for our patients' needs **2. Background to approval of the CCG Prospectus** Our prospectus is aimed at telling people who we are, how we spend our budget, what standards they can expect from their local health service, who we work with and how we listen to them, and how to get involved. NHS England asked all Clinical Commissioning Groups to publish a CCG prospectus. Dame Barbara Hakin sent a letter to all CCG clinical leaders on 29 April clarifying the arrangements for publishing a CCG prospectus. The letter from Dame Barbara Hakin states that: "The intention of the prospectus is to be a very short guide which explains to your local community what the CCG is, and the ambitions you have for

	your local population's health services. Each CCG's prospectus should be locally determined to reflect the needs of the people you serve. NHS England will not be providing any central requirements around content or the means of communication since we consider that it is essential it reflects what you, in discussion with key stakeholders, believe will meet your population's needs and wishes. There are a few principles which we consider are important and assume that you will take into account since they will clearly be of interest to your patients and the wider public such as: • reflecting the local health and wellbeing strategy and as such ensuring your prospectus has been agreed with your Health and Wellbeing Board; • setting out what the key health priorities are for your population; • describing the standards that local people can expect from the services you have commissioned on their behalf; • a high level description of how the budget for these services will be spent; • demonstrating how you and your key partners will address health inequalities; and • clarity on how your population's views have been, and will continue to be, heard. We also expect that the form and distribution of the prospectus will mean it is as accessible as possible to all your population." Following receipt of this letter, HealthEast is asking for approval of its prospectus by the Norfolk and Suffolk Health and Wellbeing Boards as part of the NHS England requirement. **3. Plan on a Page** Each CCG was required to produce a Plan on a Page. HealthEast's is attached for information.

Report author	Rebecca Driver
Job Title	Director of Engagement, HealthEast
Date	13th June 2013

NHS
Great Yarmouth and Waveney
Clinical Commissioning Group
HealthEast

Version 10: 1 5 13 NHS Great Yarmouth and Waveney CCG Draft 'Plan on a Page' 2013/14

Vision

Better health	Better care	Better value

Key elements of transformational change

Quality Improvement

- Dignity
- Access
- Choice and experience

Examples: NHS Institute 15 steps to better care, GP extended hours, out of hospital team, managing variation (eg: fair shares methodology), stroke services, support team for practices facing challenging times, quality monitoring meetings with providers

System leadership and Integration

- CCG as system leader
- Mature System Leadership Board – with a clinical Chair
- Delivering efficiency through integration

Examples: integrated joint commissioning teams for adult and children in GYW with Norfolk and Suffolk County Councils, generic worker project – working across agencies, Suffolk Lead Project, co-location of social work and health teams, integrated teenage pregnancy and alcohol approaches

Patient

- Know our patients
- Hear our patients
- Empower our patients

Examples: Gorleston Connected Care project, Kirkley Ageing Well project, proactive long term condition management plans (Eclipse), mental health and stroke insight work, Joint PPG Forum, Patient and Public Experience Group (feedback), complex children - new psychological and wellbeing service, carers' strategy

System Capacity

- Workforce
- Estates
- IT
- Data

Examples: GP fellowship initiative, capital planning and new facilities development plan, generic workforce transformational project, Governing Body development programme

Our Strategy

- Commissioning Plan
- Primary Care Strategy
- Out of Hospital Strategy
- Communications and Engagement Strategy
- Integration Strategy

Examples: Implementation of Out of Hospital Strategy, Rapid Response Team, Primary Care Strategy, system integration

Safety

- Patient
- Clinician
- Data

Examples: Unannounced visits, deep dives, shared learning from SIs and complaints, patient feedback, yellow card system, ECLIPSE, reliable validated information including HSMR

Delivery Now

- QIPP
- Performance
- Finance

Examples: Transformational QIPP eg Out of Hospital Strategy, regular and robust performance reporting (focusses on key issues eg clinical engagement with ambulance contract), robust financial planning that delivers, review of CCG delivery capacity

Long term plans

- Incentivising
- Moving towards an Integrated Care Organisation
- Strengthening primary care

Examples: Eclipse development, new forms of contracts with providers, GP practice self-learning development, new GYW joint commissioning team covering adult and children's services, with Norfolk and Suffolk County Councils

Clinical leadership

- Identifying
- Developing
- Empowering

Examples: CCC, Retained Clinicians, Protected Time for Learning, Clinical Leads, Integrated commissioning model between secondary and primary care, succession planning, Retained GP led practice visits

Improving patient outcomes

- Improving the patient experience in Great Yarmouth and Waveney
- Delivering care closer to home: eg looking after people better at home though increased resources in our communities for example by recruiting to the out of hospital team, and transforming care through the Gorleston Connected Care Project
- Reducing avoidable admissions
- Achieving targets in primary and secondary prevention: eg our diabetes project
- Reducing inequalities: eg public health programmes, for example the integrated Tier 2 and 3 weight management service and the teenage pregnancy services
- Improving services and choice in end of life care

Risks

- QIPP: non delivery of QIPP savings target
- Capacity: manpower plans and transformational plans fail to deliver
- Primary care resilience: leading to practice disengagement in commissioning and to reduction in clinical leaders' time to devote to delivering change, affecting ability to deliver
- Continuing Health Care: potential value of retrospective claims
- Key Performance targets: non delivery by providers
- Reconfiguration: media, resource and service impact
- Quality: failing to triangulate quality data from providers effectively to identify risk
- Scale of the organisational challenge: clinical financial and reputational – creates anxiety in our member GPs and drives disengagement rather than engagement at the same time as primary care pressures escalate
- NHSCB and primary care delivery: failure to deliver and support primary care capacity, will impact on secondary care activity (demand rises)

NHS
Great Yarmouth and Waveney
Clinical Commissioning Group
HealthEast

HealthEast Prospectus 2013/14

All about this prospectus

This prospectus is a short guide for the 230,000 people we serve who live in communities across Great Yarmouth and Waveney. It explains what the new Clinical Commissioning Group (CCG), 'HealthEast', is all about. It tells you:

- who we are
- how we spend our budget
- what standards you can expect from your local health services
- who we work with
- how we listen to you.

After reading this, if you have any questions, please get in touch with us:

- by phone on **01502 718629**
- by email at **gywccg.your-views-matter@nhs.net**
- or through our website at **www.greatyarmouthandwaveneyccg.nhs.uk**

Who are we?

HealthEast (NHS Great Yarmouth and Waveney Clinical Commissioning Group) is a membership organisation made up of 27 GP practices. HealthEast is responsible for planning and managing health services for patients across Great Yarmouth and Waveney – we call this 'commissioning'. This includes planning what services we need and agreeing contracts with hospitals, community services, mental health services and other organisations to provide care for patients within the budget we are given by the Government. We have a major responsibility to make sure that our population receives safe and high quality services every day.

A bit about the new NHS

The NHS has dramatically changed over the last year. Strategic Health Authorities and Primary Care Trusts have gone. In their place, we have Clinical Commissioning Groups (CCGs) and NHS England. Local clinicians including GPs, nurses and therapists, now have far greater involvement in the design and management of your local health services. Clinicians in Great Yarmouth and Waveney have embraced this opportunity and are already working more closely together across health services and social care. HealthEast is committed to providing more care that is closer to or in patients' homes, with the best and most up-to-date services for the people, with the resources we have.

CCGs are different because we have clinical input in all areas of our work, and much stronger clinical engagement. We have GPs, hospital doctors and nurses on the HealthEast Board and on all our decision making forums. We are a clinically led organisation.

Our ambitions for better health in Great Yarmouth and Waveney

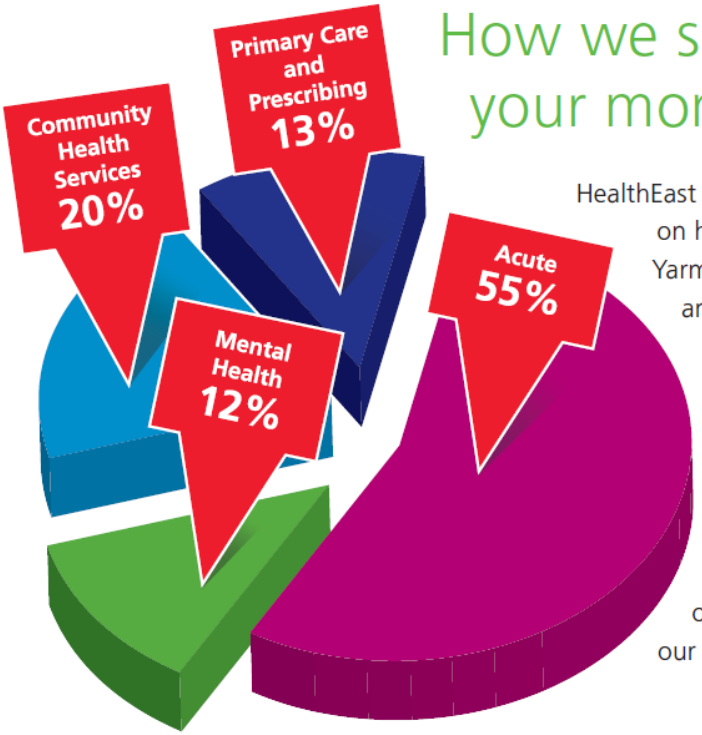
Alongside these changes there has been an increased emphasis on making sure that patients sit at the very centre of how we organise services. We are ambitious, and we want to deliver better services and make the best use of the money and staff we have available.

We will commission services that are flexible and modern. Working with all our partners in health, social care and the voluntary sector, and of course, patients and carers, this new approach will deliver our vision 'better care, better health, better value' by:

- addressing the major causes of illness and ill health in our population
- designing services to meet the needs of patients and carers
- delivering more care to people at home to help prevent them having to go into hospital
- bringing together GPs, clinicians and other professionals so that the care they give to patients is fully co-ordinated and is delivered without delay closer to, or in patients' own homes
- working closely with local authorities and the voluntary sector to deliver care in an integrated way, working closely with the new Health and Wellbeing Boards
- offering greater support for people with long term conditions
- being in touch with patients and clinicians.

We have an 'Out of Hospital' strategy that says much more about our ambitions. You can find a summary on our website at www.greatyarmouthandwaveneyccg.nhs.uk. Our current healthcare system does not always deliver the integrated care that people need and want, with gaps between different services, and duplication and delays for patients. Many people could be treated very well in their own homes, without the need to go to hospital. If they are not actively cared for, their illness may result in a poor quality of life and needing emergency care in a hospital. More importantly, integration can also be beneficial for individual patients and service users. The lack of joined-up care is a huge source of frustration for patients, service users and carers, as well as for health and social care professionals. If we can deliver fully coordinated services, this will really improve quality and safety for all those that use these services.

That is our ambition.



How we spend your money

HealthEast currently spends £800,000 every day on healthcare for people living in Great Yarmouth and Waveney. This is the same amount as we had last year, but we need to start spending it in a different way to make sure that our services continue to meet the needs of our population. The largest proportion of total expenditure is spent on acute care including maternity and accident and emergency services. The chart opposite shows how we plan to spend our money this year.

Our priorities for YOUR health in 2013/14 and beyond:

- ensuring high quality, safe services for our patients
- focusing on the major causes of ill health in our communities – respiratory illness, diabetes and people who are elderly and frail
- strengthening our GP practices
- improving emergency care and reducing hospital admissions
- being transformational and innovative in the services we buy, focusing on better care for people with long term conditions
- delivering modern 21st century health care in settings that are comfortable and clinically appropriate for your needs.

Good quality health services, safe for you and your family

There has rightly been a strong national focus on high quality services that are safe for the patients who use them. We are already working to implement the recommendations of the Francis Report. We are committed to commissioning services for patients that have always been assessed by local NHS clinicians (doctors, nurses and therapists) and that meet the national statutory requirements for providing multidisciplinary safe and high quality care. We expect all our health providers to:

- improve patients' experience by improving the complaint process, and focusing on staff engagement and safe staffing levels to improve patient experience
- improve patient safety, delivering harm-free care and improving patient documentation
- improve clinical outcomes and effectiveness by meeting national performance standards in the care of patients that suffer a stroke, improving services for patients with dementia and increasing the use of national audits and compliance with NICE guidance.

HealthEast will work with GP practices to further improve quality and safety in prescribing. And we will support their business leadership to make sure there is a vibrant future for general practice in our area, as well as having the capacity and capability to manage rising demand on health services.

How we will work to tackle health inequalities

Our population is changing. People are living longer, and many of them will live with significant, often complex, health and social care needs, like dementia, diabetes and heart problems. Here in Great Yarmouth and Waveney, we have one of the highest mortality gaps in the East of England: 8.5 years for men and 4.9 years for women. We are also experiencing a rise in the number of people with dementia and we expect this to grow further, resulting in an estimated 12% increase through 2013/14.

As well as a growth in the number of people over 65, we are facing a real challenge with rising levels of obesity, which contributes to poor health. And we have other challenges too, around smoking and high levels of admissions to hospital related to alcohol.

At HealthEast, we will meet these challenges head on. Community development, getting residents to work together to improve their health, is very important to us. We all know that disadvantaged neighbourhoods often have pockets of ill health and make high demands on the resources of the NHS and other local services. By boosting prevention, early intervention and support in their neighbourhoods, the health and wellbeing of the whole area can benefit substantially.

A really good example of this in action already is our recent work in Gorleston with our Connected Care Project, with the national charity Turning Point. Here we are working with trained community advocates to listen to the issues faced by local patients with long term conditions. This work is being taken forward now in an integrated way with our partners, and we are planning similar projects in the future in areas like Kirkley.

To deliver all this, we continue to work with Public Health and with the Health and Wellbeing Boards of Norfolk and Suffolk to address challenges like rising obesity levels. This work is supported by our innovative System Leadership Partnership Board which acts as a local Health and Wellbeing Board, drawing together partners from across the community including health, social care, third sector and patient representation. We are building on past successes and address these challenges through smoking cessation services, Tobacco Control initiatives, NHS HealthChecks, and public awareness campaigns.

Remember, you can help us meet these challenges. Being healthy and well is your biggest asset. By taking responsibility for your health, looking after yourself, eating well and taking regular exercise, you can make a difference too.

How we listen to you

Patients are the focus of all we do in HealthEast. Every day we work with patients and the public to get your views on our work and the decisions we make. We want to know what patients think about the quality of their local health services, so that they can influence how they are commissioned. Over the next five years, as the pressure on money to buy services in NHS finances becomes tighter and commissioning decisions more difficult, HealthEast will make sure we effectively engage, consult and feedback to people across Great Yarmouth and Waveney, telling you clearly how we are investing tax payers' money.

We do this by working with our local patient groups in practices, by asking your views, most recently on stroke and mental health services, and through engagement and public consultation work in our local communities, like our public consultation in Lowestoft. And we will work closely with the newly formed Healthwatch groups in Norfolk and Suffolk, keeping the local Health Overview and Scrutiny Committees informed at every stage about our plans.

As a new organisation, communications and engagement with patients and carers are central to all we do. We will always:

- value the patient voice, and develop a culture that listens, hears, and uses these insights to inform commissioning and service transformation
- harvest the experience and views of local clinicians – built on patient stories – about services, and use these to provide a rich resource to improve the design and delivery of patient care
- gather the views of our population about our priorities and plans.

A few last words

We hope this has given you a flavour of what HealthEast is all about. If you want to know more, go to our website. Or you could get involved by joining the Patient Participation Group (PPG) at your local GP practice. Thank you for taking the time to read our prospectus.

Published by the Board of HealthEast, the NHS Clinical Commissioning Group for Great Yarmouth and Waveney
May 2013

If you would like a copy of this publication inanother format such as Braille, large print, audio cassette or in another language please contact HealthEast on **Tel: 01502 718629**

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NHS
West Norfolk Clinical Commissioning Group

Norfolk Health & Wellbeing Board

Progress update from West Norfolk CCG covering:

- Our 3 local priorities, informed by the Joint Health & Wellbeing Strategy
- In-year progress against the 3 local priorities
- Our 'Plan on a Page'
- Our draft Prospectus (**Note** – **The Prospectus is to follow)**

The Health & Wellbeing Board is asked to endorse the West Norfolk CCG 3 local priorities and draft Prospectus

West Norfolk CCG – 2013/14 Local Priorities and Progress

Norfolk Health & Wellbeing Priority	Local Priority	Definition	Numerator	Denominator	Measure	In-year Progress
Supporting people to live Independently	End of Life	*Proportion of people who are able to have end of life care in their preferred place.* 2013/14 is the Hospice at Home service's first full year of operation and the CCG's 2 year goal is to increase this proportion of people having their preferred place of care to 90% by March 2015. **Numerator** Number of patients who have end of life in their preferred place, as per their care plan. **Denominator** Number of Patients referred to the Hospice at Home service	130	200	65%	On track
Promoting good mental health and wellbeing	Mental Health	*Proportion of diagnosed Dementia patients referred to a specialist community dementia service.* **Numerator** Number referred to a specialist community dementia service **Denominator** Number of diagnosed Dementia patients based on Quality Outcomes Framework indicator This is a new service planned to deliver for 13/14	558	1116	50%	On track
Promoting healthy lifestyles	Lifestyle Referral	*Proportion of people who improve their WHO Health and Wellbeing Score through the Hearty Lives - Lifestyle Referral Pathway.* **Numerator** Number of patients who improve their health and wellbeing score **Denominator** Numbers of patients referred to the service who have a personal health plan	252	360	70%	On track

13/14 Plan on a page

NHS
West Norfolk Clinical Commissioning Group

Health and Wellbeing	Strategic Priorities	Commissioning Themes	Objective	13/14 Outcomes	Key Risks to Delivery
Lifestyle factors • Alcohol • Smoking • Physical • Activity • Obesity **Life expectancy** **Diabetes** **Coronary heart disease** **High frail/ older population** **Dementia** **Emergency admissions for** • COPD • CHD • Ambulatory care sensitive conditions	**Quality** Improve the quality of services and value for money within the existing CCG budget **Performance** Minimise variations in performance and reduce the gap in inequalities **Integration** Build further on integration between health and social care, working closely with local authorities, the voluntary sector and the local population	**End of Life** NHS Outcomes Framework - 2,4,5	• Improve end of life care choices for patients • Improve co-ordination of community and specialist services • Improve quality of training throughout the health system on end of life care.	• 65% of Hospice at Home - EoL patients achieve their preferred place of care • £125,000 if QIPP savings from reduced acute admissions and fast track CHC packages.	• Delay or inability to recruit to key posts • Split service delivery through community partnership.
		Urgent Care NHS Outcomes Framework - 2, 3, 4	• Ensure a whole system approach is adopted to deliver and actively manage patient pathway developments across health and social care service providers through the 1% CQUIN initiatives - *next day consultant clinics, expansion of the rapid assessment team, joint assessment team, and routine review of frequent attender's* • Increase availability of community beds within West Norfolk • Enhance the delivery of the Acute GP service.	• Emergency Admissions will not exceed 10/11 levels • £750,000 efficiency savings.	• Effectiveness of provider partnerships at a strategic and operational level • Restricted availability of community beds.
		Reducing Unwarranted Variation in Care NHS Outcomes Framework - 1, 2, 3, 4	Optimise pathways to align with best practice whilst reducing activity to national and cluster levels. • Digestive system disorders • Cardiology • Ophthalmology • Urology and • Ambulatory care sensitive conditions (ACSC).	• Reductions in activity across the acute care resulting in efficiency savings of £2 million.	• Limited clinical engagement from primary and secondary care • Delayed implementation of initiatives due to extent of review and notification and deliverability of pathways and services.
		Long Term Conditions NHS Outcomes Framework - 1, 2, 3, 4, 5	• Increase community capacity and capability to manage the increase in demand for Continuing Health Care (CHC) • Continue development of Community Matron service • Improved patient self management of long term conditions. • Enable the delivery of best practice pathway for Stroke – Efforts focused on community rehab and early supported discharge	• A reduction in base line growth in CHC from 15% to 10% saving £600,000 • 20% increase in emergency admissions avoided through the Community Matron service.	• Limited resources across the system to deliver growth in CHC • Co-ordination of multiple agencies in the delivery of CHC • General Practice engagement in pathway delivery/activities.
		Mental Health NHS Outcomes Framework - 2, 4, 5	• Review and develop the Dementia care pathway • Enhance the deliver of the Memory service • Improve access to IAPT and Wellbeing service • Enhance community mental health support for adults and those with long term conditions.	• A 5% increase in Dementia diagnosis rates • Increase in diagnosed Dementia patients referred to a specialist community service • 13% of patients with depression and/ or anxiety disorders access IAPT • IAPT recovery rate to remain above 50%.	• Ensuring equality of service provision in West Norfolk with specific reference to NSFT's radical redesign • Capacity of current memory clinic.
		Prescribing NHS Outcomes Framework - 1, 2	• Optimise wastage initiatives • Facilitate QIPP prescribing initiatives in general practice in high cost areas such as stoma, diabetes, respiratory and pain • Deliver an effective General Practice Prescribing Incentive Scheme • Support community matron and specialist nurse medication reviews.	• Achievement of specific QIPP prescribing initiatives compliance targets. • Remove base line 5% growth • Efficiency savings of £1.6 million.	• General Practice adherence to incentive scheme • Internal capacity to deliver QIPP initiatives.
		Prevention NHS Outcomes Framework - 1, 2	• Enable practice members to deliver Lifestyle Referral Pathway, for patients needing to make behavioral changes in healthy eating, physical activity • Improve the capabilities and capacity at general practice to optimise cardiac care.	• A minimum of 70% of those referred will achieve an improved WHO Health and Wellbeing score.	• Control and monitoring over the new Health Trainer contract • Engagement of General Practice in the prevention agenda.

Clinical Quality and Patient Safety.

Stakeholder Engagement Patients, Providers, Commissioners and those with vested interests within health and wider system.

Patients Experience Ensure the delivery of the Friends and family Net promoter scoring card.

Corporate Governance Delivery the Equality Delivery System, Developing a Sustainability Development Management Plan and Ensuring compliance of information governance. Key Strategic risk of assuring delivery of plan at sufficient pace to deliver efficiency savings

Contract Management provider contract challenges, review of non-healthcare contracts, county wide pathology procurement.

South Norfolk CCG

Report to Norfolk Health and Wellbeing Board

July 2013

In-Year Monitoring on Health & Wellbeing Priorities – NHS South Norfolk CCG

Presented by: Dr Jon Bryson – Chair, NHS South Norfolk CCG

Purpose: For Information

Summary:

This paper sets out to contextualise NHS South Norfolk Clinical Commissioning Group's progress towards the health priorities of its locality, as developed and defined by the Joint Health & Wellbeing Strategy and the CCG's own Integrated Commissioning Plan.

As requested by the Norfolk Health & Wellbeing Board, NHS South Norfolk CCG is providing the following papers:

- South Norfolk CCG 2013/14 'Plan on a Page'
- South Norfolk CCG Draft Prospectus [For approval]
- Presentation – CCG priorities and delivery to date

Recommendation

The Board is asked to note the report.

South Norfolk Clinical Commissioning Group

NHS
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Clinical Commissioning Group

SOUTH NORFOLK CLINICAL COMMISSIONING GROUP

Health and Wellbeing Board

10th July 2013

To deliver the highest quality integrated healthcare which is appropriate, effective, efficient and sustainable, in order to improve the health and well-being of the whole and diverse population of South Norfolk

Context	Vision	Aims	Strategies	QIPP Work Streams	Outcomes	Programmes	Iniatives Include	Engagement	Governance
High incidence of long term conditions Ageing Population Unhealthy Lifestyles Health Inequalities Variations in Access to Services Financial Restraints & Challenges	Delivering the highest quality integrated healthcare in order to improve the health and well-being of the people of South Norfolk	Promoting a safe and innovative approach to clinical commissioning, fully utilising local patient experience to inform and challenge our processes	Fully integrated community health & social care teams	Frail older people £1.8 million efficiency saving	•Right care, right setting, right team •Improvement in patient reported outcomes •Increased % of patients who die in their preferred place of care	Integrating health and social care Integrated pathways of care Case management	•Frail & older people project (FOPP) •End of life/continuing care pathway improvement. •Reablement •Falls service review •Pathway and service integration	Patient and Public Engagement – 'Your Voice Portal', SNCCG Public Website, Patient and Public Groups, County Council Engagement Networks Local Media Stakeholder Engagement – Voluntary Sector, Local Councils, MPs, Providers, Charitable Groups Member Engagement – Locality meetings, Website, Involvement in Pathway	Governing Body and Health and Well Being Approval Assurance Framework Organisational Risk Register Monthly Performance Monitoring Programme Management Individual accountability
			Review referral rates, prescribing and outcomes to minimise unwarranted variation	Planned care and tackling variation £4 million efficiency savings	•Clinically effective •Integrated pathways of care •Reduced variation in referrals •Reduced variation in access •Promotion of patient choice	Redesigning care pathways Referrals management Prescribing practice Reviewing thresholds for surgical intervention	•MSK pathway review •Remodel audiology •Review pain, Upper GI, dermatology & T&O pathways •Access to community diagnostics •Prescribing incentive schemes		
				Emergency and urgent care £1.4 million efficiency savings	•Improved management of LTCs •Less reliance on acute sector •Reduced variation in access •Reduce variation in, and improve performance of providers	Reforming the urgent care system Avoiding unnecessary hospital admission(s)	•Reduce levels of cardiac hospital admissions •A&E attendance followed by zero length of stay		
			Promotion of healthy lives , well-being and self management	Mental health	•Personalised budgets •Implement national dementia strategy	Improving management of dementia Improving access to psychological therapies	•Implement dementia strategy •Organic mental health pathway review		
				Women and children	•Reducing levels of childhood obesity •Improve children's activity levels	Tackling childhood obesity	•5 year health y weight strategy •Procure TOP local service •Maternity PbR review		
			Review and maximise value of current investments	Finance £1.2 million contract, procurement and performance savings	•Rigorous planning •Commissioning and ongoing review of service delivery •Tackle high spend areas of mental health •Cancer and circulatory disease •Prescribing costs reduced	QIPP CQUINs including reduction of emergency hospital admission(s) KPIs with specific targets and outcomes for all providers	•PbR for Mental health •Reducing GP prescribing expenditure •Spending review on continuing healthcare		

Priorities

- Tackle high incidences of adult and childhood obesity, smoking and alcohol consumption
- Integrating Health and Social care, and integrated pathways of care
- Reducing variation within care pathways across South Norfolk

Progress on Priorities

- Ongoing development of South Norfolk CCG's 'Healthy Weight Strategy' – currently being assessed by clinicians across South Norfolk before wider consultation
- Developing shared outcomes with Public Health and District Councils to deliver an impact on smoking cessation and alcohol consumption
- Mid Norfolk's Community Geriatrician Project and ongoing contact with health and social care providers via quarterly forums
- Engaging clinicians in discussions regarding reviewing referral rates

NHS
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Clinical Commissioning Group

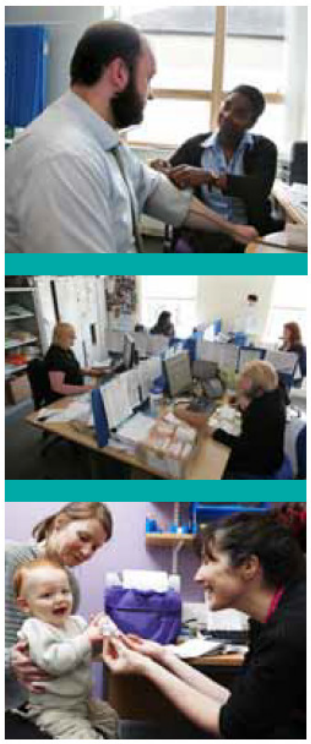
South Norfolk Clinical Commissioning Group

Prospectus

Mission statement of SNCCG

"SNCCG aspires to deliver the highest quality integrated healthcare, which is appropriate, effective, efficient and sustainable, in order to improve the health and well-being of the whole and diverse population of South Norfolk."

Overview



SNCCG comprises 26 General Practices and has a population of 223,000 (weighted 227,000). The CCG covers a predominantly rural area to the south and west of the city of Norwich and the main district towns are: Thetford, Dereham, Attleborough, Watton and Diss.

SNCCG spans two District Councils:

- South Norfolk District Council
- Part of Breckland District Council (the remainder forming part of West Norfolk CCG).

SNCCG also commissions services for a section of population who live in Suffolk, but registered to practices in Thetford and Diss.

The current model of delivery in SNCCG is locality based. Its constituent member Practices are organised into four localities:

- Breckland,
- Ketts Oak,
- Mid-Norfolk,
- South Norfolk Health Improvement Partnership.

The CCG has strong collaborative commissioning partnerships with other CCGs in Norfolk, NHS Anglia Commissioning Support Unit, Norfolk County Council and Breckland & South Norfolk District Councils.

Health & Wellbeing Strategy

South Norfolk CCG has a Consultant in Public Health and a Public Health Officer aligned to it as an organisation from colleagues working in Public Health Norfolk, based at Norfolk County Council. The CCG has consulted with Public Health frequently to ensure its Integrated Commissioning Strategy reflects the Health Intelligence of the needs of the population, and the overall aims and objectives of Norfolk's Health & Wellbeing Board.

- People in SNCCG's area enjoy relatively good health compared with the rest of England. Deprivation is lower than average and life expectancy higher than average but the CCG wide data mask variation at local level between localities, with some with poor health status largely linked to deprivation, unemployment and the low level of educational attainment.

- Over half the population are of working age, there are higher numbers of older people than across Norfolk as a whole and the number of older people is set to rise over the next 20 years.

- Mortality rates from all causes have fallen over the last ten years, although there is a high incidence of Diabetes, chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), Dementia, depression, Stroke, cancer (skin & breast) and hip fracture.

- Whilst it is important to tackle these diseases it is equally important to focus on the health improvement issues including adult and childhood obesity, smoking, alcohol consumption and teenage pregnancy.

Summary of priorities:

- ✓ Stopping smoking
- ✓ Tackling alcohol misuse
- ✓ Addressing obesity in children by promoting healthy lifestyles.

For the ageing population the CCG will have an increased focus on:

- ✓ Prevention and management of age related LTCs such as Dementia, Diabetes, cancer and falls.

For primary prevention the CCG will also tackle:

- ✓ Reducing variation in referrals and access to healthcare
- ✓ Improve flu immunisation

Ensuring high standards of commissioned services for our population

The CCG's strategy is to commission the best possible health services & outcomes for local people in financially challenging times by:

- Critically reviewing & maximising the value of our current investment in services (which could lead to disinvestment)

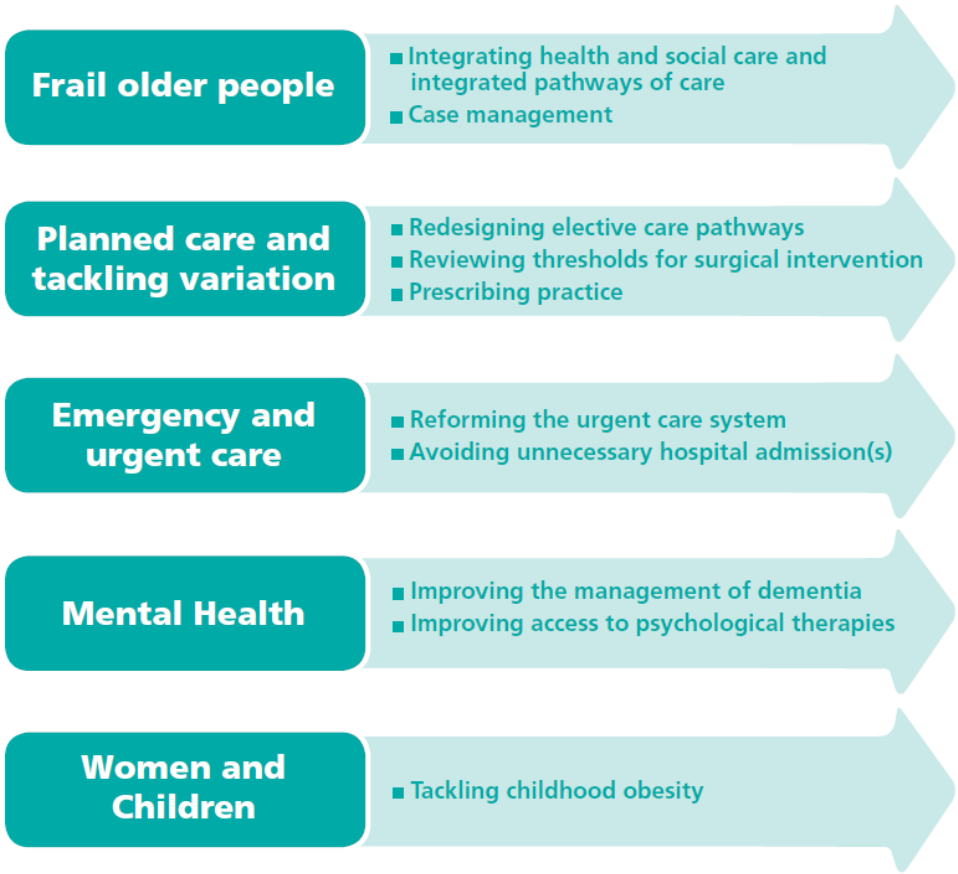
- Rigorously driving up the quality, effectiveness and efficiency of our commissioned services by better engagement of clinicians and intelligent but rigorous performance management of contracts

- Relentlessly reviewing Primary Care quality markers, such as referral rates, prescribing and outcomes across our Practices so as to minimise unwarranted clinical variation

- Commissioning care in the right setting, at the right time by the right team and practitioner

- Delivering fully integrated community health and social care teams as the norm, working in full partnership with local General Practice to support people in their homes

Our priorities are summarised in this diagram:



CCG Budget and Allocated spend, 2012/13

The following table indicates South Norfolk CCG's budget for the 2013/14 financial year:

	2013/14
	Annual Plan £000
2013/14 Notified Allocation (Programme)	234,253
2013/14 Notified Allocation (Running Costs)	5,580
Other Allocations	1,351
Total resources available	***241, 184***

Addressing Health Inequalities

SNCCG's Integrated Commissioning Strategy is being shaped by the health needs of, and the unique service delivery challenges faced by, the population of SNCCG:

- An older population living longer with at least one long term condition (LTC).
- A large rural area with poor transport infrastructure making access to services and the need to deliver more care at or closer to home more challenging.
- Unwarranted variation in health status and outcomes in particular parts of the locality, particularly for young people.
- A need to promote healthy lifestyles and improve quality of life.
- The need to prioritise resources accordingly in a time of economic constraint.

We will work collaboratively with key partners in local government and across the statutory and voluntary sectors to meet the challenges of these inequalities. Some of our ongoing activity includes:

- Supporting Public Health's 'Healthy Communities' network across South Norfolk, as driven by the 'Thetford Healthy Town' project that was supported by local clinicians and the CCG.
- Developing a GP-driven 'free leisure centre passes' project with South Norfolk Council's Leisure services department to encourage people with high BMIs to access physical activity services and support.

Engagement with population

How we currently communicate with the population living within the boundaries of SNCCG:

- Reports / Updates to Patient Participation Groups
- CCG patient information leaflets / posters / displays – for surgeries
- Press releases / stories
- CCG Public Website
- 'Your Voice' service – commissioned by Norfolk County Council: http://www.yourvoicenorfolk.co.uk/

How the CCG involves the population and listens to its feedback:

- Public made aware of South Norfolk CCG as an organisation – what we are, what we do / do not do, how they can be involved [via – CCG website, information in Practices, press relations]
- Publically accessible CCG Prospectus – outlining the CCG's work and intentions, drawing on Integrated Commissioning Plan
- Patient Participation Groups – made aware of Integrated Plan and some of the CCG's key health priorities; asked to comment and highlight areas of interest relating to their practice
- When engagement is required for specific commissioning proposals – contact PPGs, Practices and public via 'Your Voice' service to summarise proposal and the type of feedback / information we are looking for
- Public consultations – drive consultations via targeted press releases, practice information, active involvement of PPGs, Your Voice
- Expert Patients – targeted work with patient / carers groups to understand current patient pathway of care, get feedback on local services, areas for improvement

Services for Adults with a Learning Disability - Outcomes of the Winterbourne View Enquiry

Cover Sheet

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

The Minister for Care, Norman Lamb, has written to all Health and Wellbeing Boards setting out the role that Boards are expected to undertake in relation to ensuring the necessary local action to address the very serious concerns arising from the Winterbourne View Enquiry. The role of the H&WB is to respond to these expectations in what the Minister describes as its 'pivotal local leadership role'.

Key questions for discussion

1. Should all CCGs adopt the same approach and processes for commissioning services for these patients?

2. Is a pooled fund beneficial?

3. Is a separate steering group required with accountability to the Health and Wellbeing Board?

Actions/Decisions needed

The Board needs to decide on:

- The need for/possible advantages of a Norfolk wide consistent approach to the operation and development of the Joint Plan

- The need for/possible advantages of a pooling of resources

- The need for/possible advantages of establishing a multi agency steering group with direct accountability to the Board.

Services for Adults with a Learning Disability Outcomes of the Winterbourne View Enquiry

Report by the Director of Community Services

Summary
This report has been prepared to update members on the progress that has been made in responding to the recommendations of the Winterbourne View Enquiry Report into abuse in a private sector assessment and treatment facility for adults with a learning disability.

The report explains the progress that is being made in delivering on the actions that relate specifically to Norfolk.

The recent letter to Health and Wellbeing Boards from the Minister for Care, Norman Lamb, sets out the role that Health and Wellbeing Boards are expected to undertake in relation to ensuring the necessary local action to address these serious concerns.

1 Background

1.1 In May 2011 BBC Panorama screened an undercover investigation report into a private sector assessment and treatment hospital for adults with a learning disability at Winterbourne View in Gloucestershire. The programme showed shocking levels of abuse taking place which has resulted in the hospital closing and 10 members of staff being prosecuted with 6 given jail sentences by the courts on 26th October 2012.

1.2 A follow up Panorama programme was screened on 29th October which provided evidence that there has been further safeguarding concerns affecting some of the people with a learning disability after their move from Winterbourne View.

1.3 The Care Quality Commission undertook a programme of urgent unannounced inspections of these types of institutions across England and Wales and identified significant concerns in many of the units that they visited. The Department of Health and South Gloucester Council has also undertaken a Serious Case Review. A full report of the findings has now been published. The investigation report has over 60 recommendations.

1.4 A national programme of review has been initiated. Reports detailing Norfolk`s response to the Winterbourne View Enquiry have been previously submitted to the Health and Well Being Board in January and April this year. This report provides a further update on progress that is being made.

1.5 A recent letter from the Minister gives further guidance on the expectations of Health and Wellbeing Boards performing a ‘pivotal local leadership role’ in this regard. The letter is attached at Appendix 1.

2 Key Objectives and Progress

2.1 Progress against the Winterbourne report recommendations which impact upon the Norfolk health and social care economy continue to be monitored and the key local actions and progress against them are given below

1) Develop a local register of people with challenging behaviour in NHS funded care and communicate this to Clinical Commissioning Groups by 31st March 2013.

The register has been completed by the required deadline and has been shared with Clinical Commissioning Groups.

2) By June 2013, all current NHS funded placements will be reviewed, everyone in hospital inappropriately will move to community-based support as quickly as possible, and by no later than June 2014.

These reviews were undertaken according to the national guidance and were completed by the deadline. It has been identified that 8 of the 35 Norfolk people reviewed could potentially be ready to move into community based support by June 2014. The remaining patients are appropriately placed and receiving treatment and will continue to be monitored using the national Care Programme Approach (CPA) procedures and future discharge planning for these patients will be part of these arrangements.

A number of care providers have already expressed interest in developing services for people who may move into community placements.

3) By April 2014, each area will have a joint plan to ensure high quality care and support services for all people with learning disabilities or autism and mental health conditions or behaviour described as challenging, in line with best practice.

Work has begun on the development of the Joint Plan, this is being overseen by the Norfolk Mental Health and Learning Disability Commissioning Board. This plan will incorporate how all Clinical Commissioning Groups in Norfolk will work with Norfolk County Council to:

- *Plan for the stepping down of those individuals identified during the reviews who should move into the community*
- *Monitor those patients who remain placed in these types of services and*
- *Establish an agreed process for new referrals.*

<u>Additional reviewing activity</u>

2.2 Social Care Placements

Norfolk County Council has 89 people placed out of county in social care funded residential and supported living placements. These people are reviewed annually by their care managers and the same national guidance will be used to ensure that;

- their current placement continues to be appropriate,
- there is family involvement in decision making,
- good advocacy services are available and
- to establish whether moving back to Norfolk is a preferred option for them and their families.

This work will be completed by 1st April 2014.

2.3 Continuing Health Care:

The Continuing Health Care Team are also using the new guidance to review their funded patients who have learning disabilities or autism and mental health conditions or behaviour described as challenging and this will be completed by 1st April 2014.

2.4 The role of Healthwatch

Healthwatch continue to develop a proposal to use their power of Enter and View to visit NHS and private sector hospitals. The Joint Commissioner will work with Healthwatch and NHS Clinical Commissioning Groups to ensure that future governance arrangements are co-ordinated effectively.

2.5 Role of Health and Well Being Boards

The letter received from the Minister (at Appendix 1) details the role of Health and Well Being Boards in overseeing the future arrangements for these groups of patients.

In particular the letter refers to

1) "A strong presumption in favour of supporting the new arrangements with pooled budgets and local commissioners will be required to justify where this is not done".

The Health and Well Being Board will wish to consider if a pooling of budgets for this group of patients should be put in place in Norfolk as part of the Joint Strategic Plan.

2) The desire to promote joint and collaborative commissioning between CCGs and local authorities to support these objectives.

Norfolk County Council and NHS West Norfolk CCG, NHS North Norfolk CCG, NHS Norwich CCG and NHS South Norfolk CCG have integrated commission for learning disability agreed under section 75 of the Health Act. There is a specific post of Joint Commissioner for Adults with a Learning Disability. However Health East makes their own commissioning arrangements for adults with a learning disability who require private sector hospital assessment and treatment services. Additionally the Clinical Commissioning Groups in Norwich, North, South and West Norfolk are looking to the NHS Anglia Commissioning Support Unit to manage their governance and contracting for these patients, whereas Health East are preferring to manage their own arrangements. The Health and Well Being Board may wish to take a view on achieving a consistent approach within Norfolk.

3) A recent request from the DH for a "stocktake" on progress refers to the need for a "commissioning group" or steering group to oversee the Winterbourne work. At present the Mental Health and Learning Disability Commissioning Board oversees progress however this meeting does not include any representation from housing providers or district councils?, children's social care or health? services or other statutory agencies.

Given the significance of the concerns raised by Winterbourne and the expectations on Health and Wellbeing Boards to ensure appropriate governance, it is proposed that a specific governance group be established to

provide focused oversight of this work. The group could be chaired by the Director of Adult Social Services for Norfolk or his nominee and function as a sub-group of the Health and Wellbeing Board to establish direct accountability of to the Board of delivery of this key programme of work.

3 Next Steps

3.1 The Joint Plan will continue to be developed in accordance with national guidance and the steer of the Health and Well Being Board.

3.2 For those patients who may require new services during the coming months, discharge planning will begin with the families and social care and health agencies. For each patient this will be led by the Care Co-ordinator using the CPA process.

3.3 The Joint Commissioner will work with care providers to encourage the development of the required services to meet the identified needs.

3.4 The Joint Commissioner will work with Healthwatch to link their proposed inspection arrangements with local governance processes that are developed.

3.5 A further update report will be brought to the Health and Well Being Board in the Autumn meeting when the draft Joint Plan is ready for approval

4 Legal Implications

4.1 NP Law will be consulted on the legal implications of the changes that may be required

5 Financial Implications

5.1 The additional expectations upon local authorities and Clinical Commissioning Groups may lead to financial pressures the extent of which will become clear as the local action plan is implemented

5.2 The potential movement of patients into community settings from private hospitals could place a significant financial burden on the local economy. Representation about the need for funding to follow the patient has already been made to the Department of Health by the Association of Directors of Social Services.

5.3 Norfolk also has higher than average number of private hospital beds and residential care establishments and is a net importer of people from outside the county. Many London boroughs and other counties place people in Norfolk and the effects on our local health and social care economy are well documented. The movement of these patients into the community could also lead to cost pressures

6 Equality Impact Assessment (EqIA)

6.1 Services for people with a learning disability are individually equality impact assessed. Any service changes that take place resulting from the development of the local action plan will also be EQIA assessed.

7 Section 17 – Crime and Disorder Act

7.1 People with learning disabilities are one of the most vulnerable groups in our society in terms of being potential victims of crime and in a small minority of cases perpetrators of crime.

7.2 The outcome of the local action plan will ensure that this group of vulnerable people are protected and safeguarded.

8 Action

8.1 Members are asked to note the contents of this report and provide a view on

- The need for/possible advantages of a Norfolk wide consistent approach to the operation and development of the Joint Plan
- The need for/possible advantages of a pooling of resources
- The need for/possible advantages of establishing a multi agency steering group with direct accountability to the Board.

Officer Contact

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

Officer contacts

Clive Rennie Assistant Director Integrated Commissioning Mental Health and Learning Disability Commissioning Tel 01603 257021

Stephen Rogers, Joint Commissioner Learning Disability Services Tel 01603 257071

IN TRAN communication for all

If you need this Agenda in large print, audio, Braille, alternative format or in a different language please contact **Lesley Spicer, Tel: 01603 638129, Minicom: 01603 223242, and we will do our best to help.**

From Norman Lamb MP
Minister of State for Care and Support

DH Department of Health

To: Chairs, Health and Wellbeing Boards
Cc: Council Leaders and Chief Executives
Chairs and Chief Operating Officers, GGCs

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

Dear Colleague,

Delivery of the Winterbourne View Concordat and review commitments

I am writing to you at the start of your taking on your statutory functions to stress the pivotal local leadership role that Health and Wellbeing Boards can play in delivering the commitments made in the Winterbourne View Concordat[1] which represents a commitment by over 50 organisations across the sector – including the Local Government Association, NHS England, the NHS Confederation, Royal Colleges and third sector organisations – to reform how care is provided to people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. There is widespread agreement across the sector that the care of this group of vulnerable people requires fundamental change.

The abuse of people at Winterbourne View hospital was horrifying. For too long and in too many cases this group of people received poor quality and inappropriate care. We know there are examples of good practice. But we also know that too many people are ending up in hospital unnecessarily and they are staying there for too long.

NHS England, NHS Clinical Commissioners, the Local Government Association, the Association of Directors of Adult Social Services and the Association of Directors of Children's Services each committed to working collaboratively with CCGs and Local Authorities to achieve a number of objectives by 1 June 2014, including that from April 2013, health and care commissioners will set out:

> *"a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of children, young people and adults with challenging behaviour in their area.*

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127312/Concordat.pdf.pdf

This could be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) process;

- *The strong presumption will be in favour of supporting this with pooled budget arrangements with local commissioners offering justification where this is not done.*
- *We will promote and facilitate joint and collaborative commissioning by local authorities and CCGs to support these objectives.*

Health and wellbeing boards have an opportunity through their role in agreeing the CCG and Local Authority Joint Plans to challenge the level of ambition in the plan and ensure that the right clinical and managerial leadership and infrastructure is in place to deliver the co-produced plan.

Health and wellbeing boards will, no doubt, also want to take an active interest in how far the other commitments in the Concordat, particularly those relating to care reviews having been completed by June 2013, have been achieved, as well as satisfying themselves that commissioners are working across the health and social care system to provide care and support which does not require people to live in inappropriate institutional settings.

It will only be through creative local joint commissioning and pooled budgets working with people who use services, their families, advocacy organisations and carers and other stakeholders (including providers) that we will deliver more joined-up services from the NHS and local councils in the future and see real change for this very vulnerable group.

Health and wellbeing boards are well placed to agree when a pooled budget will be established (if not already) and how it will promote the delivery of integrated care – care that is coordinated and personalised around the needs of individuals; which is closer to home and which will lead to a dramatic reduction in the number of inpatient placements and the closure of some large in-patient settings.

The Department of Health has supported the establishment of an NHS England and Local Government Association-led Winterbourne View Joint Improvement Board. This Board will be working closely with a range of partners to develop and implement a sector-led improvement programme working with local health and social care communities to deliver real and lasting change in the support and

Department of Health

care for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. It will shortly be in touch with you separately to take stock of progress in your area so that any appropriate level of support can be arranged.

Due to the very public nature of these failures in care, I am sure that you will want to ensure that your health and wellbeing board is able to provide transparent public information and assurance on progress locally.

Further information about the work of the improvement programme, including a recently issued framework for conducting reviews of care locally, is available on the LGA website. If you have any innovative practice to share, or views on how the programme can be designed and developed to ensure rapid progress and real and lasting change, please contact the programme chair via Chris.Bull@local.gov.uk

Yours sincerely,

NORMAN LAMB

We hope to publish progress around the country in meeting the commitments made in the Concordat in the Summer.

Thanks so much for your work on this incredibly important issue!

MINUTES OF HEALTHWATCH NORFOLK SHADOW BOARD HELD ON TUESDAY 5 MARCH 2013 – 2.00 P.M. ABBEY CONFERENCE CENTRE, NORWICH.

PRESENT:-

Marion Headicar (Chair)
Claire Abbs
Jon Clemo
Graham Dunhill
Mary Ledgard
Emily Millington-Smith
Fiona Poland
Julia Redgrave
Linda Rogers
Joy Stanley
Pa Musa Jobarteh

OFFICERS IN ATTENDANCE:-

Christine MacDonald
Chris Walton
Jo Webb

APOLOGIES FOR ABSENCE:-

Apologies for absence were received from Nick Baker and Moria Goodey.

1. DECLARATIONS OF INTEREST

None.

2. MINUTES OF THE MEETING HELD ON 11 FEBRUARY 2013

The Minutes of the above meeting were confirmed as a correct record.

3. MATTERS ARISING

The Chair provided a process update on Plan B, reporting that alternative options for delivering back office functions had been emailed to the Board members as agreed, highlighting the urgent issue of accommodation. As a result of the email, a majority of the Board voted “in principle” for the Keystone Innovation Centre at Thetford for accommodation, which enabled the next stage of the process to be progressed. This included confidential information and was therefore being fully discussed at the end of the meeting, along with quotes for payroll and financial services.

With regard to core staff, Alex Stewart was keen to advertise all four posts at the same time once a decision had been taken on location. Drafts were currently with the Design Delivery Group and bandings were aligned to the NJC scale. It was agreed that at

this stage it would not be appropriate to advertise these jobs as being available for job share.

With regard to financial reporting etc. the Quality and Commissioning Manager's role had been rebalanced to take account of this, as had job descriptions of the other posts.

Linda Rogers noted that the Board had been content with the advice given on TUPE but she wished to raise the issue that some of the advice contained within the legal advice related to Voluntary Norfolk not to Local Healthwatch.

The Chair reported she had written to Rob Cooper, Commissioner, Norfolk County Council, who had contacted Norman Lamb concerning the issue of funding. Following a short discussion members agreed that securing funding over a longer period than two years was key to making Local Health Watch a success but that if the funding agreement was for only two years then there may need to be some negotiation around the outcomes that could be achieved.

It was agreed that Jon Clemo and Mary Ledgard would review the specification and discuss any amendments thought necessary with Rob Cooper at the county council.

On the subject the suggestion from Joy Stanley of a piece of work on skills training, the feedback received from Board members had been positive but there still remained concerns over resources and therefore this would be referred to the incoming Chief Executive for prioritisation.

With regard to election of provider members it was noted that the successful candidates had been Jon Clemo, Moira Goody and Steve Cheshire and that one vacancy remained which would be reoffered to provider members.

4. FIRST MEETING OF HEALTH WATCH NORFOLK (COMPANY)

The Chair handed over to Graham Dunhill who explained that as part of the process of forming the new company a formal meeting of the Board would now take place. The notes of this meeting are attached to these minutes.

5. LINk LEGACY PROJECTS

As part of the handover of LINk legacy issues a QCI panel met on 13 February 2013 to review the ambulance turnaround project and the mental health in prisons projects. It was noted that the original project on ambulance turnaround had been agreed as a regional priority. It was resolved:-

Ambulance turnaround project

- Liaise with HOSC to ensure that the action plan is delivered and properly timetabled

- Monitor implementation of the action plan (via direct HWN CEO contact with partners at CEO level)

- HWN to monitor the effect on ambulance response times (with necessary access to data from the commissioners)

- QC1 Panel to advise both LINk and NHOSC that the above recommendations have been approved by HWN Shadow Board and that HWN will consider commissioning further work if the situation regarding ambulance turnaround does not improve.

Mental health in prisons

- The QC1 Panel should write to the governor at HMP Norwich to confirm that HWN supports the work carried out by LINk in terms of facilitating the forums but as it is not a service provider we anticipate that the Governor would take ownership of the forums.

- HWN to monitor the effectiveness of the healthcare forums and to commission further work if this proves to be necessary.

- HWN to share best practice with other prisons across Norfolk in terms of advocating they set up similar forums.

6. HEALTH WATCH NORFOLK EQUALITY AND DIVERSITY POLICY

Julia Redgrave introduced a draft policy for the Board's consideration. This had been updated to take account of the issue of rurality and also included a co-production commitment, encouraging people to take part in shaping services and an additional reference to discrimination. Julia went on to introduce the Impact Quality Assessment screening tool and explained that Norfolk County Council had a more user friendly tool and she would be working to adapt that to fit the circumstances of Local Health Watch. She was asking the Board to commit in principle to the Norfolk County Council approach and to evaluate it in the light of usage and would also make any amendments necessary to take account of rurality. It was agreed:-

1. To adopt the equality and diversity policy.

2. To agree in principle to the Norfolk County Council Equality Impact Assessment screening tool and to ask Julia Redgrave to adapt it to fit the purposes of Local Health Health Watch and to take account of rurality and that a future workshop be arranged to familiarise stakeholders with it.

7. HEALTH WATCH NORFOLK SAFEGUARDING CHILDREN'S POLICY

Julia introduced a draft policy which was currently out for comment and when that had been received she would bring it back to the Board for formal sign off. It was agreed to endorse the current draft and reconsider it once comments had been received. It was further agreed that the Health Watch Board and the incoming Chief Executive be asked to decide who the policy was "owned by" and whether a Board member should be appointed as a Champion.

8. PROGRESS ON DAY ONE SET UP/READINESS ASSESSMENT

The Chair indicated that she would be deferring this item until after consideration of the issue of accommodation.

9. UPDATE RISK LOG

The Board received the updated Risk Log and it was agreed to add an indication of which risks were increasing and which reducing (attached to these minutes).

10. UPDATE ON RECRUTIMENT PROCESS FOR CHAIR

The Chair explained that it had been decided not to appoint as a result of the last recruitment exercise and that a significant majority of members of the Board had supported the proposal to appoint head hunters. This process was now under way and if members were aware of suitable candidates they should pass it via the Chair to Odgers who were acting for the Board. Jon Clemo would be running the recruitment process. Advice received from Odgers was that £4K was low as remuneration, but there was significant variation in what other HWs paid –and indeed some were offering no remuneration. Whilst the Article of Association limited any payments to £4,000 - £5,000 it was suggested and agreed that Christine MacDonald be asked to have a conversation with the lawyers and Health Watch England about the level of remuneration offered and in the light of that advice, if appropriate, to discuss with the Charity Commissioners the possibility of increasing the remuneration to £7,500, on the basis of LG/NHS comparators.

With regard to the interim chair, the current Chair's term of office ended on 31 March 2013 and therefore the first meeting of the Board would appoint a new interim Chair until the independent Chair was in place.

11. UPDATE ON GOVERNANCE ARRANGEMENTS FOR MEMBERS

Jon Clemo reported that 184 applications for membership had been processed with a good demographic spread. He considered that by the time elections were undertaken there would be significant legitimacy by virtue of the numbers of members. It was possible that the issue of smaller organisational membership needed to be clarified. He also sought clarification from the Board on the elections for individual and small organisation members to be held on 28 March 2013 and whether voting should be anonymous. The Board agreed that this should be the case.

12. OUTCOME OF CONSULTATION WITH REPRESENTATIVE GROUPS/COMMITTEES

Graham Dunhill reported that a questionnaire had been sent to all LINk members and committee/group leads of those committees that LINk had been involved with to date. The results had been analysed and the main themes were shown in the report. Graham added that it was important for Local Health Watch to set not just to follow the agenda. Clearly Local Health Watch would not want to lose valuable LINk members and Jon Clemo suggested that this could be something that could be picked up on at the proposed event on the 28 March 2013. Following a brief discussion it was agreed that there would be two separate events on the 28 March 2013; an election and an earlier event for members based on sharing progress so far and consulting community members on how HWN might best engage in standing consultation and other groups. It was further agreed that Graham Dunhill and Jon Clemo would progress this and Graham was given delegated authority to agree a budget to cover an extension to Jon's contract to deliver

this event on the 28 March 2013 and that Jon would provide marketing material and also provide information to members of the Board to allow them to circulate it further.

13. UPDATE ON THE SCOPING OF PRIORITY PROJECTS

Four priority projects had been identified:-

- Enter and view
- Child adolescent and mental health service
- Under represented groups
- Complaints

The proposal was that these would now go to the next Quality Control stage. It was agreed to progress this as a priority and that three members would meet together and progress all four projects

14. OPTIONS FOR A SOFT LAUNCH

It was agreed to await the input of the Chief Executive before taking this further.

15. CONFIDENTIAL AGENDA: ACCOMMODATION AND HR/FINANCIAL SERVICE PROVISION

At this stage it was moved and agreed that the public be excluded from the meeting in view of the fact that commercially sensitive information would be disclosed if they were present.

The Chair gave some background to this item and acknowledged that this was a difficult decision but critical to Day 1 readiness. She set out the advantages of locating at the Keystone Innovation Centre in Thetford and pointed to its availability, affordability and co-location with other health and the voluntary sector organisations. However, the venue did raise issues of accessibility to the rest of the County. The view of the Chief Executive was that location of back office functions was not significant as Local Health Watch would have to be out and around the County to reach people. The Chair explained that the alternative which had been put forward was temporary accommodation in County Hall, which could continue to accommodate Local Health Watch while a property search was undertaken. But the Chair pointed out that this would delay operational effectiveness from 1st April, in particular the ability to appoint permanent staff. On the basis of the email vote, the Chair circulated possible heads of terms for the Keystone Innovation Centre for members to consider as part of the next stage of the procurement process. The Chair invited contributions and the following comments were made.

Graham Dunhill would wished to have been assured that if the Thetford location was taken up Local Health Watch would be available to stakeholders locally and a clear message needed to be given out to that effect. Jon Clemo was concerned at the possible officer travel time by locating at the very periphery of Norfolk and was also not convinced that the value for money of this building was well demonstrated. Linda Rogers agreed with Jon Clemo. Fiona Poland thought that Local Health Watch would need strong cross county links and locating in Thetford might actually act as a catalyst to embracing partnerships and joint working which would in reality would be extremely valuable. Julia Redgrave pointed out that break clauses could only be activated on the 31 March each year, though the Chair pointed out that annual break clauses were in fact a bonus – more

than one a year was unheard of. Pa Musa Jobarteh was not in favour of Thetford and felt that it was unwise to rush into an option, though both he and Julia Redgrave admitted the Keystone development comprised good office accommodation. Joy Stanley said that she felt in the early stages that Thetford was a preferable option and while she still had reservations she continued to support it.

The Chair pointed out that failing to agree a permanent location would have a knock on effect on the timescale for appointing staff. Linda Rogers did not concur with the point about recruitment. Mary Ledgard supported Thetford and added that whichever location was selected would not be central to all of Norfolk and she didn't feel that a temporary location with a subsequent move was sensible. The two options were therefore clarified as accepting the suggestion to locate at the Keystone Innovation Centre in Thetford from 1st April or to take temporary accommodation at County Hall whilst a property search was undertaken. On a show of hands, with four members voting in favour of locating to Thetford and five members voting to locate on a temporary basis to County Hall with a subsequent property search, the latter option was adopted. (An email "vote" from an absent board member was disallowed by Chris Walton).

With regard to the provision of payroll and financial services, the Chair circulated external tendering information with regard to payroll and financial services. After some discussion it was agreed to delegate this decision to the Chief Executive with the instruction that he achieves best value whilst clarifying the issue of book keeping and job descriptions.

The meeting then resumed in public.

16. PROGRESS ON DAY ONE SET IN READINESS

The Board discussed the practical steps that would need to be put in place on day one. It was suggested that staff would need to be in place to answer the telephone and to make sure that the website was up and running. To this end the Board proposed several options, including the use of temps, secondees from NCC and the loan of NRCC's admin team (including office space if desirable).

It was agreed to ask the officers to do some more work on Day one readiness and to assess the HWN's requirements, in the light of existing staff capacity, together with the above suggestions, and email them to the board for a view. (excluding Jon Clemo because of his declared interest).

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17. DATE OF NEXT MEETING

It was agreed to ask officers to come up with a proposal for the first meeting of the new Board.

18. ANY OTHER BUSINESS

It was agreed at this stage not to progress the pen pictures of the Shadow Board given the timescale. Christine MacDonald fed back on the internal tendering lessons learned.

19. OUTGOING CHAIR

The Board paid tribute to the contribution of Marion Headicar in leading the Board through its shadow period and thanked her sincerely for her contribution. In response, the outgoing Chair thanked the Board for their hard work and commitment in taking what was clearly a very exciting project almost through to its inception.

The meeting concluded at 5.15 p.m.

CW/MJL-minshwnsboard50313
7 March 2013

HEALTHWATCH NORFOLK ("the Company")

Minutes of the first meeting of the Board of Directors of the Company held at the Company's registered office at the Abbey Conference Centre, Norwich on the 5th day of March 2013.

PRESENT: Linda Rogers
Pa Musa Jobarteh
Fiona Poland
Julia Louise Redgrave
Claire Abbs
Jonathan Michael Clemo
Graham Stanley Dunhill
Joy Stanley
Emily Millington Smith
Mary Ledgard

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1. A quorum being present **IT WAS RESOLVED** that Graham Dunhill be chair of the meeting. Graham accordingly took the chair and declared the meeting open.

2. In accordance with section 177 of the Companies Act 2006 and the Company's articles of association, the directors who were personally interested in the proposed transactions to be discussed at the meeting declared the nature of their interests.

Incorporation

3. The Chairman reported the registration of the Company and produced the Certificate of Incorporation (No. 8366440) dated the 18th day of January 2013.

4. **IT WAS RESOLVED** to confirm the appointment of Linda Rogers, Pa Musa Jobarteh, Fiona Poland, Julia Louise Redgrave, Claire Abbs, Jonathan Michael Clemo, Graham Stanley Dunhill, Moira Phyllis Goodey, Joy Stanley, Emily Millington Smith, Nicholas Baker and Mary Ledgard as the directors of the Company.

5. The following documents were produced to the meeting:

   (a) Certificate of incorporation of the Company together with copies of:

      (i) the articles of association of the Company;
      (ii) the memorandum of association;
      (iii) form IN01

   filed with the Registrar.

(b) Company statutory registers.

6. It was noted that the Provider Members of the Company upon incorporation were as follows:-

   (i) Voluntary Norfolk;
   (ii) Norfolk Coalition of Disabled People;
   (iii) Norwich and Central Norfolk Mind; and
   (iv) The Norfolk Rural Community Council.

7. It was noted that the Community Members of the Company upon incorporation were as follows:-

   (i) Graham Stanley Dunhill;
   (ii) Emily Millington Smith;
   (iii) Joy Stanley; and
   (iv) Mary Ledgard.

8. **IT WAS RESOLVED** that accounting reference date of the Company should be 31 March in each year and that the first period should run from the date of incorporation of the Company to 31 March 2014 and that any director be authorised to sign Form AA01 on behalf of the company.

9. It was noted that invitations to tender for the provision of accountancy services have been sent out in order to permit the Company to appoint accountants.

10. There being no further business the meeting was closed.

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Chairman

Healthwatch Norfolk Shadow Board Meeting

Updated risk log following 5 March 2013

Things that may impact upon success of HWN	Likelihood x consequence score	Possible mitigations	Increasing Risk/Decreasing Risk/ No change in risk rating
Unable to transfer members from LINk to HWN	1 x 4 = 4	Keep issue at forefront of Board agenda and keep to proposed timescale	▼
Failure to successfully engage with LINk members and transfer of appropriate legacy	1 x 2 = 2	Continue with regular dialogue with LINks members in an open, transparent manner. Workshop 28 March 2013 for all members to contribute on priority assessment.	►
Failure to recruit permanent chair by 1 April	3 x 3 = 9 3	Consider interim arrangements – rotation of chair by Board members	▲
No clarity as to leadership during process to recruit permanent chair and prior to CEO start date	3 x 4 = 12	CEO to start 8 April and therefore potentially only relates to the period 1-7 April – shadow chair to remain in post until 8 April or designated member of board to be responsible until 8 April	▲
Failure to appoint a strong, effective, permanent board	1 x 4 = 4	Explore possibility of some shadow board members to continue in the transition period – provider and member elections ongoing	►
Reputation is damaged by: • Perceived lack of independence • Perceived organisation provider bias • Failure to communicate with stakeholders resulting in loss of goodwill/breakdown in existing relationships	3 x 4 = 12 2 x 4 = 8 2 x 4 = 8	Robust communications plan (suggested engagement with GP practice managers to be included) Development of engagement framework, mapping networks Working hard over the next few weeks to secure independent accommodation	►
Lack of financial controls	2 x 4 = 8	Successful procurement of appropriate financial services/appropriately skilled in-house staff	▲
Failure to arrange payroll and pension arrangements prior to	2 x 4 = 8	Procurement of pension provider needs to take place	▲

first payroll run		asap	
Poor handling of TUPE issues	1 x 4 = 4	Be guided by independent legal advice	▼
Failure to deliver during shadow board period due to poor monitoring and performance of sub-contracting	1 x 4 = 4	Adherence to policies and procedures already in place, regular monitoring of risks identified	▼
Failure to award contracts as a result of ITT	4 x 3 = 12	Consider and progress alternative options (Plan B) i.e. external tender process implemented, sub contract, agency, provide in-house	▲
Failure to be accepted as a charity	1 x 3 = 3	Proactively monitor application currently with Charities Commission	▼
Monitoring requirements are disproportionate	1 x 3 = 3	Draft monitoring requirements agreed with NCC – requirements will be reviewed at end of first 6 months	▼
Failure to demonstrate value for money	1 x 4 = 4	All governance arrangements fully implemented	►
Failure to deliver on time due to capacity issues	2 x 4 = 8	Appoint necessary staff/members to timescale, sub-contract if possible	▲
Failure of HWN to have access to the NHS Heron database	1 x 3 = 3	Ongoing discussions with NHS Commissioning Support Unit and identifying other sources of information/directories	▲
Failure to address equality issues in each project	1 x 3 = 3 3	Ensure all projects comply with Equality Impact Assessment	►
Failure to have minimum operational support in place on 1 April 2013 (minimum staffing, telephone, email, website, office accommodation)	2 x 4 = 8	Ensure all options considered, pursued and implemented by 1 April. Engage property search experts	▲

Norfolk County Council
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NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD ON 11 April 2013

Present:

Mr R Bearman	Norfolk County Council
Mr J Bracey	Broadland District Council
Mr M R H Carttiss (Chairman)	Norfolk County Council
Mrs J Chamberlin	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Mrs A Claussen-Reynolds	North Norfolk District Council
Mrs M Fairhead	Great Yarmouth Borough Council
Mr D Harrison	Norfolk County Council
Dr N Legg	South Norfolk District Council
Miss J Virgo	Norfolk County Council
Mr A J Wright	Norfolk County Council

Also Present:

James Joyce	Norfolk County Councillor
Margaret Somerville	Public
Sue Spooner	Public
Dr Bernadette Auger	Locum Consultant Palliative Care, Great Yarmouth and Waveney Specialist Palliative Care Team, James Paget University Hospitals NHS Foundation Trust
Tina Cookson	Director of Nursing, James Paget University Hospitals NHS Foundation Trust
Dr Dean Blackburn	Consultant in Palliative Medicine, The Queen Elizabeth Hospital NHS Foundation Trust
Val Woods	Deputy Director Clinical Services, The Queen Elizabeth Hospital NHS Foundation Trust
Jo Segasby	Director Women, Children and Cancer Services, Norfolk and Norwich University Hospitals NHS Foundation Trust
Dr Katie Soden	Lead Consultant, The Priscilla Bacon Centre for Specialist Palliative Care Services, Norfolk Community Health and Care NHS Trust
Michael Scott	Chief Executive, Norfolk Community Health and Care NHS Trust
Chris MacDonald	Healthwatch Development Manager, Healthwatch Norfolk
Mrs Jenny Beesley	Public
Mrs Denise Charlesworth Smith	Public
Roberta Lovick	Public
Maureen Orr	Scrutiny Support Manager (Health) Norfolk County Council
Tim Shaw	Committee Clerk, Norfolk County Council

1. Apologies for Absence

Apologies for absence were received from Mr R Kybird, Mr J Perry-Warnes and Mr G Sandell.

2. Minutes

The minutes of the previous meeting held on 07 March 2013 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

There were no declarations of interest.

4. Items of Urgent Business

There were no items of urgent business.

5. Chairman's Announcements

a) HealthWatch Norfolk

The Chairman welcomed to the meeting Chris MacDonald, Healthwatch Norfolk Development Manager, who was attending the Committee for the first time. The Chairman said the April edition of the Member Briefing included an update on the work of this new patient and public champion organisation and that there was a draft working protocol between the County Council's scrutiny committees and Healthwatch Norfolk in the agenda papers for this meeting that was closely based on the way the Committee had worked in the past with Norfolk LINk. The Chairman added that the Committee could look forward to hearing from Alex Stewart, the new Chief Executive of Healthwatch Norfolk, at a future meeting, as this organisation began to provide a strong and independent voice for patients and the public.

b) County Council Election

The Chairman placed on record thanks for their hard work to those Members of the Committee who might not be Members of the Committee after the County Council election on 2 May 2013.

6. Norfolk Health Scrutiny Regulations

The Committee received a briefing paper and presentation from Maureen Orr, Scrutiny Support Manager (Health), about the new health scrutiny regulations that came into force on 1 April 2013 which provided Members with an opportunity to discuss the changes to the health scrutiny function under the Health and Social Care Act 2012.

A copy of the presentation can be found as an Appendix to these minutes.

In the course of discussion it was pointed out that the position regarding Suffolk County Council's delegation of health scrutiny powers to the Great Yarmouth and Waveney Health Scrutiny Committee would be clarified before the next meeting of the joint committee. It was also pointed out Members of the NHOSC might wish to take part in an event organised by the Centre for Public Scrutiny to bring together NHS England and Public Health England regional and area staff with health

scrutiny members and officers. Maureen Orr said that the CfPS had proposed holding such an event in June 2013 and Members of the Committee would be given details in due course.

7. Forward Work Programme

The Committee agreed the list of items on the current Forward Work Programme, subject to an update on the outcome of the Care Quality Commission's inspections of the East of England Ambulance Service NHS Trust and of the Norfolk and Norwich University Hospital's NHS Foundation Trust being included in the May 2013 edition of the Member Briefing.

8. Use of Liverpool Care Pathway in Norfolk's Hospitals.

The Committee received a suggested approach from the Scrutiny Support Manager (Health) to a review of how the Liverpool Care Pathway (LCP) for the dying was implemented in acute and community hospitals in Norfolk.

The Committee received evidence from Dr. Bernadette Auger, Locum Consultant Palliative Care, Great Yarmouth and Waveney Specialist Palliative Care Team at the James Paget University Hospitals NHS Foundation Trust (JPH), Tina Cookson, Director of Nursing at the JPH, Dr. Dean Blackburn, Consultant in Palliative Medicine at the Queen Elizabeth Hospital NHS Foundation Trust (QEH), Val Woods, Deputy Director Clinical Services at the QEH, Jo Segasby, Director Woman and Children and Cancer Services at the Norfolk and Norwich University Hospitals NHS Foundation Trust (N and N), Dr. Katie Soden Lead Consultant, The Priscilla Bacon Centre for Specialist Palliative Care Services, Norfolk Community Health and Care NHS Trust, and Michael Scott, Chief Executive, Norfolk Community Health and Care NHS Trust (NCH&C). The Committee also heard from Mrs Denise Charlesworth Smith and Mrs Roberta Lovick who were members of the public with their own views about the LCP.

In the course of discussion the following key points were noted:

- The witnesses said that the LCP intended to provide the best quality of care possible for dying patients in the last hours and days of life whether they were in hospital, at home, in a care home or in a hospice.
- The LCP was recommended as a model of best practice by the Department of Health. It was not a treatment in itself but a framework for good practice that included consideration of a patient's spiritual as well as physical and physiological needs.
- There were currently no local financial incentives associated with the use of the LCP. Where such incentives had existed in the past, they had been designed to support the implementation of better care within the LCP.
- The witnesses said that it was essential for the LCP to be underpinned by a robust education and training programme. Before the introduction of the LCP Norfolk's acute hospitals had not provided the training in palliative care that they did today. Currently, each Trust arranged it's own training in the use of the LCP but it was likely the Department of Health would in future make LCP training a national training requirement.
- It was pointed out that Health Care Assistants at the QEH were able to get the same level of training as was made available to nurses.

- The witnesses said that the LCP existed to support, but not replace, clinical judgement.
- It was pointed out that the LCP was used as a matter of routine at The Priscilla Bacon Centre and that it could be discontinued following a review of the patient's condition. This was known to happen on average once in every six weeks at The Priscilla Bacon Centre.
- There were no NHS hospice beds in West Norfolk.
- It was not possible to provide enough palliative care beds for everyone who might like to make use of them.
- For many people facing end of life issues, familiar surroundings were more important than being placed in specialist palliative care beds.
- The Chief Executive at the NCH & C said that they had received no formal complaints about the LCP since it was introduced by the NHC & C approximately eight years ago.
- Members asked the witnesses to provide statistical information to support the statements contained in their written evidence.
- In reply, it was estimated by Dr Soden that a year ago 83% of those who died at The Priscilla Bacon Centre were on the LCP. This compared with 63% of those who died at The Priscilla Bacon Centre six months ago.
- Dr Auger said that no such comparative information about the LCP was kept at the JPH, but that the Trust would consider whether to collect such information in the future. The JPH had performed above the national average for most of the end of life issues for which it had been assessed as part of a national audit. Training in the use of the LCP was provided for all newly qualified doctors who came to work for the Trust. Such training was mandatory at the hospital for all newly qualified nursing staff. The LCP was designed to be used at the hospital by non-specialist doctors and nurses. The hospital recognised that is was important to identify that a patient was dying before they were placed on the LCP. The LCP focused on providing quality care and on the dignity of the patient. There was, however, a recognisable reluctance on the part of some patients at the JPH to enter into a discussion with hospital staff about the LCP in the current national climate.
- It was estimated by the witnesses from the QEH that one third of all deaths at that hospital were sudden and unexpected. Of those who died at the QEH six months ago, 40% to 45% were on the LCP which compared with 20% to 22% at the current time.
- Jo Segasby said that at the N and N, there had been a recognisable drop in the number of patients who had been placed on the LCP in the last six months. She said that in March 2013 there had been 240 deaths of which 31 patients were on the LCP.
- Some Members commented that nationally some relatives had claimed in the press that loved ones were sometimes placed on the LCP without their consent which might have hastened death in relatives who were not dying immediately. Members asked whether it was really possible for doctors to predict when death was imminent, or whether placing a patient on the LCP could be self-fulfilling.
- In reply to such questions, the witnesses said that they recognised that all decisions leading to a change in care delivery had to be communicated to the patient where possible, and deemed appropriate, and always to the relative and carer. They said that while it was very important to listen to relatives and carers, at the end of the day, like all other clinical decisions in health care, clinical decision making was the responsibility of the clinical team that looked after the patient.

- The Committee heard from Mrs Denise Charlesworth Smith who lives in Norfolk and had started to campaign about the LCP after her father's death in a Nottinghamshire hospital when the LCP was used without her family's knowledge. She had met Baroness Knight who had pressed for the review into use of LCP but was unable to speak about the national review because it was ongoing. Mrs Charlesworth Smith said she was of the opinion that the LCP could be misinterpreted and misused by junior doctors who are not confident or able to make these kinds of decisions. She suggested that should the Committee again consider the LCP it should also raise questions about the use of the Gold Standards Framework, the use of "Do Not Resuscitate" forms, and the training requirements of part-time medical staff.
- In reply, Dr. Auger said that the Gold Standards Framework set important standards for end of life care and was being rolled out for the use in care homes. The use of "Do Not Resuscitate" forms referred specifically to resuscitation and did not mean that palliative care would come to an end. The JPH made use of a non-denominational chaplaincy service and had others who could be called upon to give spiritual guidance. The chaplaincy service was made aware of training sessions at the hospital about the LCP.
- The Committee also heard from Mrs Roberta Lovick who some years ago had lost a daughter at a young age and had more recently seen the LCP used during the final days of another relative at the JPH. She spoke highly about the LCP and said that her relative had been allowed to die with dignity and respect. She said she that had been kept fully informed about what was happening and had been allowed to be present when key decisions were taken. She emphasised that there is a responsibility on immediate family to communicate with the wider family about the patient's care.

The Committee took the view that it might wish to re-examine the use of the LCP again in 12 months time, when the results of the current national review were known.

The meeting concluded at 1.15pm.

Chairman

IN TRAN communication for all

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Report to Norfolk Health and Wellbeing Board
10 July 2013
Item 17

Pharmaceutical Needs Assessment – Interim Report

Cover Sheet

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, 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.

Health and Wellbeing Boards have taken on the responsibility for these assessments from Primary Care Trusts. The assessments are intended to provide information to help NHS England assess if, when and where new pharmacies are needed in an area. The first Pharmaceutical Needs Assessment has to be completed by 2015 and will have required public consultation.

Key questions for discussion

None - this item is to note

Actions/Decisions needed

The Board needs to note the current position and planning for the PNA 2015

Report to Norfolk Health and Wellbeing Board
10 July 2013
Item No 17

Pharmaceutical Needs Assessment – Interim Report

Report by the Interim Director of Public Health

Summary
The Health and Social Care Act 2012 transfers responsibility for the developing and updating of Pharmaceutical Needs Assessments to health and wellbeing boards (HWBs). This report summarises the position on Norfolk's current Pharmaceutical Needs Assessment (PNA) and outlines the timetable and process for preparing the Norfolk PNA 2015.

Action
The Health & Wellbeing Board is asked to note the current position and the timetable for preparing the PNA 2015.

1. Background

1.1 The Health and Social Care Act 2012 transfers responsibility for the developing and updating of PNAs to health and wellbeing boards (HWBs). Under the Act, the Department of Health has powers to make Regulations and the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs. The regulations can be found at the following link:
http://www.dh.gov.uk/health/2013/02/pharmaceutical-services-regulations/

1.2 In April 2013, the Health & Wellbeing Board agreed a Forward Plan to provide a clear structure to the work of the Board for the coming year and to ensure that it fulfils its statutory responsibilities. Included in the Forward Plan for the July 2013 meeting is an interim report on the current PNA and next steps.

1.3 An introduction to the legislative background and information about pharmaceutical services, the minimum information required in a PNA, the requirements for publication and updating, consultation requirement and other matters to consider can be found in the Department of Health Information Pack for Health and Wellbeing Boards:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/197634/Pharmaceutical_Needs_Assessment_Information_Pack.pdf

2. Norfolk's current PNAs

2.1 PNAs are used by the NHS to make decisions on which NHS funded services need to be provided by local community pharmacies. These services are part of local health care and public health and affect NHS budgets. PNAs are used by NHS England to determine applications from GPs, pharmaceutical companies and appliance contractors to open new or additional premises to provide pharmaceutical services within Norfolk or to move to new premises. The decision about whether or not a pharmacy opens is made by NHS England.

2.2 Prior to the Health and Social Care Act 2012 there were two Primary Care Trusts (PCTs) that had responsibility for areas of Norfolk; NHS Norfolk and NHS Great Yarmouth and Waveney. Both PCTs were required to publish a PNA and as such there are two PNAs relevant to Norfolk County.

2.3 Both PNAs considered the provision of pharmaceutical services to the population and whether or not this was adequate. Both PNAs also considered how community pharmacy, through its nationally commissioned or through locally commissioned services, could support the PCTs to deliver their priorities for improving health and wellbeing for the population Norfolk.

2.4 The NHS Norfolk PNA concluded that at the time of writing there was sufficient access to a broad range of services both in terms of location and opening times through the week. NHS Great Yarmouth and Waveney PNA also found that there was sufficient access to a broad range of services across the week for the population. In order to improve the health and wellbeing of the population the PCTs would work with community pharmacies to:

- increase access to preventative services to enable positive lifestyle change
- enable early detection of disease through provision of health checks
- raise awareness in the general population of what NHS funded services are available from pharmacy
- target specialised and enhanced services to areas of most need

2.5 Three years have elapsed since the publication of the initial PNAs and under the old regulations a new and refreshed PNA would have been due by February 2014. Since publication of the initial PNAs NHS Norfolk has published one supplementary statement and NHS Great Yarmouth and Waveney has published four. Both PNAs have been used to determine applications prior to the closure of the PCTs. The PNAs are probably fit for purpose for a short time and it would be sensible if the production of the new PNA for Norfolk was started sooner rather than later. This is reflected in the timeline.

3. Developing a PNA 2015

3.1 The HWB will be required to produce the first assessment by 1 April 2015. The development of the 2015 PNA will be led by the Director of Public Health and overseen by a steering group.

3.2 The steering group may include representatives from the Local Pharmaceutical Committee (LPC), Local Medical Committee (LMC), Health Watch, Public Health, Medicines Management and Clinical Commissioning Groups.

3.3 The stages involved in developing a PNA are:

- assessing current and future need of necessary, specialist and other relevant services and other relevant services
- assessing gaps in current and future provision necessary, specialist and other relevant services and other relevant services
- mapping of services
- seeking views from the public on their views on pharmaceutical services
- consulting with the relevant bodies at least once during the process of developing the PNA allowing a minimum period of 60 days for consultation responses
- publication of the first PNA
- publication of a revised PNA or supplementary statement depending on changes in either health need, demography or pharmaceutical service provision

4. PNA 2015 - timeline

4.1 October 2013 - set up steering group and the needs assessment (to include information from JSNA, travel time analysis and a review of current essential and enhanced service provision)

4.2 December 2013 - engage with a cross section of the public (via Norfolk Voice and other methods) asking for their views on pharmaceutical services.

4.3 December 2013 - survey providers of pharmaceutical services such as pharmacies, dispensing doctors, appliance contractors and also other providers of services e.g. Contraceptive Advice and Sexual Health etc. to ascertain opening hours, services provided (essential, advance and enhanced as well as locally commissioned), IT capability, consultation facilities etc.

4.4 April 2014 - present to HWB to ask for permission to go out to consultation

4.5 June 2014 - incorporate results from consultation and revise PNA accordingly

4.6 July 2014 - present to HWB for final sign off

4.7 August 2014 - publish PNA

5. Next Steps

5.1 The next steps are:

- make sure that the current PNAs and supplementary statements are available in one place (Norfolk Insight or NCC external facing website)
- review existing PNAs relevant to Norfolk County
- engage with relevant bodies to set up the steering group for the PNA
- raise awareness of the responsibilities of the HWB members, officers and executive for the PNA

6. Action

The Health & Wellbeing Board is asked to note the current position and the timetable for preparing the PNA 2015.

Officer Contact

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

Lucy Macleod	Tel: 01603 638407	lucy.macleod@norfolk.gov.uk
Tim Winters	Tel: 01603 638359	tim.winters@norfolk.gov.uk

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