Health & Wellbeing Board

Date: **Wednesday 23 October 2013**

Time: **10am**

Venue: **Green Room, The Archive Centre, County Hall site, Norwich**

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

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

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

1	**Apologies**	Chair	
2	**Minutes** To confirm the minutes of the meeting held on July 2013.	Chair	(Page **5**)
3	**Members to Declare any Interests** If you have a Disclosable Pecuniary Interest in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter. If you have a Disclosable Pecuniary Interest in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter. In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with. If you do not have a Disclosable Pecuniary Interest you may nevertheless have an Other Interest in a matter to be discussed if it affects: - your well-being or financial position - that of your family or close friends - that of a club or society in which you have a management role - that of another public body of which you are a member to a greater extent than others (in your ward). If that is the case then you must declare such an interest but can speak and vote on the matter.	Chair	
4	**To receive any items of business which the Chairman decides should be considered as a matter of urgency**	Chair	
	Items for Business	Chair	
5	**Early Help (Intervention) Strategy** Presentation by the Chair, Norfolk Early Help Programme Board	Sandra Dineen	
6	**Integration of health and social care services in Norfolk - an update** Report by the Director of Community Services	Harold Bodmer	(Page **23**)
7	**Developing a Norfolk Joint Health and Wellbeing Strategy 2014-17** Report by the Head of Planning, Performance &	Debbie Bartlett/Lucy Macleod	(Page **30**)

	Partnerships, NCC and the Acting Director of Public Health		
8	**(a) Community led Health Improvement Work Programme - Update** Report by the Acting Director of Public Health	Lucy Macleod	(Page **45**)
	(b) Funding allocation to Community-Led health Improvement 2013-14 Briefing Note by the Head of Planning, Performance & Partnerships, NCC	Debbie Bartlett	(Page **69**)
9	**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 **73**)
10	**Public Health Outcomes Framework** Presentation by the Acting Director of Public Health	Lucy Macleod	
	Standing Items	Harold Bodmer	
11	**Healthwatch Norfolk** • Minutes of the meeting held on 8 July 2013	William Armstrong	(Page **79**)
12	**NHS England** • Verbal update including feedback from the Local Quality Surveillance Group (QSG)	Tracy Dowling, NHS England	
13	**Norfolk Health & Overview Scrutiny Committee** • Minutes of the meetings held on 20 June and 5 September 2013	Chair	(Page **85**)
	Items for Information	Chair	
14	**Norfolk County Council Budget Consultation** Verbal report from Head of Planning, Performance & Partnerships, NCC	Debbie Bartlett	

Close

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

Venues to be confirmed/Green Room provisionally booked for all

- 8 January 2014
- 16 April 2014
- 16 July 2014
- 22 October 2014

Norfolk County Council
at your service

Health and Wellbeing Board
Minutes of the meeting held on Wednesday 10 July 2013
at 10am in the Anna Sewell Room, County Hall Annexe

Present:

Cllr Yvonne Bendle	South Norfolk Council
Harold Bodmer	Director Community Services
Dr Jon Bryson	South Norfolk Clinical Commissioning Group
Dr Anoop Dhesi	North Norfolk Clinical Commissioning Group
Tracy Dowling	Director of Operations & Delivery, NHS England, East Anglia Team
Richard Draper	Voluntary Sector Representative
Cllr Angie Fitch-Tillet	North Norfolk District Council
Kate Gill	Great Yarmouth & Waveney Clinical Commissioning Group
Joyce Hopwood	Voluntary Sector Representative
Cllr Penny Linden	Great Yarmouth Borough Council
Dr Ian Mack	West Norfolk Clinical Commissioning Group
Lucy Macleod	Interim Director of Public Health
Jenny McKibben	Deputy Police and Crime Commissioner
Dan Mobbs	Voluntary Sector Representative
Dr Chris Price	Norwich Clinical Commissioning Group
Cllr Andrew Proctor	Broadland District Council
Cllr Dan Roper	Cabinet Member for Public Protection, Norfolk County Council
CS Jo Shiner	Norfolk Constabulary
Alex Stewart	Chief Executive, Healthwatch Norfolk

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

1 Election of Chairman

Cllr Dan Roper, Norfolk County Council was elected Chair of the Health and Wellbeing Board.

Cllr Dan Roper, Norfolk County Council in the Chair.

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

2 Apologies

Apologies were received from Cllr Brenda Arthur, Norwich City Council; Stephen Bett, Norfolk Police & Crime Commissioner (Jenny McKibben substituted); Lisa Christensen, Norfolk County Council; Pip Coker, Voluntary Sector (Dan Mobbs substituted); T/ACC Nick Dean, Norfolk Constabulary (Chief Superintendent Jo Shiner substituted); Andy Evans, Great Yarmouth & Waveney CCG (Kate Gill substituted); Anne Gibson, Norfolk County Council; Cllr James Joyce, Norfolk County Council; Cllr William Nunn, Breckland District Council; Elizabeth Nockolds, KLWN BC; Cllr and Cllr Sue Whitaker, Norfolk County Council.

3 Minutes of the Health and Wellbeing Board meeting held on 17 April 2013.

The minutes of the Health and Wellbeing Board (H&WB) meeting held on 17 April 2013

were agreed as a correct record and signed by the Chairman, subject to the following amendment to paragraph 12.2 to replace the words “a reablement service” to read “the reablement service”.

The Director of Community Services, Norfolk County Council informed the Board that the proposal for spend of the funding transfer from NHS England to the County Council was nearing completion and once the document had been finalised it would be forwarded to NHS England and the CCGs for final comments before publication.

4 Declarations of Interest

There were no declarations of interest.

5 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.

6 Director of Public Health – Annual Report

6.1 The Board received a presentation (copy attached at Appendix A) by the Interim Director of Public Health (DPH) during which the following key points were highlighted:

- The forecast population increase from approximately 990,000 in 2012 to approximately 1,100,000 in 2022 was predominantly made up from older people rather than an increase in birth rates, with people tending to live longer.
- Further work would be needed to ascertain the reasons for the widening gap between the best off and worst off male population figures in South Norfolk; this figure was increasing in South Norfolk whilst figures were decreasing in the other local authority areas in Norfolk.
- The impact of an aging population would provide huge challenges which would need to be considered in relation to all forms of care, including palliative care and end of life.
- The impacts of deprivation and inequality would need to be considered in relation to future service challenges and not solely in relation to individual behaviours.
- Finding breakpoints in the cycle of deprivation would be key.
- This is, or will be, a community wide problem and requires solutions to be developed and co-ordinated across communities.

6.2 The following points were noted during the general discussion:

- The DPH emphasised that the issues raised in her Report suggested that this was about systems change, rather than making small or incremental changes, to address for example, the attainment in the most deprived areas versus birth-rate.
- A clearer understanding was needed of need in rural areas– ie understanding individual need, not just the totality.
- A discussion took place about the benefits of using a social marketing approach to capture and identify the most deprived people across Norfolk. It was felt this kind of approach could help provide the flexibility needed and enable us to target people, rather than areas.

- The DPH's annual report would be finalised and published on-line on the JSNA, with a web-link to the report circulated to the Board.

6.3 The Board agreed that the DPH Annual Report helped set the context for its work going forward and that the key messages would form part of the evidence base for the development of the Joint Health and Wellbeing Strategy.

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

7.1 The Board received a report setting out the key findings from a workshop held on 13th June 2013, which brought together voluntary and statutory agencies to look at the potential impact of welfare reforms. The purpose of the workshop was to share concerns and consider mutual and effective responses, especially in identifying the needs of those most at risk. Shared concerns and common themes were fed back to the Health and Wellbeing Board and the report suggested some possible courses of action.

7.2 In presenting the report, Dan Mobbs confirmed that the workshop had identified that the welfare reform in Norfolk was causing greater inequality because it was disproportionately cutting income from the poorest households and that an integrated approach was needed, with the Health & Wellbeing Board taking a strategic leadership role.

7.3 The following points were noted during the ensuing discussion:

- There was some discussion about inequality and poverty, and where the focus should lie and it was noted that the workshop had concluded from the evidence that inequality was the biggest determinant of health and wellbeing problems.

- There were clear links with the earlier discussion under item 6 about 'targeting people rather, than targeting areas' and that the people who were most affected by this would be the same as those the Board would be concerned about in relation to other health and wellbeing issues, such as obesity.

- It was noted that Norfolk County Council's Community Services Overview and Scrutiny Panel were looking at fuel poverty and its impact on the health and wellbeing of the population of Norfolk, both in rural and urban areas, and the outcome of this might usefully feed into this.

- Board members expressed their concerns about the impact on inequality in Norfolk, as outlined in the report. A possible way of tackling some of these problems might be to set up Healthy Towns and Health Community schemes in areas of deprivation.

- A practical and pragmatic approach would be needed and the Board focus on what it could influence in terms of inequality, for example, in relation to housing, employment, education including early years, access to care and advice, etc.

- It was recognised that this was something where the wider partners had a role to play and considered useful for the impact to be collectively monitored. The DPH confirmed that, if the Board could agree collectively what was useful to measure, and where that data was, then she would take this forward as there were

appropriate skills and sufficient resources from within the public health team to drive such a monitoring group.

7.4 The Board considered the report of the workshop and agreed:

- To undertake a piece of work on sharing the information that enables individual partners to better target their communities, not geographies.
- To think about the evidence of what works
- That rather than taking this forward as a separate workstream, the key issues should feed into the development of the Board's Joint Health and Wellbeing Strategy 2014-17.

8 A Review of Norfolk Joint Strategic Needs Assessment – outline approach.

8.1 The Board received the annexed report (8) by the Interim Director of Public Health (DPH), proposing improvements both to ensure that the Joint Strategic Needs Assessment (JSNA) can support the development of the 2014/17 Health and Wellbeing Strategy, and longer term development proposals for the Board to consider.

8.2 In presenting the report the DPH referred to one of the development proposals in the report for immediate action which was to 'bring the JSNA to life by having a programme of regular briefings on topics of interest drawing information from partners and the JSNA'.

The DPH asked Board members to let her know their suggestions for topics for JSNA briefing sessions by emailing her at the following address: lucy.macleod@norfolk.gov.uk

8.3 The following points were noted during the discussion:

- In response to a question about integrated data sharing the DPH agreed to look at other areas and to locate a template document which might be populated with the relevant information and linked into the JSNA.

- The DPH also asked all Board members to help define the data-sharing by thinking about what they wanted to know - what data they wanted - from the other Board members around the table and to let her know by email to the following address: lucy.macleod@norfolk.gov.uk.

- There was some discussion about the need for information in the JSNA to be at the lowest level of geography and to be 'live' over a period of time so that it could be used to evaluate progress, for example, to better understand why some people access services and other don't. The DPH confirmed that work was being undertaken with the CCGs to understand the health needs of the population and identify any correlation between those needs and the people who were accessing the services.

- The DPH referred again to the benefits of using a social marketing approach to identify those people who needed services and target those most affected wherever they are. It was noted that there would be a resource implication to this and the DPH suggested that the Board could look to utilise the County Council's resources in terms of community engagement skills and techniques. Dan Mobbs, voluntary sector representative, confirmed that the voluntary sector was well placed to help with such work.

8.4 The Board agreed:

- To note the findings of the JSNA Review.
- To 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. In future years, the report would be published in March/April.
- The rest of the proposals for development, as outlined in the report.
- The creation of a JSNA Officer Working Group to oversee the developments, agree the prioritisation of the JSNA work plan going forward and to deliver the agreed actions.

9 Norfolk Joint Health and Wellbeing Strategy 2014-17 – outline approach.

9.1 The Board received the annexed report (9) by the Head of Planning, Performance and Partnerships and the Interim Director of Public Health, NCC. The report consolidated the work that had been done to date on the development of a three-year Health and Wellbeing Strategy which added value to the work on health and wellbeing already taking place in Norfolk.

9.2 In presenting the report, the Head of Planning, Performance and Partnerships (PPP) confirmed that, whilst there were a number of areas that the Board could potentially look to improve, there had been a strong message from the workshop that the Board needed to focus its efforts through its strategy on a small number of priorities where it could make a difference. It had been suggested that three priorities were an optimum number and 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.

9.3 The Head of PPP drew the outlined the two options (A or B) contained in the report and asked the Board for their views on how to progress.

9.4 The following points were noted during the discussion:

- Driving integration was strongly threaded through both the options as outlined in the report and this was considered a key area for the Board.

- Option A would enable the Board to target key population groups and take an holistic approach through which it could drive forward integration. This option would also enable the Board to focus on the necessary culture change that will be required.

- Option B would enable the Board to adopt three overarching goals for the 14-17 period and a set of priorities and deliverables towards meeting them. It would facilitate all partners working together for the benefit of Norfolk's diverse populations and would enable the Board to focus on working differently.

- It was also noted that all partners had their own set of priorities they were currently working on and the Board's job, regardless of whether we choose option A or B, should be to challenge each other and ask, for example, how they were working to

address integration.

- It was important for the Board to deliver results and any goals set would need to be effective and measurable. The Board should also look to learn from work undertaken in other areas.

- In many respects, options A and B represented two different ways of looking at the same thing, perhaps just a difference of approach.

9.4 The Board voted on whether to proceed with Option A or Option B. With 4 votes for Option A and 11 votes for Option B, the Board agreed to use Option B as the basis for the development of the strategy.

The Head of PPP would take this option forward for discussion and development at the workshop to be held on 19 August 2013, the details of which had already been circulated.

9.5 Any nominations for members to be appointed to the sub-group of the Board to progress the development of the JHWS to be forwarded to the Head of Planning, Performance and Partnerships by the end of July 2013. Please send nominations to **Debbie.bartlett@norfolk.gov.uk**

9.6 The Board agreed:

- To support the principles and content outlined that would underpin the development of the JHWS 2014/17.
- To use Option B as the basis for the development of the strategy.
- The steps identified and the key milestones were reasonable.
- To keep up the momentum of work outside of formal Board meetings, through the establishment of a sub-group of the Board to progress the development of the JHWS.
- That they were committed to early engagement with service users, providers and commissioners on how to tackle the strategy's priorities.

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

10.1 The Board received the annexed report (10) by the Director of Community Services which set out the approaches to integration which are being taken in Norfolk and provided an update on activity towards integration in Norfolk. The report also outlined the recent launch of the national Integration Pioneer Programme, where invitations were sought from local areas to spearhead implementing models of integration. Three bids had been prepared in Norfolk and the Health and Wellbeing Board were asked to support and endorse them.

10.2 In introducing the report the Director of Community Services said that this was about whole system change – which had resonated throughout the discussion so far at this Board meeting. It was about working very differently, with very different models, and it was broader than health and social care – housing, public health, education, the third sector, etc were all key partners.

10.3 The Director of Community Services confirmed that the work included in the three Integration pioneer bids was already underway but that those bids would not, in

themselves, change the way services were delivered – this would require a change in the culture. Additionally, some work was also underway with social workers and other key workers to try to establish a different way of providing health and social care services. This was being resourced by some monies from the Kings' Fund.

10.4 The following points were noted during the discussion:

- The 3 x Integration Pioneer bids were formally endorsed by the Board.

- The Director of Community Services stated that it would be helpful to set some challenges – to think about what the Board wanted to see by way of progress in a year's time.

- There followed some discussion about the potential for pooled budgets and both our preparedness for doing this in Norfolk and the capacity needed in the system to support it. It was agreed that partners should continue to build on the work underway in progressing integration and prepare for the longer term - so that Norfolk was well placed and ready to make the best use of pooled budgets when the time was right.

- There was some discussion about the pivotal role of housing in this and the strong view that it needed to be a part of the work at the outset.

- It was noted that the Board had just agreed that Integration would be an overarching goal in the Joint Health & Wellbeing Strategy and that even if the Integration Pioneer Bids were not successful the work contained within them would continue and the Board – or a Task & Finish Group could provide the strategic support needed for it. The Board needed, collectively, to look at the issues.

- It was suggested that Integration be included as a standard item on future agendas so that the Board could monitor its progress.

- It was agreed that the Director of Community Services would set up a Task and Finish Group and report back to the next Board meeting in October. The following Board members were appointed to the Task & Finish Group to progress integration in service provision:
    - Angie Fitch-Tillett, North Norfolk District Council
    - Kate Gill, Great Yarmouth & Waveney CCG
    - Joyce Hopwood, Voluntary sector
    - Lucy MacLeod, Interim Director for Public Health
    - Alex Stewart, Healthwatch Norfolk

10.5 The Board:

- Noted the progress and proposed approaches to integration in Norfolk.
- Confirmed its support for the three Norfolk bids to the Integration Pioneer programme from:
    - West Norfolk
    - North Norfolk
    - Great Yarmouth and Waveney
- Agreed to set up a task and finish group, 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.

11 Accountability framework – outline of performance and quality measures.

11.1 The Board received a report (11) by the Head of Planning, Performance and Partnership, NCC, outlining the thinking on possible means for the performance monitoring of the work of the Health and Wellbeing Board over the next three years. The Board was asked to review and comment on the content of the report specifically to adopt a performance monitoring framework that was light-touch and able to provide a good understanding of how the Board was functioning, what impact it was having on the health and wellbeing of the people of Norfolk, what progress it was 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.

11.2 The Board agreed:

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

12 In-year monitoring of Health and Wellbeing priorities.

12.1 The Board received a report (12) by Norfolk's Clinical Commissioning Groups and the Head of Planning, Performance and Partnerships, NCC, outlining the submissions from each of the CCGs' annual 'Plan on a Page', their three local priorities identified for the purpose of the national 'Quality Premium' and their Prospectuses for residents and patients.

12.2 Dr Anoop Dhesi, Chairman, North Norfolk CCG presented their report and outlined the priorities. It was noted that since it had been established North Norfolk Clinical Commissioning Group had built up an excellent working relationship with North Norfolk District Council. A North Norfolk and Rural Broadland Strategic Partnership Board had been set up and had met on five occasions and that Board had set out their key objectives and good developmental and learning outcomes were being achieved.

12.3 Kate Gill, Director of Operations, Great Yarmouth and Waveney CCG presented their annual plan, and outlined their local health priorities, the details of which were included in the report.

12.4 Dr Jon Bryson, Chairman, South Norfolk CCG, presented the plan for South Norfolk CCG. The plan included working with the local government to tackle their priorities which included alcohol abuse, smoking cessation and an obesity strategy, and an integrated approach and how this could be achieved.

12.5 Dr Chris Price, Chairman, Norwich CCG, presented their plan, outlining the three local priorities they had chosen as a result of feedback from patients, GP practices and the

voluntary sector. Work had already commenced on the gathering of patient views on the services they received, which it was hoped would give an indication of where problems may occur in the future.

12.6 Dr Ian Mack, Chairman, West Norfolk CCG presented their plan and outlined the priorities, the detail of which could be found in the report.

12.7 During the general discussion, the following points were noted:

- CCGs were required to produce an annual plan and that, in future, the plans would need to be approved by the Health and Wellbeing Board before they were formally adopted. It was noted that this had been reflected in the Boards' forward work programme.

- It had been very useful to see the range of work being done by the different CCGs in the region.

12.8 The Board **noted** the report, the annual plans, local priorities and the prospectus from each of the CCG's and agreed that consideration of future prospectuses would need to be completed earlier in the year and would be added to the forward work programme.

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

13.1 The Board received a report (13) by the Director of Community Services, Norfolk County Council, updating members on the progress that has been made in delivering on the actions that related specifically to Norfolk from the Winterbourne View Enquiry Report into abuse in a private sector assessment and treatment facility for adults with a learning disability.

13.2 The Director of Community Services confirmed that Children's Services Department would be included within the multi-agency steering group.

13.3 The Board **agreed** the need:

- For a Norfolk wide consistent approach to the operation and development of the Joint Plan
- To establish a multi-agency steering group with direct accountability to the Board

The multi-agency group would include representatives from Mental Health & Learning Difficulty Commissioning Board, Children's Services and the Social Care sector. The multi-agency steering group would bring their Terms of Reference to the next meeting of the Board for approval.

14 Healthwatch Norfolk

14.1 In commenting on the minutes, Alex Stewart, Chief Executive, Healthwatch Norfolk (HWN), announced that William Armstrong, the retiring coroner for Norfolk, had now been appointed Chair of the HWN Board. The H&WB received and noted the Healthwatch minutes of the meetings held on 5 March 2013.

15 NHS England

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

- The first round of quarterly checkpoint meetings with the CCGs were taking place, although the frameworks were still being developed. The interim framework was being used to carry out the checks until the frameworks had been finalised.

- The draft CCG emergency plans for care had just been received. These plans would be used to identify what could be done differently for Accident and Emergency Departments and emergency care to eliminate the long waiting times that had been experienced in the past.

- The local Quality Surveillance Group (QSG) had met on 9 July 2013 and Tracy Dowling provided the following brief feedback:

    - The rates of C.difficile infections had been discussed and it had been recognised that good work was being done to address the root causes. The next meeting of the QSG would focus on C.difficile infections and the further feedback would be provided at the next meeting of the Board.

    - The full report from a recent Care Quality Commission (CQC) visit to the Queen Elizabeth Hospital at King's Lynn was being drafted. One of the key issues was how long patients had been required to wait in the Accident and Emergency Department and how this issue could be addressed in future.

    - In the light of the major changes taking place with the Norfolk and Suffolk NHS Foundation Trust's (Mental Health) plans for radical pathway redesign the QSG was keeping a watching brief on waiting times for appointments.

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

16 Norfolk Health Overview and Scrutiny Committee

16.1 The Board received and noted the minutes from the Norfolk Health Overview and Scrutiny Committee meeting held on 11 April 2013.

17 Pharmaceutical Needs Assessment – Interim Report

17.1 The Board received and noted the annexed report (17) by the Interim Director of Public Health, summarising the position on Norfolk's current Pharmaceutical Needs Assessment (PNA) and outlining the timetable and process for preparing the Norfolk PNA 2015.

18 Election of Vice-Chairs

Dr Ian Mack, West Norfolk CCG and Cllr Yvonne Bendle, South Norfolk District Council accepted nominations to be Vice-Chairs of the Board and were duly appointed.

The next meeting would take place on **Wednesday 23 October 2013** at 10am in **the Green Room, Norfolk Archive Centre,** County Hall site, Norwich.

The meeting closed at 12.40pm

Chairman

Norfolk County Council

Appendix A

Report of the Director of Public Health for Norfolk and Waveney 2012-13

Lucy Macleod, Interim Director of Public Health

Norfolk County Council

A Word on Jargon…..

- MSOA – Medium Super Output Area
- Quintile – 20%, one fifth of the population
- IMD – Index of Multiple Deprivation

…..and time delays….

Norfolk County Council

Population Headlines for Norfolk and Waveney

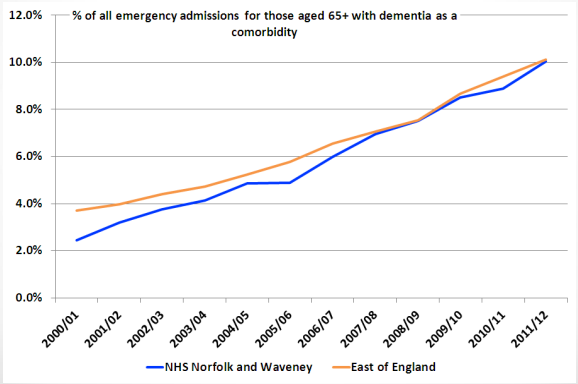
- a greater proportion of older people than elsewhere in England
- a smaller proportion of working age people between 25 and 39
- a smaller proportion of children under 15
- Registered population is forecast to increase from about 990,000 in 2012 to about 1,100,000 in 2022

Norfolk County Council

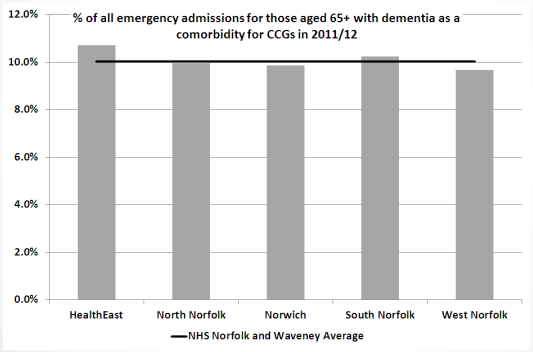
Implications for services

- The old and the very young increase the demand on health and social care services.
- Lower proportion of working age people - there may be fewer people to provide services for the aging population.
- Higher proportion of older people means more people are likely to have long term conditions and chronic diseases
- Over the next ten years the number with dementia is forecast to increase by about 5,000.
- About 10% of hospital admissions for the over 65s have a comorbidity of dementia.
- This is increasing and appears to be consistent across the CCGs in NHS Norfolk and Waveney. In line with the East of England at about 10% of admissions.

Trend in Dementia as Co-morbidity in Emergency Admissions



At CCG Level



Norfolk County Council

Life Expectancy Headlines

Male:

•Great Yarmouth and Norwich lower than the national average. All other districts significantly better than the national average.

•Ranges from 71.3 years for an area in Great Yarmouth to 83.7 years for part of North Norfolk.

•The gap in years of life expectancy between the best-off and worst-off is highest in Great Yarmouth.

•In most local authorities the gap between the best off and the worst off is decreasing. However, the gap in South Norfolk appears to be increasing.

Norfolk County Council

Life Expectancy Headlines

Female:

•For Norfolk overall is significantly higher than the England average.

•Female life expectancy in Great Yarmouth is significantly lower than the national average.

•All other districts significantly better than the national average.

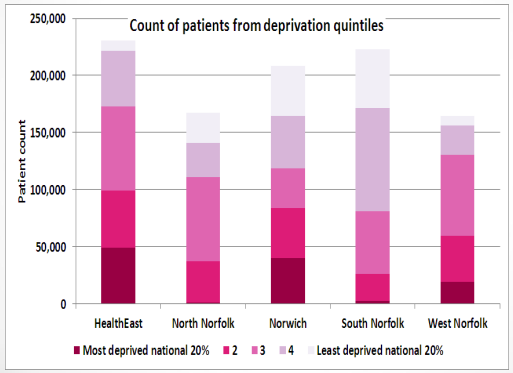
•Ranges from 77.5 years for an area of Great Yarmouth to 90.4 years for an area of North Norfolk.

•The gap between the best-off and worst-off is highest in Waveney.

•In most District Council areas the gap between the best off and the worst off is remaining the same or decreasing.

Norfolk County Council

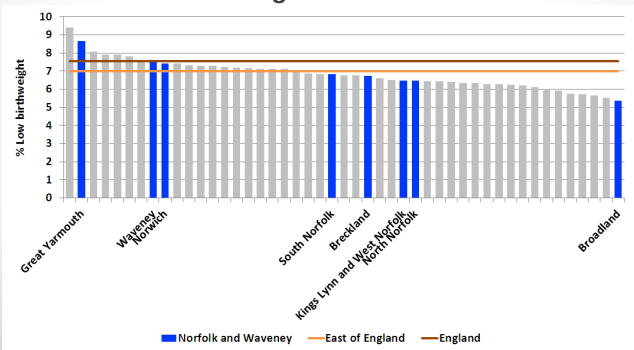
Deprivation



Norfolk County Council

Implications for Individuals and Services

Children: Low Birth Weight

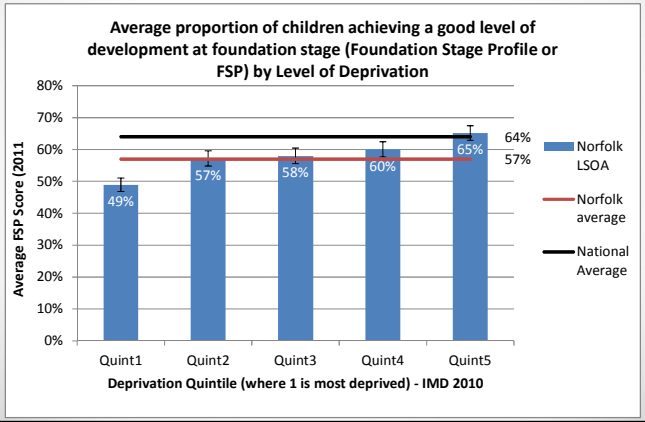


Norfolk County Council

- The proportion of children in poverty is significantly higher than the national average for the districts of Norwich and Great Yarmouth.
- Great Yarmouth has the highest inequality in child poverty across Norfolk and Waveney and contains area with the highest proportion of child poverty (49%) and the area with the lowest proportion of children in poverty (6.5%).
- The districts with the lowest proportion of children in poverty are Broadland and South Norfolk.

Norfolk County Council

Deprivation and Attainment



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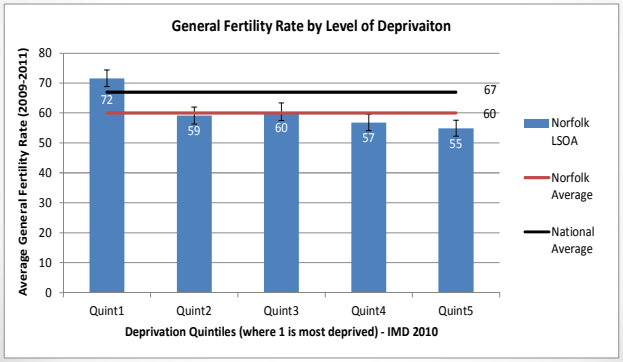


Norfolk County Council

Working Age Adults – Early Death (Male)

Male all cause mortality under 75 2008-10	Local Number	Local Value	Eng Avg	Local Worst	Norfolk and Waveney Range	Local Best
Breckland	656	266.0	345.5	378.3		182.8
Broadland	605	256.4	345.5	392.9		151.5
Great Yarmouth	659	378.4	345.5	693.3		204.2
King's Lynn and West Norfolk	861	315.0	345.5	606.4		209.8
North Norfolk	628	290.0	345.5	375.0		168.7
Norwich	728	416.7	345.5	695.4		223.6
South Norfolk	599	264.0	345.5	393.0		225.0
Waveney	700	320.5	345.5	589.3		179.7
Norfolk	4,736	306.0	345.5	695.4		151.5

Directly age-standardised mortality rate due to all causes, including mortality at all ages registered in the respective calendar years. Standardised using the European Standard Population. Source: ERPHO

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

England average
Worst
Best
local authority range

Norfolk County Council

Working Age Adults – Early Death (Female)

Female all cause mortality under 75 2008-10	Local Number	Local Value	Eng Avg	Local Worst	Norfolk and Waveney range	Local Best
Breckland	490	192.5	219.5	310.2		107.5
Broadland	427	173.5	219.5	234.1		128.5
Great Yarmouth	460	245.1	219.5	428.1		144.1
King's Lynn and West Norfolk	563	196.2	219.5	352.7		97.8
North Norfolk	381	164.4	219.5	220.7		100.1
Norwich	418	231.2	219.5	345.4		149.8
South Norfolk	443	194.0	219.5	248.9		142.5
Waveney	460	197.6	219.5	301.9		131.8
Norfolk	3,182	196.1	219.5	428.1		97.8

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

to all causes, including mortality
ndard Population. Source: ERPHO

England average
Worst
Best
local authority range

e calendar

Incapacity Benefit and Mental Ill Health

Incapacity Benefit / Severe Disablement Allowance with a diagnosis of mental health May 2011 per 1000	Local Number	Local Value	Eng Avg	Local Worst	Norfolk and Waveney Range	Local Best
Breckland	1,335	17.9	21.7	29.3		9.1
Broadland	1,175	16.6	21.7	23.1		12.7
Great Yarmouth	1,695	30.2	21.7	70.1		10.9
King's Lynn and West Norfolk	1,865	23.6	21.7	50.0		8.3
North Norfolk	1,230	23.4	21.7	49.4		13.9
Norwich	3,060	30.9	21.7	69.6		8.2
South Norfolk	1,125	16.3	21.7	25.7		7.2
Waveney	1,435	22.0	21.7	55.9		7.6
Norfolk	11,485	22.9	21.7	70.1		7.2

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

England average
Worst
Best
local authority range

Claimant count (rounded to the nearest 5) for IB/SDA with a diagnosis of mental health, crude rate per 1000 resident working age population. Working age is defined as females aged 16 to 59 and males aged 16 to 64. Source: Department of Work and Pensions

Norfolk County Council

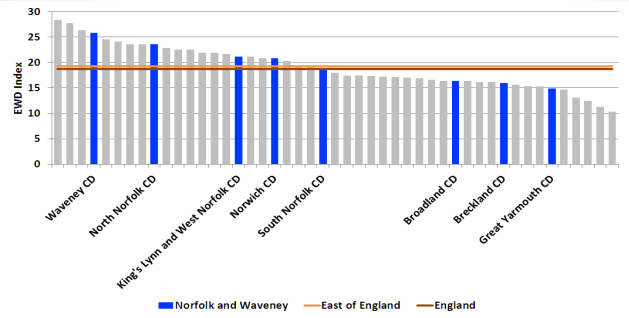
Other Measures

- About 11% of the Norfolk population are in the most deprived group in England
- Over a quarter of households in North Norfolk are estimated to be fuel poor.
- Fuel poverty ranges from over 40% of households for an MSOA in West Norfolk to about 10% for an area in Broadland.
- Long term unemployment for Norfolk as a whole is lower than the England average, however in Great Yarmouth and Norwich Districts it is higher.
- Between MSOAs the long term unemployment rate ranges from 1 per 1000 to 35 per 1000.

Norfolk County Council

Deprivation and Older People

- Excess Winter Deaths



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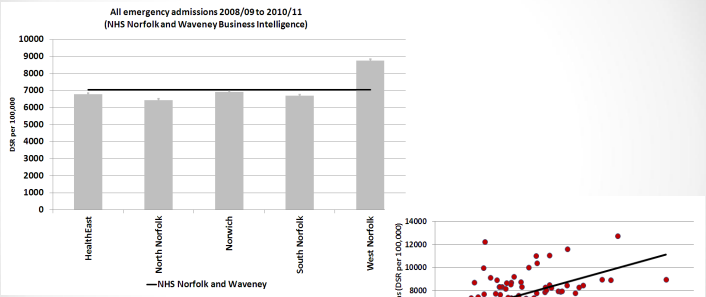
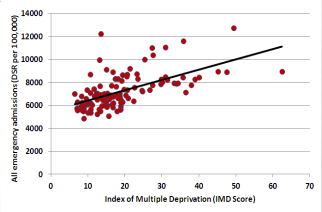
- Emergency Admissions and Deprivation





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Lifestyles and Behaviours

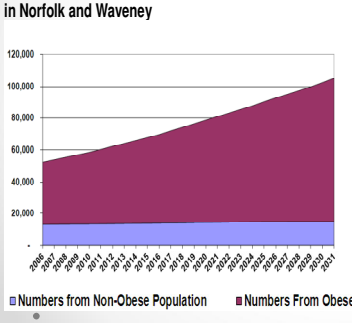
In 90% of cases the risk of a first heart attack is related to nine potentially modifiable risk factors;

- Smoking/tobacco use
- Poor diet
- High blood cholesterol
- High blood pressure
- Insufficient physical activity
- Overweight/obesity
- Diabetes
- Psychosocial stress – linked to ability to influence the potentially stressful environments in which people live
- Excess alcohol consumption

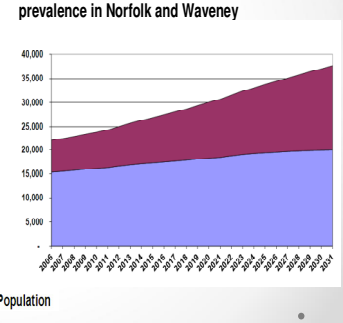
Obesity

Over the next 25 years if trends continue it is estimated that there will be an additional, 50,000 diabetics and an additional 9,000 strokes due to obesity.

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



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



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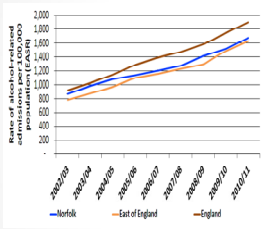
Smoking

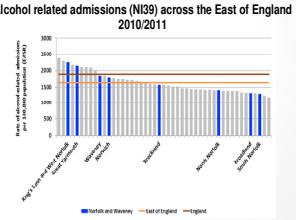
- Inequality in male death rates attributable to smoking is largest in NHS Great Yarmouth and Waveney.
- Great Yarmouth and Norwich have death rates higher than the national average
- Range in male death rates attributable to smoking from 115 for a MSOA in South Norfolk to 529 for a MSOA in Norwich.
- Range in female death rates attributable to smoking from 55 for a MSOA in South Norfolk to 243 for a MSOA in Great Yarmouth.

Alcohol Related Admissions

Trend in alcohol related admissions (NI39)



Alcohol related admissions (NI39) across the East of England 2010/2011



Health Protection

- **MMR immunisation** under 24 months is increasing across Norfolk and Waveney. However there is still considerable variation between practices.
- **Cervical screening** uptake has been declining slightly over the last few years though it is above the national average.
- The districts with the lowest uptake are King's Lynn and West Norfolk and Norwich.
- The range in practice uptake is from about 55% to 93%.
- **Flu immunisation** uptake for those aged 65 and over has been decreasing and is below the 75% target. At a local authority level only South Norfolk and Waveney are close to or better than the target.

Norfolk County Council

Infection Prevention and Control

- In 2012/13 there were no cases of MRSA arising the Norfolk hospitals
- C. difficile infections were within the ceiling set by the Department of Health in both community and hospital settings as was MRSA.
- Norovirus levels were low compared with national rates which increased by approximately 80% on the previous year.
- Notifiable diseases – whooping cough reports in 2012 were considerably increased compared to previous years. Food poisoning notifications are rising year on year. Acute Infectious Hepatitis also appears to be increasing.

Norfolk County Council

Key Messages

- The impact of an aging population will provide huge challenges which need to be considered in relation to all forms of care including palliative care and end of life.
- The impacts of deprivation and inequality must be considered in relation to future service challenges and not solely in relation to individual behaviours.
- Finding breakpoints in the cycle of deprivation is key
- This is, or will be, a community wide problem and requires solutions to be developed and co-ordinated across communities.

Integration of health and wellbeing services in Norfolk – update from integration task and finish group

Cover Sheet

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

The Health and Social Care Act 2012 and subsequent guidance sets out a clear role for the Health and Wellbeing Board in encouraging integrated working between health and social care commissioners, including encouraging partnership arrangements for health and social care services, such as pooled budgets, lead commissioning, or integrated provision.

At the last meeting of the Board on 10 July 2013, the NCC Director of Community Services agreed to set up a task and finish group with the remit of enabling an assessment to be made of progress to date with integration of key health and social care services.

Key questions for discussion

1. Are the proposed terms of reference and programme of work supported?
2. Is the programme of work outlined ambitious enough?
3. Is the scope of this work too great for a task and finish group?
4. Is the Board happy with the progress that is being made with the work to support the Integration Pioneer bids?

Actions/Decisions needed

The H&WB needs to review and comment on the content of the report, specifically:

1. The approach adopted by the task and finish group, as outlined in the terms of reference
2. The programme of work has been outlined
3. The current position with the integration pioneers.

Integration of health and wellbeing services in Norfolk – update

Report by the Director of NCC Community Services

The Health and Social Care Act 2012 and subsequent guidance sets out a clear role for the Health and Wellbeing Board in encouraging integrated working between health and social care commissioners, including encouraging partnership arrangements for health and social care services, such as pooled budgets, lead commissioning, or integrated provision.

At the last meeting of the Board on 10 July 2013, the NCC Director of Community Services agreed to set up a task and finish group with the remit of enabling an assessment to be made of progress to date with integration of key health and social care services. The Board also requested an update of progress with the bids to the Department of Health for 'Integration Pioneers' in Norfolk.

This paper outlines the outcome of the first meeting of the task and finish group, the terms of reference and work programme. It also provides the requested update on the integration pioneers.

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

1. The approach adopted by the task and finish group, as outlined in the Terms of Reference
2. The programme of work has been outlined
3. The current position with the integration pioneers.

1. Background

1.1 At the last meeting of the Norfolk Health and Wellbeing Board (HWB) on 10 July 2013, a paper was presented outlining progress to date with work to integrate the commissioning and provision of health and social care services for adults. As part of the discussions the Board decided to set-up a task and finish group to enable an assessment to be made of progress to date and of the impact that it has had. This task and finish group met on 17 September 2013 and this report provides an update on their work.

1.2 An update will also be given on the progress with the 3 Integration Pioneers bids that had been made to the Department of Health. These were West Norfolk, North Norfolk, and Great Yarmouth and Waveney.

2. Health and Social Care Act 2012

2.1 The Health and Social and subsequent guidance spells out a clear role for the Health and Wellbeing Board in encouraging integrated working between health and social care commissioners, including encouraging partnership arrangements

for health and social care services, such as pooled budgets, lead commissioning, or integrated provision. Where both the Act and the guidance are less clear is around the broader integration of services that either support good outcomes from integrated health and social care interventions and services, such as appropriate housing, or contribute to prevention, such as access to green space and leisure facilities.

2.2 The discussions at the Board meeting on 10 July 2013 suggested that there was some interest in looking at how the integration of services could be opened out from a relatively narrow focus on health and social care services. This was reflected in discussions at the first meeting of the task and finish group.

3. Task and Finish Group

3.1 The task and finish group met on 17 September 2013 and agreed both the Terms of Reference and a programme of work. The Terms of Reference are attached in Appendix 1 and the programme of work is outlined below:

3.2 **What does success look like** - develop a clear statement or description of what an effective and high quality integrated service looks like. This will be aspirational and so help drive the integration of services in a way that raises quality and improves outcomes. The statement or description will be informed by:

- national expectations of what makes good integrated care and support, as outlined in the terms of reference for the group
- the views of local commissioners and providers of health and social care services
- service user and carer views of what makes a good service.

3.3 The statement or description could be developed into a specification of requirements to be considered when commissioning services.

3.4 **What progress are we making** - develop an assessment tool, with the assistance of HealthWatch that enables the Board to understand the progress being made with integration and whether outcomes have improved for service users and their carers. This will help to:

- provide the evidence base for the Board members to challenge themselves and others
- highlight areas where there may be scope of greater integration
- repeat on a 6-monthly or annual basis to enable progress to be tracked.

3.5 **Where does integration start and finish** - identify what services are in scope for enhanced integration over the next 3 years, the period of the 2014/17 Joint Health and Wellbeing Strategy. The Government focus is upon health and social care and there is a strong financial imperative behind this. It is recognised, however, that addressing health and social care needs without addressing the wider needs of an individual and their family, such as housing, will not always lead to a positive or sustainable outcome.

3.6 The intention is to complete the programme of work within the next 3 months and bring recommendations to the meeting of the Health and Wellbeing Board in January 2014.

4. Integration pioneers

4.1 At its meeting in July, the Health & Wellbeing Board learnt that a call had been 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.

4.2 The pioneers needed to demonstrate they addressed 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.

4.3 The Board gave its support to the three Norfolk Bids which were submitted to the Department of Health. (The three Norfolk bids can be found at this link). The outcome of the Integration Pioneer bids has been:

- **North Norfolk**: not shortlisted, but the commitment to the programme outlined in the bid will continue. This focuses on the long term conditions programme and develops the integrated care programme.

- **Great Yarmouth and Waveney**: not shortlisted, but the commitment to the programme outlined in the bid will continue. The Great Yarmouth System Leadership Group met in September and has set out key ambitions for moving forwards.

- **West Norfolk's bid**: shortlisted and the leadership team attended an interview with the DH on 16 September. Outcomes are expected in October. The West Norfolk Alliance (the vehicle for working together) is progressing, including agreement of terms of engagement and a work programme.

5. Action

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

1. The approach adopted by the task and finish group, as outlined in the Terms of Reference
2. The programme of work has been outlined
3. The current position with the integration pioneers.

Background Papers

- Report to the Health and Wellbeing Board (July 2013) Item No 10, 'Integration of health and social care service in Norfolk: an update'- available at this link

- Department of Health (May 2013) 'Integrated care and support: our shared commitment' – available at this link

Officer Contact

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

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Catherine Underwood	01603 224378	catherine.underwood@nhs.net

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

Appendix 1

Terms of Reference for the Task and Finish Group on integration

Frequency – this is a task and finish group. It is anticipated that the work will be completed in the space of three formal meetings, or less.

Membership – the following members of the Health and Wellbeing Board volunteered to take part in this task and finish group at the July meeting of the Board:

- Harold Bodmer, Norfolk County Council
- Angie Fitch-Tillett, North Norfolk District Council
- Kate Gill, Great Yarmouth & Waveney CCG
- Joyce Hopwood, Voluntary sector
- Lucy MacLeod, Interim Director for Public Health
- Alex Stewart, Healthwatch Norfolk.

The following people have also been asked to take part in this group:

- Catherine Underwood, Norfolk County Council – nominated by Harold Bodmer
- Daniel Harry, Norfolk County Council – nominated by Debbie Bartlett

Role – to look at the means by which the Health and Wellbeing Board can assess the progress that is being made with integration and whether outcomes have improved as a result.

Context – as specified in the Health and Social Care Act 2012, the Health and Wellbeing Board has a statutory duty to encourage integrated working between commissioners of health and social care services.

The following extract from the report to the 10 July 2013 meeting of the Health and Wellbeing Board (Item No 10, 'Integration of health and social care service in Norfolk: an update', report by the Director of Community Services) provides a framework for the work of this task and finish group.

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:

1. Reinforcing the National Voices definition of integration as 'patient-centred coordinated care'
2. Locally based determination of how integration will be achieved rather than a nationally prescribed approach
3. An expectation of major change in existing service outcomes
4. High quality, compassionate care as essential
5. Integration which is broader than health and social care: public health, education and the third sector are all noted as key partners
6. A focus on avoiding crisis and avoiding unnecessary hospital admission
7. Ensuring the use of new technology
8. A call for scale and pace
9. Learning fast, sharing the lessons
10. An emphasis on people and leadership, not systems

11. Underpinned by personalisation and outcomes for individuals
12. Integration to become a standard approach in every area for everyone with health and care needs over the coming five years.

Chair – the Health and Wellbeing Board nominated Harold Bodmer as the chair of the group. The Chair will be accountable to the Health and Wellbeing Board for the performance of the task and finish group.

Reporting – the task and finish group will report directly to the Health and Wellbeing Board. The first report will be to the October meeting and then by arrangement thereafter.

The action notes of the meetings of the task and finish group will be made available to the Norfolk Health and Wellbeing Board.

Daniel Harry
Planning, Performance and Partnerships
Norfolk County Council
30 August 2013

Developing a Norfolk Joint Health and Wellbeing Strategy 2014-17

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

The Health and Social Care Act 2012 sets out a number of legal responsibilities for the Health and Wellbeing Board, including a **duty to prepare a Joint Health and Wellbeing Strategy**

The Health & Wellbeing Board is currently developing a Joint Health and Wellbeing Strategy 2014-17 with a view to sign off of the Strategy in April 2014.

Key questions for discussion

Q1. Is the principal role of the Health & Wellbeing Board the right one - as outlined by the strategy group in 2.4?

Q2. What are your views about the proposals for a 'tighter' objective for each of the 3 priorities and a framework of actions at different levels?

Q3. The next steps include beginning a programme of engagement with a range of groups before deciding on any specific actions – who from your experience/knowledge does the Board need to talk to?

Actions/Decisions needed

The Board needs to:

- Consider the report and note the progress
- Comment on the strategy group's conclusions
- Agree to begin a programme of engagement under each of the 3 priorities

Developing a Norfolk Joint Health and Wellbeing Strategy 2014/17

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

Summary
This paper provides an update to the Board on the development of the Joint Health & Wellbeing Strategy 2014-17 (JH&WBS 14-17), including the outcome of the Health & Wellbeing Board workshop session held on 19 August 2013 and the work of the Joint Health & Wellbeing Strategy Group. This paper asks for the Board's steer on some issues and also asks for agreement to begin a programme of engagement under each of the 3 priorities.

Action
The Board is asked to:

- Consider the report and note the progress
- Comment on the strategy group's conclusions (para 2.4)
- Agree that the strategy group, and others, should begin a programme of engagement under each of the 3 priorities to help identify and shape the specific actions that the Board could take that would add value

1. Background

1.1 At its meeting on 13 July 2013, the Health &Wellbeing Board agreed the approach for the development of the Joint Health & Wellbeing Strategy 2014-17 including the principles which would underpin it. The principles are as follows:
The Health & 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.

1.2 The Board agreed the following overarching goals and three priorities through which it would progress those goals:

Overarching Goals
Drive integration
Reduce inequalities
Promote healthy lifestyles and prevent problems

Progressed through three priorities*		
Early life (0-5)	Obesity	Dementia

1. 3 The full report to the July meeting of the Health & Wellbeing Board on the approach to the Joint Health & Wellbeing Strategy (JH&WBS) 2014-17 can be found at this link.

1.4 It was also agreed to set up a sub-group of the Board (strategy group) to progress the development outside of formal Board meetings and move the strategy on. All those partners interested in working to progress this work as part of the strategy group came forward and a list of members, together with Terms of Reference, for the strategy group is at Appendix A.

2. Moving the strategy development forward

2.1 The Board agreed that it needed to think in more depth about the 3 priorities and did this at a workshop on 19 August 2013. The workshop drew on a series of Public Health background briefing papers which gave evidence and context on each priority. The Public Health briefing papers are available at the following link.

2.2 It provided an opportunity to use the practical experience and knowledge of those people in the room to consider actions and activities set against the overarching goals agreed by the Board. For each of the three priorities, groups were asked to consider:

- What could be done to prevent poor outcomes of each priority
- What could be done to tackle inequalities when considering each priority
- What opportunities might there be for improving outcomes by better integration

2.3 Full details of the findings of the workshop is provided in Appendix B. Whilst the workshop itself did not reach any final conclusions about specific actions, it did generate a number of issues common to all priorities.

Issues common to all priorities:

1. **Vision** - the priorities, as currently framed, are too broad and a set of clear objectives for each needs to be developed. It is suggested that the DPH leads this.

2. **What is working already** – a need to understand whether what is currently being commissioned, procured and delivered is effective

3. **Targeting** – by geography, risk/need, social group, behaviour

4. **Technology** – to harness new social media and other technology

5. **Behaviour change** – understanding and exploiting what is a growing body of knowledge about what works when changing lifestyles and behaviour, rather than relying on people 'doing the right thing'

6. **Parents** – the key role that parents have to play in establishing social and behavioural norms for their children

7. **First contact** – key role that GPs, schools, Police and others play as the first point of contact for people in need

8. **Coherence** – a sense that there is a lot of activity associated with the three priorities but that it may lack coherence

2.4 The strategy group took the work from the August workshop and reached the following conclusions:

Strategy Group Conclusions

- **The principal role** of the Health &Wellbeing Board in developing and implementing the strategy is providing leadership on an evidence-based approach for decisions, and being the 'conscience' of the public sector system around reducing inequalities

- **Each priority** (dementia, early life, obesity) needs to have a tighter objective or objectives so all partners are clear about what is trying to be achieved and can hold each other to account

- **A framework** for the strategy could usefully segment actions at different levels, drawing on the style and approach of guidance published by NICE. This should describe specifically the type of actions public sector bodies could and should undertake; the type of actions that front-line staff, GPs etc in contact with users and patients could and should take, and the type of change that individuals can make for themselves

- **Before deciding on any specific actions**, there needs to be **engagement** with a range of groups, including users, representative bodies, health professionals and subject experts on each of the three priorities. This will build a better understanding of the current picture and shape where the Board needs to add value.

3. Next Steps in relation to each priority

3.1 The strategy group also considered next steps in relation to each priority:

- **Dementia** - The Acting Director of Public Health (DPH) recommends that the Board should adopt 'Making Norfolk a dementia friendly place to live' as its objective. This reflects the important role of the wider community in responding and adapting to increasing numbers of people with dementia. The strategy group recognised the work of Norfolk and Suffolk Dementia alliance and Norfolk Older People's Partnership and agreed the next steps were to engage with the work of these and other relevant groups.

- **Early Life** – the group felt it important, as a first step, to seek advice from the interim Director of Children's Services about where the Board could add value to existing work, particularly in the light of the Ofsted improvement action plan.

- **Obesity** – this was felt to be a priority where a simple, not onerous, stocktake of existing activities taking place aimed at preventing more people from becoming

obese would be a helpful step. The DPH undertook to frame this and commission subsequent analysis.

4. Action

4.1 The Board is asked to:

- Consider the report and note the progress
- Comment on the strategy group's conclusions (para 2.4)
- Agree that the strategy group, and others, should begin a programme of engagement under each of the 3 priorities to help identify and shape the specific actions that the Board could take that would add value

Officer Contact

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

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IN TRAN communication for al

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.

Joint Health and Wellbeing Strategy Group
Terms of Reference

Frequency
To start off with the strategy group will normally meet quarterly between each formal meeting of the board with additional work being done between meetings via email whenever possible.

Core duties
1. Be responsible for progressing the development and then the delivery of the Joint Health and Wellbeing Strategy between formal meetings of the Health and Wellbeing Board.
2. Advise on the development of, and lead on the delivery of, a communications plan for the Joint Health and Wellbeing Strategy.
3. Advise on the development of and lead on a performance management framework for the Joint Health and Wellbeing Strategy.
4. To ensure active participation of key stakeholders when and where appropriate.

Possible additional responsibilities
5. Propose and review any changes necessary to the operation of the Board in light of amendments to legislation/government guidance.
6. Planning and delivering organisational development activities for the Board.
7. Consider and advise the chair on the Board's forward plan.
8. To lead on the preparation of an annual report for the Health and Wellbeing Board.
9. Maintain an overview of the Board's work between meetings including that undertaken through standing and task and finish sub-groups.
10. Undertake further work on behalf of the Board at the request of a formal board meeting or the Chair and Vice Chairs of the Board.

Chair and Vice Chair
The Chair and Vice Chair will be appointed by the Strategy Group and they shall be accountable to the Health and Wellbeing Board for the performance of the Strategy Group.

Reporting
The action notes of all the Health and Wellbeing Strategy Group meetings shall be submitted to the Health and Wellbeing Board.

Membership
Healthwatch Norfolk and NHS England will have a place on the strategy group. Membership from other sectors will be decided on by those sectors. Members of the strategy group will be a combination of board members (to provide the link back to the board) and people nominated by board members to broaden and deepen ownership of the Board's agenda.

Name	Title	Organisation
Daniel Roper	Cabinet Member, Public Protection & Chair H&WB (ex-officio member)	Norfolk County Council
Debbie Bartlett	Head of Planning, Performance & Partnerships	Norfolk County Council
Lucy Macleod	Interim Director of Public Health	Norfolk County Council

Tim Eyres	Head of 11-19 Strategy & Commissioning	Norfolk County Council
Chris Price	Chairman	Norwich CCG
Bob Purser & Kim Arber	-	Great Yarmouth & Waveney CCG
Jocelyn Pike	Chief Operating Officer	South Norfolk CCG
Yvonne Bendle	Cab Member for Housing and Public Health, and Joint Vice-Chair H&WB	South Norfolk District Council
Martyn Swann	Housing and Public Health Manager	South Norfolk District Council
Elizabeth Nockolds	Cabinet Member Health & Well Being	
Vicki Jackson	-	King's Lynn and West Norfolk BC
Penny Linden	Councillor	Great Yarmouth Borough Council
Rob Gregory	Group Manager, Neighbourhood and Communities	Great Yarmouth Borough Council
James Elliott	Chief Operating Officer, Norwich CCG	On behalf of Norwich City Council
Sam Revill	Research Manager	Healthwatch Norfolk
Tracey Dowling	Director Operations & Delivery, NHS England, East Anglia Team	NHS Commissioning Board
Joyce Hopwood	Norfolk Council on Ageing (also Chair Norfolk's Older People's Partnership)	Joint Health, Social Care and Voluntary Sector Strategic Forum
Dan Mobbs	Chief Executive	MAP
Jenny McKibben	Deputy Police & Crime Commissioner	Office of the PCC
CC list/Subs		
Richard Draper	Norfolk Specialist Partnership rep, and Chief Exec of The Benjamin Foundation	Joint Health, Social Care and Voluntary Sector Strategic Forum
Claire Collen	Voluntary Sector Engagement Project Manager	Joint Health, Social Care and Voluntary Sector Strategic Forum
Ian Mack	Ex officio	West Norfolk CCG

Key messages from workshop – 19 August 2013

Norfolk Health and Wellbeing Board
Workshop on the Joint Health and Wellbeing Strategy 2014-17
19 August 2013

Introduction

What follows is a summary of the discussions on the development of the Norfolk Joint Health and Wellbeing Strategy 2014/17 that took place on 19 August 2013. The discussions focussed on how work on the three agreed priorities (Early Years, Obesity, Dementia) could help achieve the overarching goals (prevention, reducing inequalities and driving integration). The summary of the discussions starts to describe a series of tasks or actions for the Board to consider as part of the emergent Strategy.

Common threads

Outlined below are the issues that were common to all three of the priorities:

- Vision - a need for the Health and Wellbeing Board (HWB) to establish a shared vision and purpose with a clear statement of what it is trying to achieve for each of the priorities and how people (Board members) can contribute
- What works - a need to understand whether what is currently being commissioned, procured and delivered is effective
- Targeting – by geography, risk/need, social group, behaviour
- Community – integrated approaches at a local level that focus upon distinct communities (and using place based budgeting)
- Motivation – understanding how behavioural change is achieved and how people are motivated to engage in services and interventions
- Parents – the key role that parents have to play in establishing social and behavioural norms for their children
- First contact – key role that GPs, schools, Police and others play as the first point of contact for people in need
- Social norms – a need to challenge commonly accepted truths and myths (across service users, providers and commissioners)
- Technology – how to use existing and new technologies, often at no cost to services
- Coherence - a sense that there is a lot of activity but a lack of a coherent approach across Norfolk.

Early Years

General comments

1. There may be difficulty in understanding the progress that is being made with work around early years as there are limitations around the indicators currently available – the key will be to keep it broader than any single indicator.
2. The Children's Trust Joint Commissioning Group may have a key role to play as the 'technical experts' for this area of work.
3. A clear focus on what exactly it is that the Board is trying to achieve is needed. This might be through 'painting a picture' of what we think is a good experience in early years – identifying the key characteristics and then all agencies checking themselves against it. This could then lead to an agreement of 'what we do' that then enables clarity about what we are working towards, thus avoiding confusion and conflicting approaches.

4. The importance of prevention and looking at the wider causal issues. This then leads to a focus upon building capacity and resilience, rather than interventions.
5. The role of schools here remains unclear, particularly how the HWB could enter into a dialogue with them and influence them.
6. How do your maintain a collective focus during a period of protracted austerity and cuts to public sector budgets?

Summary of discussions
(Note – gaps in the table are not an omission but a result of activity not being identified at the workshop across all three of the overarching goals.)

Prevent	**Reduce inequalities**	**Drive integration**
Financial stress – promote access to (stable) employment	Monitor the impact of welfare reforms (underway through HWB)	Long term influence upon the development of the local economy via the Local Enterprise Partnership
Do we know what is currently being commissioned/provided in Norfolk and whether it is effective? Is there anything that can be learnt from the local implementation of Family First (Troubled Families)?	Do we know what works? Different learning styles - learning from experience/seeing/doing rather than tuition or being told. Identify what the Board can do from a cultural level.	Commissioning workshops to drive more integrated approaches – linking the priorities in with the developing Norfolk Commissioning Academy.
Create a stable home by addressing housing issues (quality, frequency of moves, loss of tenancy)	Differences between urban and rural experience of access to housing	How best to engage with partners on housing issues – data led using an indicator that shows that scale and impact of the issue
Work from an assets based approach, building upon strengths to create resilience – to build sustainable solutions	Need to understand what the inequalities of outcomes are and which we most want to focus upon reducing – Assets based research	How do we collectively (as a HWB) engage with families?
Ante-natal classes are a key route in to engage with families from the earliest stage	Incentivise take up amongst the target population	Group services around ante-natal classes and interventions
Community development	Community budgets and a geographical pooling of budgets to target communities at risk of disadvantage	
Look at the way in which people live their lives and adapt interventions to fit		Offer integrated services to people where they are most comfortable and stigma and

Prevent	Reduce inequalities	Drive integration
		inconvenience is low
Accessibility to services – location, opening hours, stigma, what's in it for me?	May be different experiences in rural and urban areas – or may not be so simplistic	
Start with the family rather than the problem	Focus in on the families who most need help or who are assessed to be 'highest risk' rather than solely deprivation statistics	
Key role that 'first contact' agencies may have to play in recognising a family in crisis and being able to refer on. For example, the Police, health visitors, social workers		How can partners work with Police and others to optimise the first contact?
Challenge cultural norms of people in need, the local community, service providers and commissioners – at what point is a family in need?		Commission integrated approaches that meet the lowest common denominator
Parental stress and impact upon ability to parent young children	Assets based approach – building resilient individuals, families and communities. Building on what is already there and what there needs to be more of.	Link to mental wellbeing, mentoring, peer support and access to talking therapies
Key role that pre-school and related services have to play in building protective factors	How do you encourage the people who need to engage to engage? Note experience of Children's Centres	
Challenge assumptions and accepted truths to enable an evidence-based and needs-led response	Good, effective engagement with families is key – by whoever is best placed to do it – in order to enable us to look ahead.	
Technological solutions, such as the use of social media		

Obesity

General comments

1. Agreed to focus on obesity as a priority, as opposed to the suggested broadening out to 'preventable death and disability free life expectancy'. Obesity recognised as being a route into a broad range of serious, long terms health conditions, such as: Coronary Artery Disease; Type 2 diabetes; and non-alcoholic fatty liver disease.
2. Two separate but linked approaches: preventing children and young people becoming overweight and obese; and helping people who are obese to change their behaviour and lose weight.
3. The data is readily available and improving. We know which groups are most likely to be at risk of becoming overweight and/or obese and also who is obese. Therefore, we are able to target limited resources.

4. It is important to keep up momentum and maintain it in the long term. Many good initiatives have ended after brief successes.

Summary of discussions

Prevent	**Reduce inequalities**	**Drive integration**
Behavioural change, nudge and creation of feedback loops for people – Cabinet Office (2010) Applying behavioural insights to health	Social marketing approaches - no immediate feedback associated with lack of exercise or unhealthy eating, this can impact upon people's motivation to change, as can societal norms.	Do we provide services and interventions that enable holistic change/recovery? Do we collectively target what motivations people - 'cycle of change' (Prochaska and DiClemente – smoking cessation model)
Diversify the channels by which key messages are delivered – trusted messengers	What is the impact of obesity on me? Disability free life expectancy? Stimulate change.	Make every contact count – shared responsibility to promote common messages throughout daily work and interactions
Challenge myths and accepted truths	Role of parents and role modelling	Do we really understand what interventions work and whether our activity reflects best practice? For example, is Public Health commissioning of Tier 2 interventions an effective use of limited funds?
Identification of funding that could be used to support longer term investment in work to reduce obesity	Place Based Budgets (Total Place)	Working together, Board members may need to accept that an investment by one organisation benefits the system as a whole but not them individually
Make a series of commitments or set a series of challenges (for example to get the whole of Norfolk walking)	Assets based approach that uses the best of what Norfolk has to offer to promote healthy, active lifestyles – green	Build upon the work of integrated, place based and community led initiatives like the Norfolk Healthy Towns Programme

Prevent	Reduce inequalities	Drive integration
	gym, blue gym	
Workplace health	Work with an individual employee has a knock effect to family, friends and peer group – increasing the reach of the Board (100,000+)	All HWB members to look at work place health initiatives (discussion at October 2013 HWB meeting) – est., 45,000 people employed by HWB member organisations
Lobbying role locally and nationally to release funding, challenge restrictive policies or practices and enable greater local regulation of processed food suppliers	Continued work with fast food outlets on reduced salt levels, fat levels and calorific values & the promotion of alternatives to cheap, mass produced foods with high levels of salts and fats and high calorific values	Promotion and enablement of allotments, use of 'common' land for planting, social enterprise and cooperatives, peer support – example of 'Men's Sheds Australia'
Clear and distinct roles for each HWB member. For example: District Council to promote leisure activities and use of green space; County Council to promote active travel plans; PCC to work with schools to encourage walking to school		An integrated Board – working as one
Make services attractive and accessible	Men identified as a group least likely to access weight loss services or groups	
Role modelling and activities that inspire, overcoming barriers	Role models that are relevant to people at risk	
	Impact assessment – agreement that all commissioners, purchasers and providers or services assess the impact upon the HWB priorities and overarching goals (and key risk groups)	Agree a set of principles by which services and interventions will be commissioned and delivered in Norfolk – in effect commissioning standards

Prevent	Reduce inequalities	Drive integration
Current health and social care architecture is confused, leading to a lack of leadership in areas of work where there is co-morbidity, like obesity		Clarity about which part of the health system is best placed to pick up which particular task or issue relating to obesity
Public Health Responsibility Deal – under review by Public Health England (alcohol, food, workplace health, physical activity) https://responsibilitydeal.dh.gov.uk/pledges/		
		Calculate the 'Return on Investment' for key lines of commissioning or intervention

Dementia

General comments

1. Concerns over the equality of both access to existing services and outcomes for people with dementia.
2. Key role of the HWB in leading a systems wide review of the identification and response to dementia.

Prevent	Reduce inequalities	Drive integration
Early identification and mitigating the social impacts	Awareness raising for carers and family members	Multi-agency training on how to identify, assess and work with people with dementia
Enable people to live independently and well in their own homes, with support from carers who are in turn supported	Planning and house building that recognises that specific needs of people with dementia and their carers	HWB role in influencing district council planning and lobbying national government
Reduce the number of unplanned admissions	Which areas or groups are at greater risk of unplanned admissions?	Reablement and discharge planning – pathway redesign
Increase awareness in the community and create a 'dementia friendly' services and communities	Deliver interventions for dementia through mainstream services and so avoid stigma and marginalisation	
	Equality of access to services –do we know who is accessing services, who is not and why?	Equity audit by HWB
	Equality of outcomes – do we know who is experiencing good outcomes, who is not and why?	Equity audit by HWB
	Support carers and enable them to have a greater voice	

Prevent	Reduce inequalities	Drive integration
	– advocacy – local HealthWatch	
Use of volunteers to mentor and support		
Technology and innovation in aids and adaptations for people with dementia and their carers		
		Role of independent social care providers?
		How do you translate operational good practice into commissioning standards?

Next steps

The intention had been to look at the process for stakeholder and public engagement on the development of the Joint Health and Wellbeing Strategy 2014/17 (from October/November) as well as the means by which we would measure progress with its implementation (over the next three years). There was not time to do so. Therefore, these issues will be picked up through a combination of follow up workshops that are already scheduled, email and existing groups that support the Health and Wellbeing Board.

The summary of the discussions outlined in this paper will be developed further into a series of distinct tasks or actions for the Board to consider as part of the emergent Strategy, at its October meeting. In doing so, the challenge remains that of adding value to work that is already underway in the county, identifying what action to take and who is best placed to lead it.

Workshop attendees

Name	Organisation
James Joyce	Cabinet Member for Safeguarding, NCC
Alex Stuart	Chief Executive, Healthwatch Norfolk
Ray Harding	Chief Executive, Borough Council of King's Lynn and West Norfolk
Sue Whitaker	Cabinet member, Adult Social Care, NCC
Mark Taylor	Chief Officer, NHS North Norfolk CCG
Dr Ian Mack	Chair, West Norfolk Clinical Commissioning Group
Claire Collen	Voluntary Sector Engagement Manager, Voluntary Norfolk
Harold Bodmer	Director of Community Services, NCC
T/ACC Nick Dean.	Norfolk Constabulary
Sam Revill	Healthwatch Norfolk
Sonia Shuter	Health Improvement Officer, NNDC
Cllr Roger Foulger	Broadland District Council
Jocelyn Pike	Chief Operating Officer, South Norfolk CCG
Adam Clark	NCAN
Cllr Penny Linden	Great Yarmouth Borough Council
Rob Gregory	Great Yarmouth Borough Council
Martyn Swann	South Norfolk District Council
Vicki Jackson	King’s Lynn and West of Norfolk Borough Council
Bob Purser	Great Yarmouth and Waveney CCG
Jo Webb	Norfolk County Council
Debbie Bartlett	Norfolk County Council
Daniel Harry	Norfolk County Council
Linda Bainton	Norfolk County Council
Lucy Macleod	Public Health
Augustine Pereira	Public Health
Shamsher Diu	Public Health
Helen Adcock	Public Health
Tha Han	Public Health

Community-led Health Improvement Work Programme – update

Cover Sheet

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

In 2012, the Shadow Health & Wellbeing Board agreed to set up a community-led health improvement work programme, using two approaches used in Norfolk which were place-based, had achieved a positive impact and could be considered for wider implementation across Norfolk (Healthy Towns and Ageing Well).

This community-led health improvement work programme is supported by part of the County Council's share of 2nd homes monies for 2012-13, which NCC's Cabinet had agreed to allocate to support the health and wellbeing partnership agenda.

Key questions for discussion

1. Is satisfactory progress being made?

2. Does the Board have any comments on the Next Steps?

Actions/Decisions needed

The H&WB needs to:

- Consider and comment on the report

Community-led Health Improvement Work Programme - update

Report by the Acting Director of Public Health

Summary
This report summarises the progress and impact made to date with the community-led health improvement work programme based on two place-based approaches to health improvement - Healthy Towns and Ageing Well. The report outlines the key progress to date, highlights some of achievements in the last 6 months and outlines the next steps.

Action
The H&WB is asked to consider and comment on the report.

1. Background

1.1 At its meeting in July 2012, the Shadow H&WB considered a report about the health improvement agenda and looked at two approaches to health improvement used in Norfolk (Healthy Towns and Ageing Well) which were place-based, had achieved a positive impact and could be considered for wider implementation across Norfolk. The Board noted that a community-led approach to health improvement was concerned with supporting communities to:

- Identify and define what was important to them about their health and wellbeing
- Identify the factors that impacted on their wellbeing, and to
- Take the lead in identifying and implementing solutions.

1.2 The Board agreed to set up a community-led health improvement work programme, using the two initiatives, and appoint the Director of Public Health, as the Lead Officer, with a Steering Group to provide the strategic co - ordination. The Board also endorsed a proposal that the programme was supported by part of the County Council's share of 2nd homes monies for 2012-13. The Board noted that NCC's Cabinet had agreed to allocate part of its share of the 2nd homes monies to support the health and wellbeing partnership agenda, with the decision about the specific sum being for the Leader of the Council.

1.3 In April 2013, the Board received a report which updated on the progress being made and agreed the overall approach for implementation, including the 10 communities identified from the health evidence base. The 10 communities are Fakenham, Cromer, Wymondham, Diss, North Walsham, Downham Market, Hunstanton, one ward in Kings Lynn and two wards in Great

Yarmouth. The Board also agreed that the project Steering Group should now be replaced with a Locality Implementation Group, to co-ordinate roll-out.

2. Progress and achievements to date

2.1 Since the last report in April 2013, significant process has been made in the planning of, project management, evaluation and community led work for Healthy Communities and Ageing Well in Norfolk. This is outlined below.

2.2 **Recruiting the team** - 2 Community Health Engagement Officers were recruited in June 2013. These posts are now engaging with community members to raise awareness of health issues, empowering communities to suggest solutions and enabling communities to lead on those suggested solutions. A further Community Health Engagement officer is joining the team on secondment from Adult Education services during September / October 2013, to help enhance training solutions within communities.

2.3 **Evaluation** - Working with the University of East Anglia and the Public Health Intelligence team, the evaluation plan and a suite of data collection and evaluation tools have been produced. Please see Appendix A for a brief summary of our evaluation plan.

2.4 As part of the evaluation process a short questionnaire has been sent to all Norfolk County Council 'Your Voice' participants (Your Voice has a membership of 6000 community members). The questionnaire will measure perceptions of community health and awareness of a variety of health services. The intention is to send a further survey out in November 2014 to re-measure this.

2.5 Detailed **health profiles** of each of the 10 Healthy Communities have been completed which give some steer to the agreement of public health priorities for each town. Please see Appendix B for an example profile for Wymondham and visit **www.norfolkinsight.org.uk/jsna** to see the full suite of profiles.

2.6 The Community Health Team has created a **community asset tool** - the Community Asset Based Inventory tool (CABI). Based on national evidence this tool has been designed and used to scope all physical, health based, institutional, organisational, cultural and individual assets in the communities identified.

2.7 The **scoping of assets with community members** and organisations has taken place in six of the ten Healthy Communities to date. This mapping has enabled the team to identify assets that can be used to improve the health of each community. It has also proved to be a useful tool to identify where gaps are in services or where there could be more joined up approaches to improve health and community services. The result of these inventories demonstrates huge potential for linking in socially isolated community members. These inventories have already begun to be shared with other Norfolk County Council services.

2.8 NCC's Community Services and Public Health have commissioned **Broadland District Council to expand their 'Grow Your Community' initiative** to cover

the towns of Aylsham, Reepham and Wroxham – these areas will adopt the Ageing Well and Healthy Communities principles towards Community Led Health Improvement. This is being monitored under a service level agreement between Norfolk County Council and Broadland District Council. This work will contribute towards the final evaluation. By working with the district council utilising this model we will be able to ascertain which approach is more sustainable and effective in the longer term.

2.9 Four **Community Led Health Improvement workshops** have been held in various towns. As a result of these workshops and using an Asset Based Community Development model the Health Communities staff were able to ask community members to suggest what would make an impact on their health in their locality. As a result of these discussions we are supporting the set-up of new social groups for adults and children by offering financial support for solutions that were suggested by community members in the form of grants. Examples of ideas suggested include supporting a new social group for adults with physical disabilities in North Walsham and links with new youth hubs in Cromer & North Walsham.

2.10 The team is working closely with other Norfolk County Council Departments, for example, with **the library service**. Fakenham & Cromer libraries both now have health posters displayed (including health checks) & dedicated health information folders. There are plans to follow suit in Wymondham, Diss and North Walsham by October 2013. We have also agreed to display key messages on the plasma screens in libraries.

2.11 The team have displayed at and supported a number of **Community Engagement Events that** have been held to promote health and healthy lifestyles. For example, at Cromer Carnival and at the Prevention First events in Kings Lynn. A bespoke health fair is also being planned for each. From increasing community engagement and from our asset based audits the team has been able to promote volunteer opportunities to community members. Examples include drivers for MediRide in Cromer, and gardeners for training at First Focus Community Centre & Gardening in Fakenham community allotment projects.

2.12 Overall the Healthy Communities and Ageing Well team have been to 75 locality based meetings, groups and event's in the last 4monthes across all of the communities selected.

2.12 25 community members have been trained in **Mental Health First Aid Training.** This 2 day course supports community awareness of how to recognise the signs and symptoms of common mental health issues, provide help on a first aid basis and effectively signpost towards mental health support services.

2.13 30 community members (including community pharmacy staff) have been trained in the Level 2 award from the Royal Society of Public Health **Understanding Health Improvement**. It provides an ideal way of equipping community members with basic health promotion advice and methods of support which they can then use to inform other community members and signpost to existing services.

2.14 A number of **marketing materials** have been designed including flyers, posters, website buttons and banners to promote health fairs, community events and community led workshops and groups. There has also been local press coverage in some communities where the programme is working.

2.15 Another key success has been the reciprocal **partnership working across the county –** the Ageing Well and Healthy Community staff in west Norfolk were able to take best practice and lessons learned from the Healthy Community Engagement events in Cromer and Fakenham and share them with West Norfolk Prevention First Steering Group, to influence and shape their forthcoming community engagement events (being held end in October)

2.16 **Partnership working has been a key driver** in the success to date. The team has contacted and met with NCC, district and town councillors in the localities they are working in. They have also worked very closely with officers both at County and district council level as well as community / voluntary organisations such as the British Heart Foundation, Sure Start centres and MIND to name a few. Of particular note is the excellent relationships developed with, and invaluable support received from, the Older People's Strategic Partnership and local Older Peoples Forums with the Ageing Well initiative.

3. Next Steps

3.1 The work continues with the following key activities:

- Continue the organisation and facilitation of the Community Led Health Improvement workshops and asset based mapping in the remaining towns where these have not yet taken place

- There will be a minimum of two health fairs in each town; these will raise health awareness, signpost to services and recruit community members to join local health groups

- Setting up of community health groups in each town, or add the community lead health improvement priorities to appropriate community groups that already exist. For example in Wymondham and Diss this platform could be the existing Neighbourhood boards

- Support further community led health improvement projects suggested by the community through either the grant support mechanism or by funding and working directly with community groups.

- Further training of community members as health champions through offering the Mental Health First Aid, Royal Society of Public Health and Grant Support training programmes

- Continuing to engage and work in partnership with a wide range of stakeholders to improve the health of the communities and to embed and sustain the projects post funding support

- Collecting and monitoring data that will contribute to the evaluation report, and test the effectiveness of the Healthy Community approach to health improvement

- As part of the wider strategic plan for Public Health, all the other community projects, such as Joy of Food and the Healthy Living Pharmacy programmes will be aligned with the Healthy Communities project and are offered in all ten areas

- Working with stakeholders such as Clinical Commissioning Groups, Norfolk and Suffolk Foundation Trust (Mental Health), Alzheimers UK, Age UK, etc., it is proposed to pilot a community led project focusing on dementia in targeted healthy community areas in Norfolk.

- The project will end in November 2014 with the final evaluation report being produced in January 2015. The Healthy Community officers are fixed term until November 2014 with the evaluation report being finalised by substantive public health staff with support from the UEA.

4. Reporting

4.1 The next report to the Health and Wellbeing Board will be in April 2014. This will consist of an update on progress to date, early evaluation results, legacy planning and a financial report.

5. Action

5.1 The H&WB is asked to consider and comment on the report.

Officer Contact

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

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Tony Trotman	01603 638339	Tony.Trotman@norfolk.gov.uk

Healthy Communities Evaluation

Project aim:

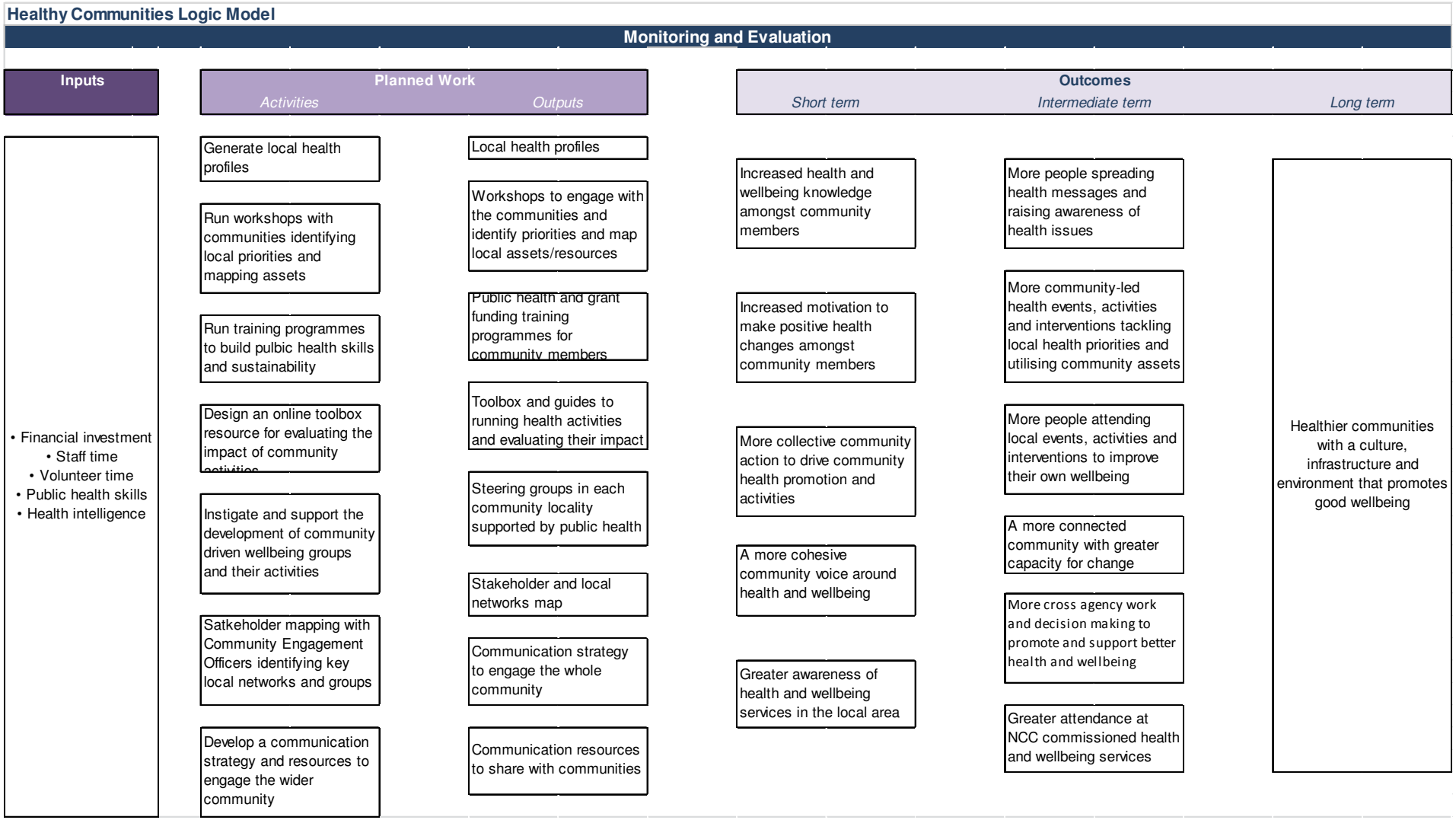
> "The project aims to support Norfolk communities to take local action to promote health and wellbeing through building health groups, raising health awareness and providing education and skills training, enabling more people to live longer and healthier lives."

Priority Area 1: Improving community awareness and understanding of health and wellbeing issues.

Priority Area 2: Improving understanding of community health priorities and increasing engagement in health and wellbeing activities.

Priority Area 3: Improving partnership working and developing long-term commitment between agencies and the communities.

Logic Model – How outcomes will be achieved



What do we need to know?

Process evaluation:

- Was the project implemented as planned?
- What worked and what didn't work about the project?
- Was the target audience reached?

Outcome evaluation:

- Did the project improve community awareness and understanding of health and wellbeing issues?
- Did the project improve understanding of community health priorities, and increase engagement in health and wellbeing activities?
- Did the project improve partnership working and develop long-term commitment between agencies and the communities?

Tools and Reporting

- Community Asset Based Inventory
- Questionnaires
  - Awareness of wellbeing services (Your Voice)
  - Measuring change in health knowledge
  - Social Impact
- Activity Logs
- Case studies and focus groups.

Final Report February 2015, interim reports based on monthly highlight reports as required.

Norfolk County Council
at your service

Norfolk County Council Public Health Team; Improving health and wellbeing, protecting the population and preventing ill health

Name of document:	Wymondham Health Profile	**File location / Filename:**	G:\6. Health Intelligence\Public\Profiles Read Only\MSOA - Healthy Town Profiles
Version:	0.1	**Date of this version:**	28/06/13
Status:	Draft	**Synopsis and outcomes of Equality and Diversity Impact Assessment (if required):**	
Owner:	Public Health	**Approved by (Committee):**	
Produced by:	Holly Gilbert	**Date ratified:**	
Relevant Public Health Programme:		**Copyholders:**	Head of Locality Development, PH Consultants, DPH, CCGs
		Next review due:	
		Enquiries to:	Holly.gilbert@norfolk.gov.uk

Wymondham health profile

Introduction

This health profile uses nationally published data at Middle Super Output Area (MSOA). A MSOA is a geographic area defined by the Office of National Statistics that is unlikely to change over time, unlike electoral wards. The data from the MSOAs has been used to build the Electoral Division profile for Wymondham.

Wymondham - www.norfolkinsight.org.uk/resource/view?resourceId=739

The location of the MSOAs is shown in Figure 1 together with the main GP practice locations. The summary information for each MSOA is shown as a spine plot (Figure 3 and Figure 4). This information may alter slightly to that presented in the Electoral Division profile as data has been updated where possible. Instructions as to how to interpret the spine plot are shown in Figure 2. Some evidence based suggestions as to what can be done about the priorities start in the section "Selected interventions to address the priorities".

Priorities

1. Giving children the best start in life

   Generally indicators pertaining to the health of children are good, although the number of low birth weight babies could be improved. The infant mortality rate is higher than average in some areas so this could be an area to investigate further.

2. Lifestyle behaviours

   Alcohol intake on more than 5 days a week is higher than average and mortality rates for females under the age of 75 from liver disease could be improved in certain areas. Levels of adult obesity could also be improved.

3. Reducing emergency admissions

   Emergency admissions for a range of areas are higher than average in parts of Wymondham including: admissions for 0-19 year olds for injury or poisoning, fractures in the over 65s and generally admissions for the over 65s. There is also a higher than average rate of excess winter deaths that could potentially be improved by increasing uptake of the flu immunisation.

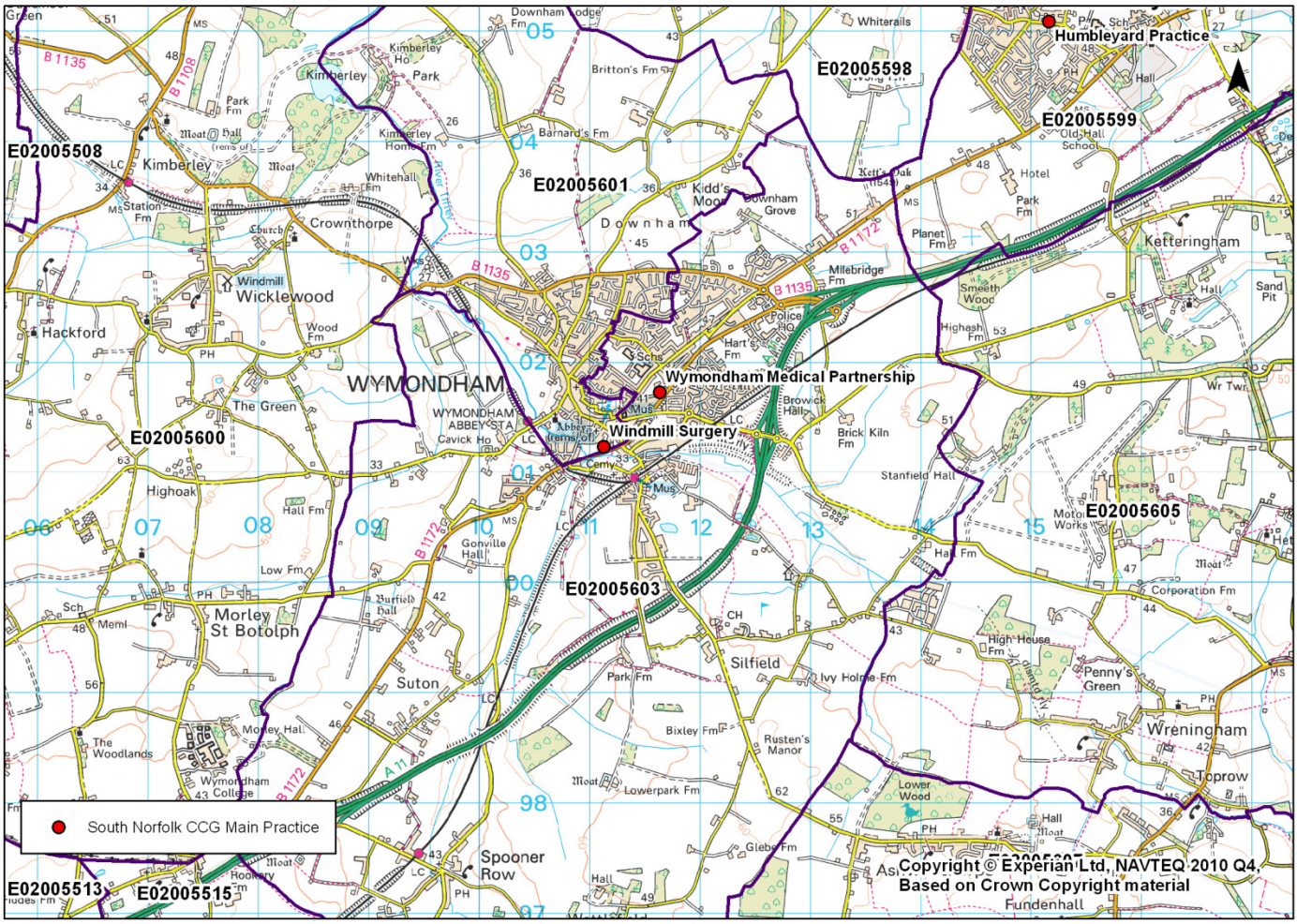


Figure 1 Map of Wymondham MSOAs E02005601 to the North and E02005603 to the South.

Selected interventions to address the priorities

Giving children the best start in life

Improving birth weight

Smoking in pregnancy is associated with a low birth weight baby. Guidance recommends the following to reduce smoking in pregnancy (http://guidance.nice.org.uk/ph26):

- Identify those that smoke using a carbon monoxide tester.
- Health professionals and the wider community should encourage pregnant women to use the NHS stop smoking services and NHS Pregnancy Smoking Helpline.
- Trained professionals should give advice on the risks of smoking in pregnancy.
- Interventions based on cognitive behaviour therapy, motivational interviewing and structured self-help and support from NHS Stop Smoking Services have been shown to be effective.
- Services should be accessible to all, being well located and available in multiple languages.
- Smoking in pregnancy is linked to a younger age of the mother and socioeconomic status so this should be considered when targeting services and interventions.
- The family and home environment should be considered; family and partners should be encouraged to quit too.

Low birth weight babies are associated with social disadvantage so the wider determinants of health should also be considered.

Poor maternal weight gain has also been linked to low birth weight babies. Guidance recommends the following practices to improve maternal nutrition (http://guidance.nice.org.uk/PH11):

- The Healthy Start scheme emphasises the need for health professionals to give mothers health and lifestyle advice, including advice about diet through pregnancy.
- The Healthy Start scheme provides access to foods for young mothers or those with low income.
- Diet will be influenced by the mother's wider family and peers so this should be considered in interventions.
- Nutritional interventions are best implemented prior to conception or in the first 12 weeks of pregnancy.

Improving lifestyle behaviours

Reducing alcohol consumption

There is guidance that looks at how to prevent alcohol-related harm http://www.nice.org.uk/PH24. Recommendations include:

- Licensing.
- Resources for identifying and helping people with alcohol-related problems.
- Children and young people aged 10 to 15 years – assessing their ability to consent, judging their alcohol use, discussion and referral to specialist services.
- Young people aged 16 and 17 years – identification, offering motivational support or referral to specialist services.
- Adults – screening, brief advice, motivational support or referral.

Other areas that can help address alcohol-related harm include:

- Working in partnership across health (providers, GPs, CCGs patient groups), local authorities and criminal justice.
- Services for high risk and dependent drinkers should be commissioned against outcomes which reflect the broad impact on individuals and social aspects.
  Services should be tiered to accommodate varied needs, points of access, and levels of dependency.

Reducing obesity

Obesity best practice guidance is available from NICE (www.nice.org.uk/CG43). Measures to reduce the number of overweight and obese individuals focus on increasing the level of physical activity, or reducing time spent sedentary, and improving diet. Creating a social, cultural and physical environment that supports these goals is a key component of many interventions instigating lifestyle change.

Creating an environment that promotes physical activity requires planning processes to take into account the health impacts of:

- Road design
- Cycle lanes
- Access to green space
- Locations of fast food outlets.

Workplaces can play a role by providing facilities and policies to encourage active travel to work, they can also offer healthy food options and improve the physical environment to encourage healthy choices. By offering recreational activities, such as lunchtime walks, they can also help employees to be active.

It is important to provide consistent, evidence based education and advice on how to maintain a healthy weight and identify families early who might be at risk. Health professionals and local authorities should also signpost appropriate individuals to evidence based weight management schemes.

Improving diet may be influenced by:

- Reducing exposure to "unhealthy" food advertising and involving Environmental Health to influence the healthy food agenda – e.g. trans fats.
- Policy change to impact on "unhealthy" food pricing, its availability and how it is marketed could be used to combat such harm.
- Consistent and clear messages should be delivered across health, social care and children's services.
- Ensure the planning process takes into account the health impacts of locations of fast food outlets.
- Create healthy organisations that encourage and support physical activity and healthy eating e.g. workplace health schemes
- Help families early who might be at risk.
- Implement NICE guidance for pregnant women (http://guidance.nice.org.uk/ph27)

Lifestyle change can be effective provided:

- There is clear choice of target behaviour with specific goals and defined outcomes give a greater chance of success.
- Readiness to change behaviour is recognised and the intervention built accordingly.
- Interventions are multi-component.

- NICE guidance for pregnant women, focusing on 'dietary interventions and physical activity interventions for weight management before, during and after pregnancy' should be implemented (http://guidance.nice.org.uk/ph27).

- Organisations should continue to work in partnership to tackle social determinants of overweight and obesity.

Improving Mental Health

Guidance recommends that the following are in place to improve mental health care (http://www.nice.org.uk/CG123):

- Ensure those with mental health problems are identified, particularly in primary care settings.
- Ensure services are accessible and that there is a clear pathway and inclusion criteria for accessing integrated care services.
- Local care pathways should be developed to ensure those with common mental health disorders from a range of socially excluded groups (e.g. black and minority ethnic groups, older people, those in prison or in contact with criminal justice system, ex-service personnel) can access the services they need.
- A stepped system of services and interventions should be in place to enable the best treatment choice to be made.

Work environments can promote high levels of stress that, if prolonged, can be linked to developing depression and anxiety disorders. Guidance is available to help promote wellbeing in the workplace, including the following recommendations (http://guidance.nice.org.uk/PH22):

- An organisation-wide approach to mental wellbeing that instils a culture of positive mental health, without stigma.
- Put in place systems to monitor and measure employee mental wellbeing.

- Ensure those that are identified as experiencing stress are offered support such as counselling or stress management.
- Support flexible working practices where practical.
- Physical activity has also been linked to positive mental wellbeing, as well as having many other physical benefits, therefore it is recommended that workplaces encourage employees to be active (http://guidance.nice.org.uk/PH13/).

The Government's mental health strategy and outcomes document focuses on mental health through the life course and the importance of starting life well (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147527/dh_124057.pdf.pdf and https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147527/dh_124057.pdf.pdf).

Poor mental health is associated with social deprivation, it is therefore also important to consider the wider determinants of health.

By encouraging alcohol consumption to within safe limits there may also be an improvement in mental health.

To improve the mental health of older people recommendations include (http://guidance.nice.org.uk/PH16):

- Organising tailored exercise programmes in the community focusing on different types of exercise (tailored to the preferences of older people), strength and resistance exercises as well as toning and stretching.
- Offer walking schemes in the community.
- Train those working with older people in occupational therapy principals and those of health and wellbeing promotion.

Reducing emergency admissions

All emergency admissions

The King's Fund has produced some recommendations and advice related to reducing emergency admissions (http://www.kingsfund.org.uk/document.rm?id=8877):

- Use tools to help identify people at high risk of future emergency admission e.g. models and simple questionnaires.
- Higher continuity of care with a GP is associated with lower risk of admission.
- Integrating health and social care may be effective.
- Integrating primary and secondary care can be effective.
- Assertive case management is beneficial for patients with mental health problems.
- Patient self-management seems to be beneficial.
- Early review by a senior clinician is effective. GPs working in the emergency department are probably effective in reducing admissions, but may not be cost-effective.
- Developing a personalised health care programme for people seen in medical outpatients and frequently admitted can reduce re-admissions.
- Structured discharge planning is effective in reducing future re-admissions.

Improving flu immunisation uptake

Immunisation itself is a central public health intervention, but to be successful a high proportion of the eligible population must be offered, and take up, the vaccinations. Effective and cost effective interventions for maximising uptake include:

- Tailored invitations and reminders for 'Did Not Attends' by text or telephone.
- Targeted promotional campaigns (social marketing techniques) including benefits/risks.
- Improved access to clinics e.g. extended times, weekends.

- Access to health professionals to discuss concerns.
- Use of vaccination and infection data to inform JSNA and plans to improve uptake.
- Dissemination of good practice.
- Domiciliary and outreach services.
- Brief advice and referral.
- Opportunistic vaccination.
- Appropriately trained and up to date staff.
- Ensure staff are in place to monitor uptake.
- Enthusiastic clinical leads together with ensuring an appropriate clinical discourse is in place to counteract incorrect messaging.
- Immunisation status checks when contact is made – refer if cannot vaccinate opportunistically.

MSOA spine plots

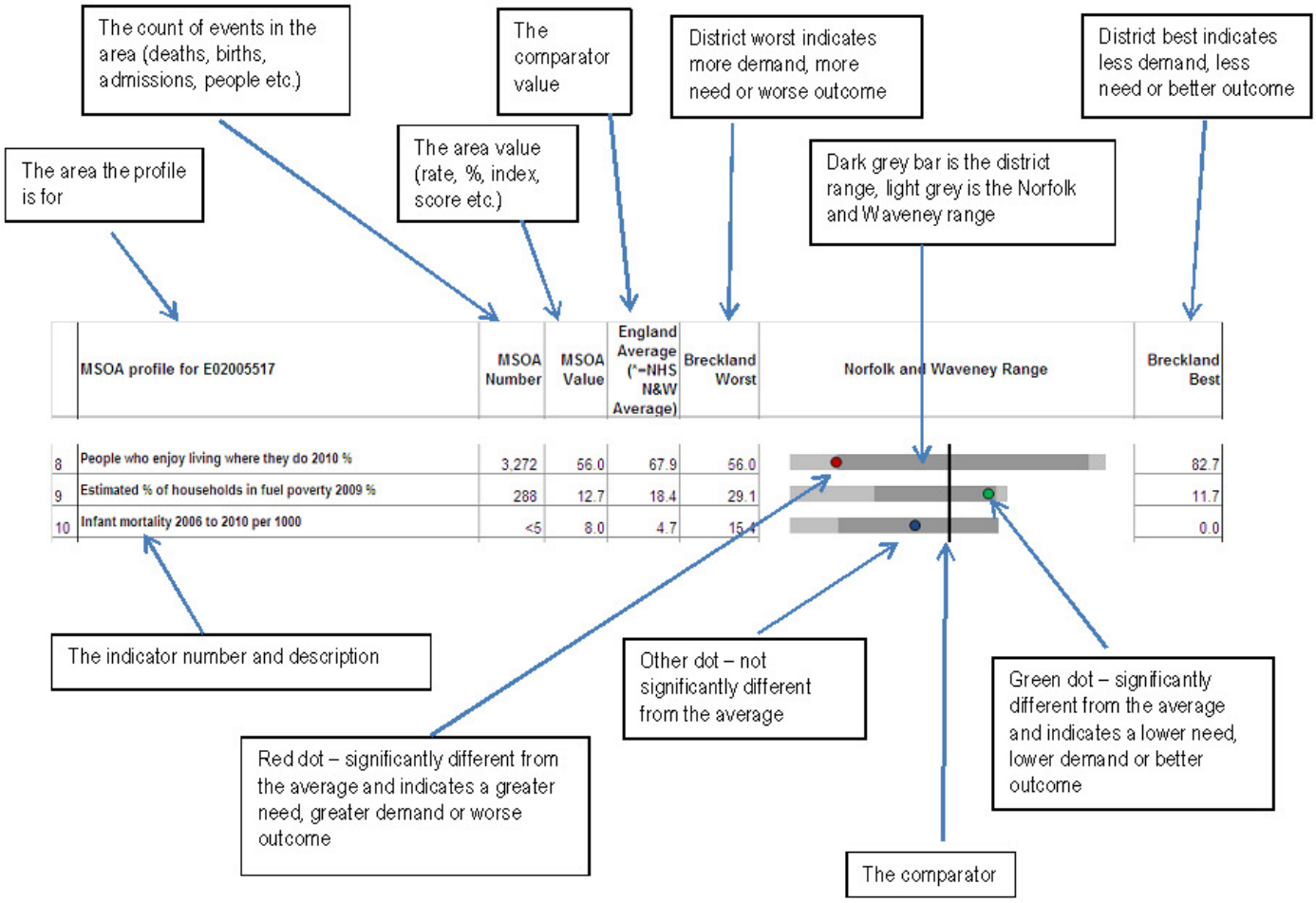


Figure 2 How to interpret the spine plot.

	MSOA profile for E02005601	MSOA Number	MSOA Value	England Average (*=NHS N&W Average)	South Norfolk Worst	Norfolk and Waveney Range	South Norfolk Best
1	Index of Multiple Deprivation 2010 IMD Score	n/a	11.6	21.5	16.7		7.0
2	IMD 2010 The percentage of the population living in low income families reliant on means tested benefits. 2010 %	n/a	10.4	14.7	12.2		6.4
3	Income Deprivation Affecting Children Index (IDACI) 2010 %	n/a	11.8	21.8	17.7		7.0
4	Income Deprivation Affecting Older People Index (IDAOPI) 2010 %	n/a	16.1	18.1	16.3		8.0
5	Proportion of Children in Poverty 2009 %	115	11.1	21.3	18.0		7.0
6	Long Term Unemployment December 2011 Dec 2011 per 1000	10	3.2	7.4	6.4		0.9
7	Incapacity Benefit / Severe Disablement Allowance with a diagnosis of mental health May 2011 per 1000	80	25.7	21.7	25.7		7.2
8	People who enjoy living where they do 2010 %	4,242	73.6	67.9	71.7		83.9
9	Estimated % of households in fuel poverty 2009 %	374	13.7	18.4	29.3		11.4
10	Infant mortality 2006 to 2010 per 1000	<5	0.0	4.7	15.9		0.0
11	Low Birth Weight 2006 to 2010 %	19	8.1	7.5	11.1		4.7
12	Breastfeeding at six to eight weeks 2010/2011 %	15	65.2	45.7	33.3		75.0
13	MMR immunisation at 24 months 2010/2011 %	41	89.1	89.1	81.3		98.5
14	Year reception healthy weight 2007/08 to 2009/10 %	102	78.5	76.1	70.9		83.7
15	Foundation stage pupils achieving a good level of development 2009/2010 %	28	57.0	56.0	46.0		68.0
16	Year 6 (10 to 11 year olds) healthy weight 2007/08 to 2009/10 %	101	69.2	65.8	63.4		78.6
17	GCSE achieved (5A* -C inc. Eng & Maths) 2010/2011 %	38	63.3	58.2	59.7		81.7
18	Persistent absence from school 2009/10 %	<5	1.5	4.2	5.8		0.7
19	Community (Non GUM) Chlamydia Screening Postivity Rate 2010/2011 %	<5	2.2	5.2	7.0		2.2
20	Emergency admissions for those aged 0 to 19 and under for conditions realting to injury and poisoning 2008/09- 2010/11 DSR	50	1700.3	1104.3	1700.3		684.0
21	Percentage of the adult population with obesity 2006-2008 %	1,190	24.9	24.2	27.4		20.2
22	Percentage of the adult population that eat healthily 2006-2008 %	n/a	29.8	28.7	26.3		38.6
23	Poor diet - eat less than two portions of fruit and vegetables per day 2010 %	1,362	23.6	23.5	23.8		17.6
24	Percentage of the adult population who are current smokers 2006-2008 %	n/a	18.5	22.2	22.6		12.9
25	Drinking alcohol more than five days a week 2009 %	1,674	29.1	26.8	35.9		28.0
26	Percentage of the adult population that binge drink 2006-2008 %	n/a	14.5	20.1	19.6		13.9
27	Cervical Screening Uptake 2010/2011 %	1,246	83.5	78.6	83.1		85.9
28	Emergency admissions for respiratory conditions 2008/09- 2010/11 DSR per 100,000 *	187	851.2	901.4	929.6		644.2
29	Emergency admissions for COPD 2008/09- 2010/11 DSR per 100,000 *	33	91.9	102.2	91.9		30.7
30	Emergency admissions for circulatory conditions 2008/09- 2010/11 DSR per 100,000 *	215	629.3	600.2	629.3		449.7
31	% flu immunisation of people aged 65 and over 2011/2012 %	949	63.7	72.8	63.7		80.4
32	Emergency admissions for those aged 65 and over 2008/09- 2010/11 DSR per 100,000 *	914	17637.0	16155.0	17637.0		12467.3
33	Emergency fracture admissions for those aged 65 and over 2008/09- 2010/11 DSR per 100,000 *	71	1320.1	985.1	1320.1		602.6
34	Population 65 and over 2010 %	1,379	24.7	16.5	25.9		16.5
35	Population 75 and over 2010 %	716	12.8	7.9	12.8		7.3
36	Population 85 and over 2010 %	218	3.9	2.3	3.9		1.7
37	Excess winter deaths 2007-2010 %	39	45.9	18.7	45.9		0.0
38	Male all cause mortality under 75 2008-10 DSR per 100,000	24	229.0	345.5	393.0		225.0
39	Female all cause mortality under 75 2008-10 DSR per 100,000	27	240.4	219.5	248.9		142.5
40	Male mortality from causes amenable to healthcare 2008-10 DSR per 100,000	5	41.6	110.7	97.9		30.0
41	Female mortality from causes amenable to healthcare 2008-10 DSR per 100,000	7	52.8	75.1	105.3		41.6
42	Female mortality rate for cancer, aged <75 2008-10 DSR per 100,000	16	139.8	99.2	145.0		56.5
43	Male mortality rate for cancer, aged <75 2008-10 DSR per 100,000	9	79.9	121.9	146.0		72.3
44	Female mortality rate for circulatory diseases, aged <75 2008-10 DSR per 100,000	5	32.0	40.9	86.4		10.7
45	Male mortality rate for circulatory diseases, aged <75 2008-10 DSR per 100,000	5	40.5	95.1	111.0		37.9
46	Female estimated deaths attributable to smoking per 100,000 population, aged 35+, 2008-10 DSR per 100,000	16	131.9	137.5	147.3		54.7
47	Male estimated deaths attributable to smoking per 100,000 population, aged 35+, 2008-10 DSR per 100,000	21	241.9	303.6	337.9		115.1
48	Female mortality rate for chronic respiratory diseases, aged <75 2008-10 DSR per 100,000	<5	5.8	20.3	39.3		0.0
49	Male mortality rate for chronic respiratory diseases, aged <75 2008-10 DSR per 100,000	<5	31.2	28.9	41.4		0.0
50	Male mortality rate for liver diseases, aged <75 2008-10 DSR per 100,000	<5	0.0	19.6	24.6		0.0
51	Female mortality rate for liver diseases, aged <75 2008-10 DSR per 100,000	<5	11.0	9.8	16.8		0.0
52	Female All Age All Cause Mortality 2008-10 DSR per 100,000	130	507.4	467.2	507.4		335.9
53	Male All Age All Cause Mortality 2008-10 DSR per 100,000	87	527.2	656.0	665.6		452.6
54	Male Disability Free Life Expectancy at Birth 1999 to 2003 Years	n/a	65.4	61.7	64.1		68.0
55	Female Disability Free Life Expectancy at Birth 1999 to 2003 Years	n/a	66.6	64.2	65.3		70.1
56	Female Life Expectancy 2008-10 Years	n/a	81.5	82.6	81.4		86.0
57	Male Life Expectancy 2008-10 Years	n/a	81.3	78.6	78.1		82.9

Figure 3 Spine plot for MSOA E02005601 Wymondham North. Dark line is average value (England or NHS N&W), light grey is Norfolk and Waveney range, dark grey is local authority range and dot is MSOA value.

	MSOA profile for E02005603	MSOA Number	MSOA Value	England Average (*=NHS N&W Average)	South Norfolk Worst	Norfolk and Waveney Range	South Norfolk Best
1	Index of Multiple Deprivation 2010 IMD Score	n/a	8.7	21.5	16.7		7.0
2	IMD 2010 The percentage of the population living in low income families reliant on means tested benefits. 2010 %	n/a	8.1	14.7	12.2		6.4
3	Income Deprivation Affecting Children Index (IDACI) 2010 %	n/a	10.2	21.8	17.7		7.0
4	Income Deprivation Affecting Older People Index (IDAOPI) 2010 %	n/a	11.9	18.1	16.3		8.0
5	Proportion of Children in Poverty 2009 %	200	10.2	21.3	18.0		7.0
6	Long Term Unemployment December 2011 Dec 2011 per 1000	15	3.0	7.4	6.4		0.9
7	Incapacity Benefit / Severe Disablement Allowance with a diagnosis of mental health May 2011 per 1000	75	15.0	21.7	25.7		7.2
8	People who enjoy living where they do 2010 %	6,064	74.8	67.9	71.7		83.9
9	Estimated % of households in fuel poverty 2009 %	476	14.4	18.4	29.3		11.4
10	Infant mortality 2006 to 2010 per 1000	7	15.9	4.7	15.9		0.0
11	Low Birth Weight 2006 to 2010 %	35	7.9	7.5	11.1		4.7
12	Breastfeeding at six to eight weeks 2010/2011 %	24	42.1	45.7	33.3		75.0
13	MMR immunisation at 24 months 2010/2011 %	88	88.9	89.1	81.3		98.5
14	Year reception healthy weight 2007/08 to 2009/10 %	220	80.9	76.1	70.9		83.7
15	Foundation stage pupils achieving a good level of development 2009/2010 %	56	60.0	56.0	46.0		68.0
16	Year 6 (10 to 11 year olds) healthy weight 2007/08 to 2009/10 %	208	73.2	65.8	63.4		78.6
17	GCSE achieved (5A* -C inc. Eng & Maths) 2010/2011 %	81	68.6	58.2	59.7		81.7
18	Persistent absence from school 2009/10 %	<5	0.7	4.2	5.8		0.7
19	Community (Non GUM) Chlamydia Screening Postivity Rate 2010/2011 %	9	3.9	5.2	7.0		2.2
20	Emergency admissions for those aged 0 to 19 and under for conditions realting to injury and poisoning 2008/09- 2010/11 DSR	69	1024.1	1104.3	1700.3		684.0
21	Percentage of the adult population with obesity 2006-2008 %	1,586	25.2	24.2	27.4		20.2
22	Percentage of the adult population that eat healthily 2006-2008 %	n/a	28.1	28.7	26.3		38.6
23	Poor diet - eat less than two portions of fruit and vegetables per day 2010 %	1,840	22.7	23.5	23.8		17.6
24	Percentage of the adult population who are current smokers 2006-2008 %	n/a	18.5	22.2	22.6		12.9
25	Drinking alcohol more than five days a week 2009 %	2,402	29.6	26.8	35.9		28.0
26	Percentage of the adult population that binge drink 2006-2008 %	n/a	16.7	20.1	19.6		13.9
27	Cervical Screening Uptake 2010/2011 %	2,057	83.6	78.6	83.1		85.9
28	Emergency admissions for respiratory conditions 2008/09- 2010/11 DSR per 100,000 *	188	690.9	901.4	929.6		644.2
29	Emergency admissions for COPD 2008/09- 2010/11 DSR per 100,000 *	18	49.7	102.2	91.9		30.7
30	Emergency admissions for circulatory conditions 2008/09- 2010/11 DSR per 100,000 *	172	449.7	600.2	629.3		449.7
31	% flu immunisation of people aged 65 and over 2011/2012 %	1,034	65.4	72.8	63.7		80.4
32	Emergency admissions for those aged 65 and over 2008/09-2010/11 DSR per 100,000 *	624	12467.3	16155.0	17637.0		12467.3
33	Emergency fracture admissions for those aged 65 and over 2008/09-2010/11 DSR per 100,000 *	46	896.8	985.1	1320.1		602.6
34	Population 65 and over 2010 %	1,419	16.5	16.5	25.9		16.5
35	Population 75 and over 2010 %	623	7.3	7.9	12.8		7.3
36	Population 85 and over 2010 %	148	1.7	2.3	3.9		1.7
37	Excess winter deaths 2007-2010 %	14	16.9	18.7	45.9		0.0
38	Male all cause mortality under 75 2008-10 DSR per 100,000	35	277.4	345.5	393.0		225.0
39	Female all cause mortality under 75 2008-10 DSR per 100,000	25	179.8	219.5	248.9		142.5
40	Male mortality from causes amenable to healthcare 2008-10 DSR per 100,000	10	78.3	110.7	97.9		30.0
41	Female mortality from causes amenable to healthcare 2008-10 DSR per 100,000	6	41.6	75.1	105.3		41.6
42	Female mortality rate for cancer, aged <75 2008-10 DSR per 100,000	8	56.6	99.2	145.0		56.5
43	Male mortality rate for cancer, aged <75 2008-10 DSR per 100,000	16	124.4	121.9	146.0		72.3
44	Female mortality rate for circulatory diseases, aged <75 2008-10 DSR per 100,000	6	35.6	40.9	86.4		10.7
45	Male mortality rate for circulatory diseases, aged <75 2008-10 DSR per 100,000	7	51.7	95.1	111.0		37.9
46	Female estimated deaths attributable to smoking per 100,000 population, aged 35+, 2008-10 DSR per 100,000	14	116.4	137.5	147.3		54.7
47	Male estimated deaths attributable to smoking per 100,000 population, aged 35+, 2008-10 DSR per 100,000	21	252.2	303.6	337.9		115.1
48	Female mortality rate for chronic respiratory diseases, aged <75 2008-10 DSR per 100,000	<5	5.9	20.3	39.3		0.0
49	Male mortality rate for chronic respiratory diseases, aged <75 2008-10 DSR per 100,000	<5	13.0	28.9	41.4		0.0
50	Male mortality rate for liver diseases, aged <75 2008-10 DSR per 100,000	<5	13.8	19.6	24.6		0.0
51	Female mortality rate for liver diseases, aged <75 2008-10 DSR per 100,000	<5	12.9	9.8	16.8		0.0
52	Female All Age All Cause Mortality 2008-10 DSR per 100,000	107	489.7	467.2	507.4		335.9
53	Male All Age All Cause Mortality 2008-10 DSR per 100,000	104	603.5	656.0	665.6		452.6
54	Male Disability Free Life Expectancy at Birth 1999 to 2003 Years	n/a	65.6	61.7	64.1		68.0
55	Female Disability Free Life Expectancy at Birth 1999 to 2003 Years	n/a	66.5	64.2	65.3		70.1
56	Female Life Expectancy 2008-10 Years	n/a	81.4	82.6	81.4		86.0
57	Male Life Expectancy 2008-10 Years	n/a	79.3	78.6	78.1		82.9

Figure 4 Spine plot for MSOA E02005603 Wymondham South. Dark line is average value (England or NHS N&W), light grey is Norfolk and Waveney range, dark grey is local authority range and dot is MSOA value.

Overall Need

To assess overall need of each area based on the indicators in the spine plot, standardised scores were calculated for each MSOA indicator and summed to give an overall score. The map below illustrates this overall level of need for each MSOA across Norfolk and Waveney (Figure 5). The indicators were also grouped into the following categories and the level of need for each MSOA calculated accordingly:

- Demography and deprivation
- Children and young people
- Working age
- Older people
- Emergency care
- Mortality and inequality.

Level of Need in Wymondham MSOAs

The Wymondham north MSOA has a medium level of calculated need compared to the rest of Norfolk and Waveney MSOAs. Wymondham south MSOA is calculated to have a low level of overall need and this is reflected in most of the sub categories of indicators (Figure 6, Figure 7, Figure 8, Figure 9 and Figure 10). However, there is a medium level of need when considering mortality and inequality in the north and south MSOAs (Figure 11), suggesting a possible inequity in mortality between population groups.

Wymondham north MSOA has a low or very low level of need when considering children and young people and demography and deprivation indicators. However, it has a high level of need for older people when compared to other Norfolk and Waveney MSOAs. For working age indicators and emergency care there is a medium level of need.

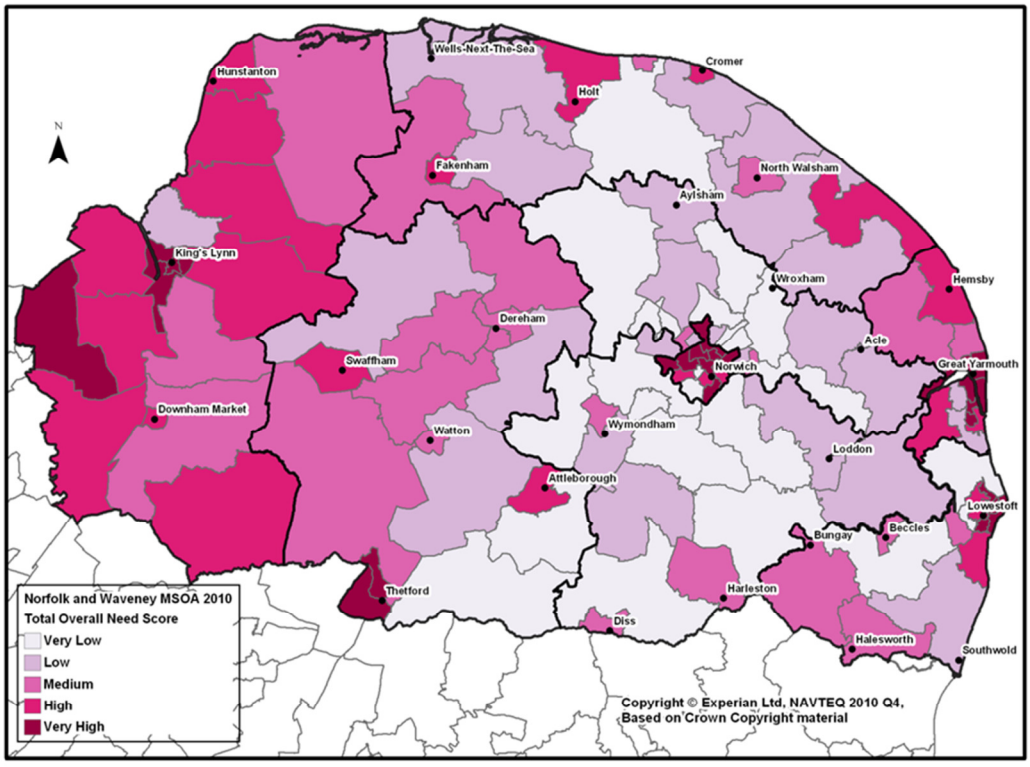


Figure 5 Total overall need for Norfolk and Waveney MSOAs calculated using a range of indicators.

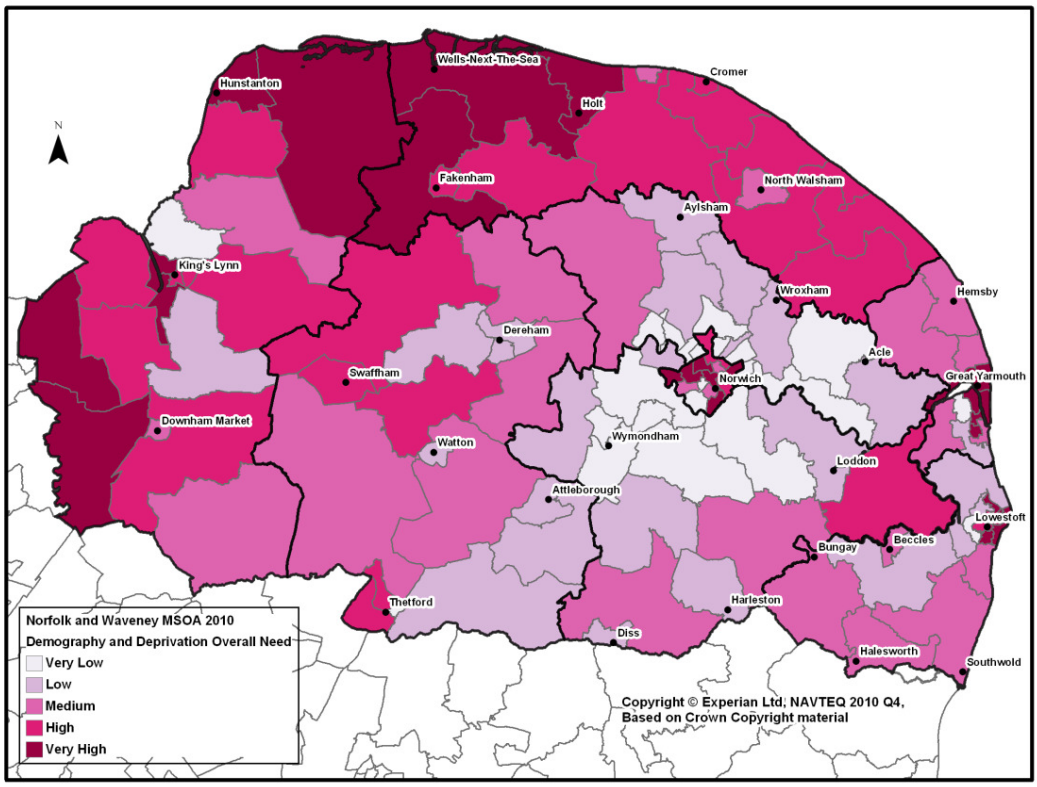


Figure 6 Demography and deprivation need for Norfolk and Waveney MSOAs based on a range of indicators.

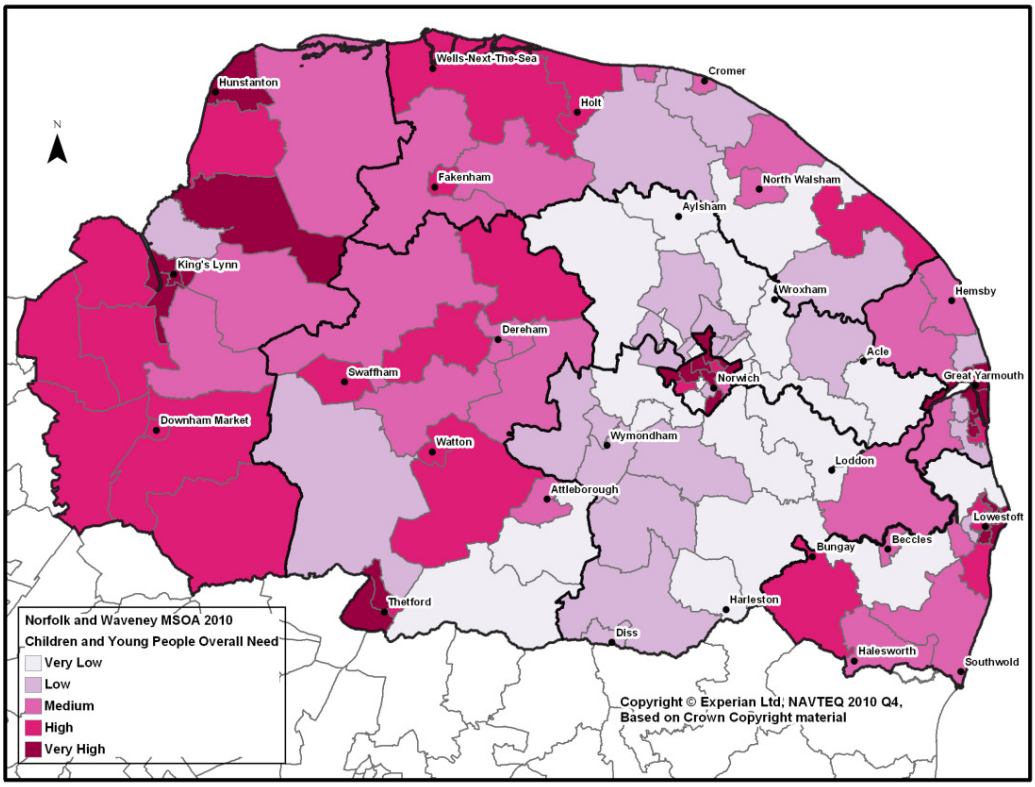


Figure 7 Children and young people need for Norfolk and Waveney MSOAs based on a range of indicators.

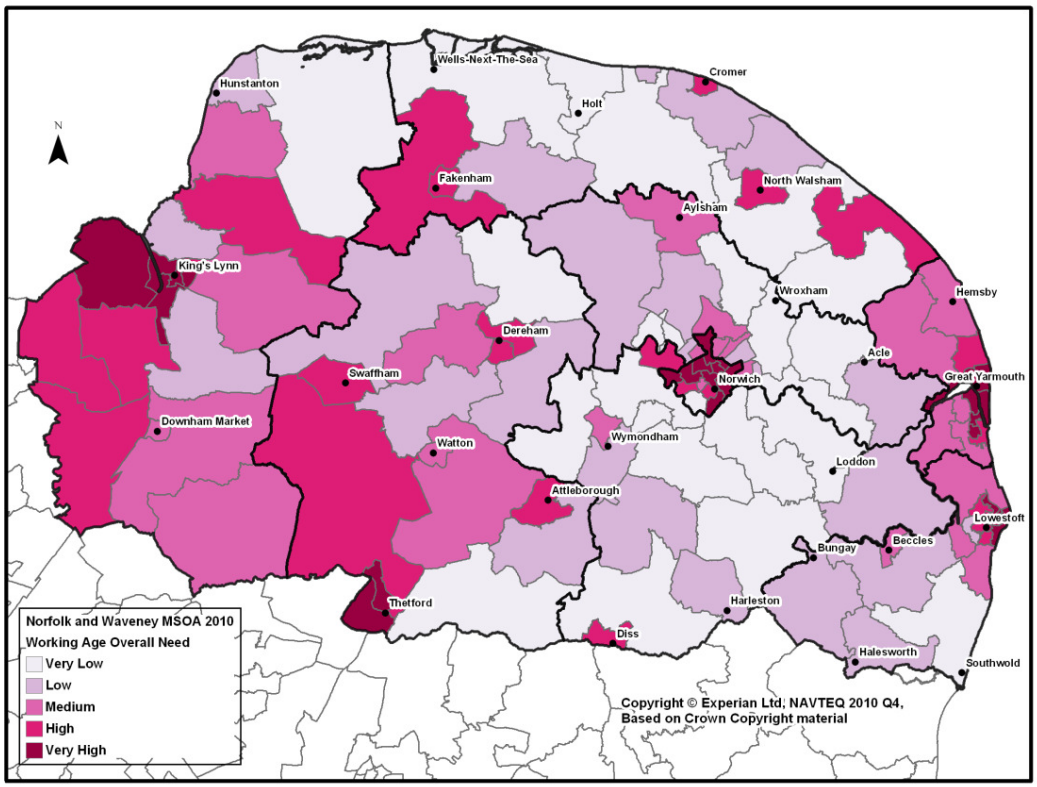


Figure 8 Working age need for Norfolk and Waveney MSOAs based on a range of indicators.

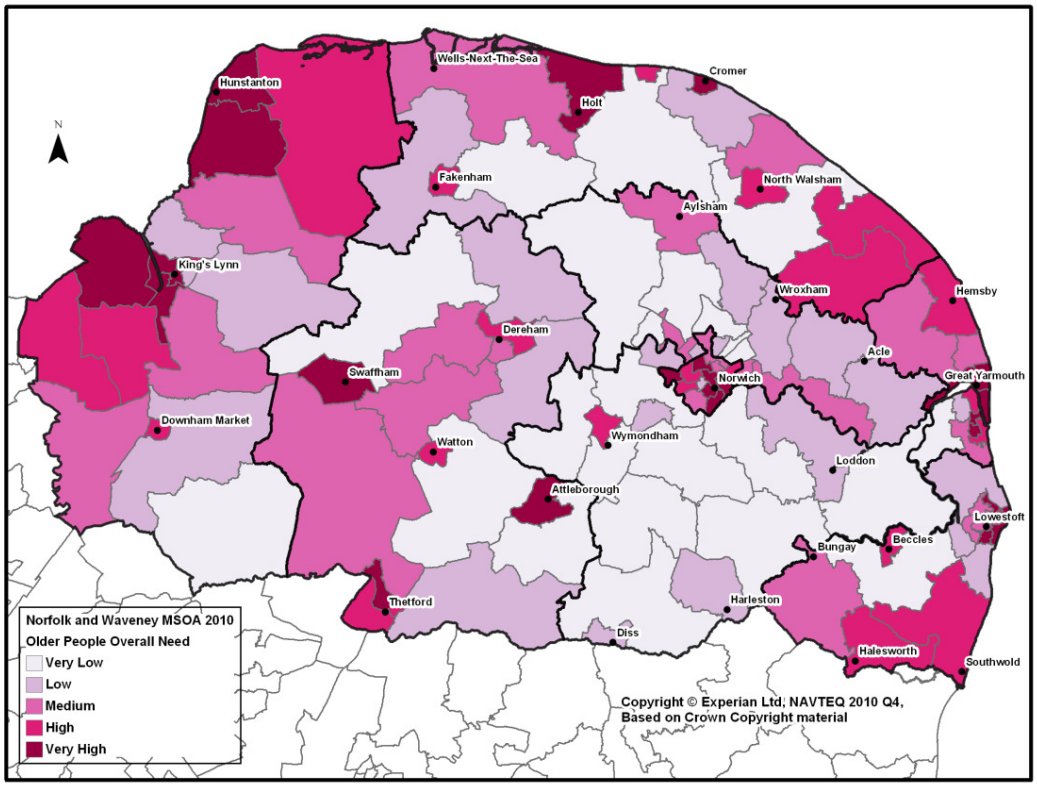


Figure 9 Older people need for Norfolk and Waveney MSOAs based on a range of indicators.

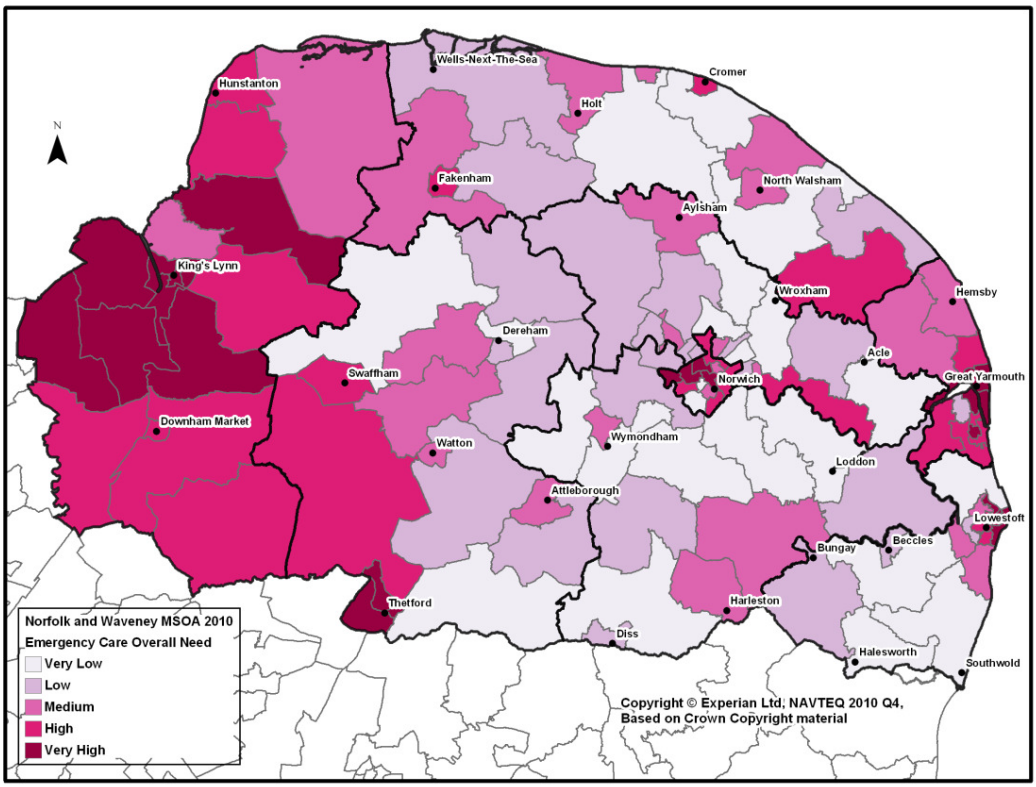


Figure 10 Emergency care need for Norfolk and Waveney MSOAs based on a range of indicators.

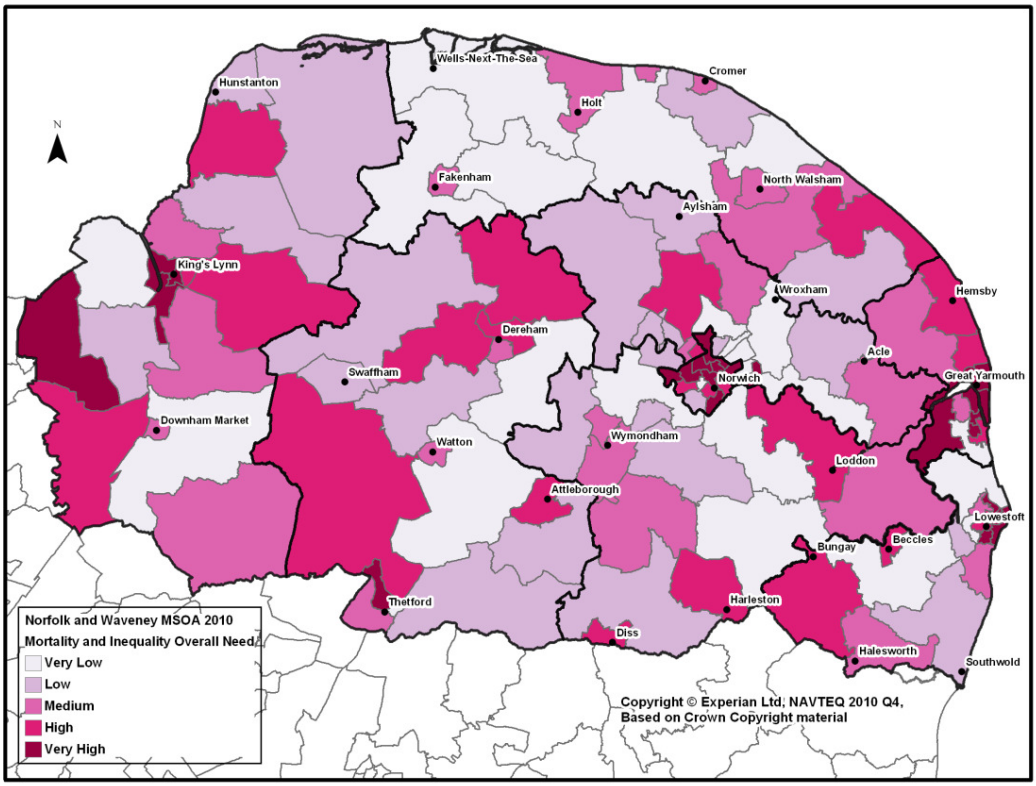


Figure 11 Mortality and inequality need for Norfolk and Waveney MSOAs based on a range of indicators.

Funding allocation to Community-Led health Improvement 2013/14

Briefing Note by the Head of Planning, Performance & Partnerships, NCC

1. Background

At its meeting on 17 April 2013 the Health & Wellbeing Board agreed that £290,000 funding should be used for locally-led health improvement activity in 2013/14. (The funding is available as NCC's Cabinet agreed to allocate part of its share of the 2nd homes monies 2013/14 to support the health and wellbeing partnership agenda).

The Board also agreed that further discussions would need to take place with local partners about the precise use of this funding – for example, it might be that there is capacity for an accelerated roll out of the projects as outlined in the Community Led Health Improvement Programme (see Item 8 on this Agenda). Alternatively, there might be other locally based health improvement initiatives, eg from CCGs, against which this funding could be used as match funding.

2. Taking this forward

The Chair and Vice-Chairs of the Health & Wellbeing Board have considered this further including the kinds of outcomes sought, the accountability arrangements needed and possible options for allocating the monies, based on preliminary discussions with local partners about how the funding would be used.

The Chair and Vice-Chairs have agreed a way forward for the use of the funding which is outlined below.

Outcomes sought

It is agreed that the funding be used to commission activities that will result in a demonstrable improvement in:

Either:

- The three overarching goals and three priorities of the developing Joint Health & Wellbeing Strategy 2014-17

  Overarching Goals = Driving Integration, Reducing Inequalities, Promote healthy lifestyles and preventing problems
  Priorities = Early life (0-5), Obesity, Dementia

Or

- One or more of the 11 priorities identified in the existing Joint Health & Wellbeing Strategy 2013-14, which are:

1. Alcohol misuse
2. Smoking
3. Healthy eating and weight management
4. Dual diagnosis – co-existing mental health and substance misuse problems
5. Support frail elderly people living independently
6. Carers of older people and carers of people with long term conditions
7. Mental health and employment
8. Young carers
9. Creating good developmental and learning outcomes for all children and young people
10. Unplanned/emergency care and admissions & preventing re-admission to hospital/health and social care interventions
11. Improving Access to Psychological Therapies (IAPT)

Overall Aims
In addition, the allocation should be aimed at encouraging and further developing:

- Empowered communities able to proactively influence and lead on improving their own health and wellbeing
- The capacity of the community and voluntary sector to contribute to the achievement of health and wellbeing outcomes
- Good and effective working relationships between partners at a local level,
- Increased awareness of, and share learning about issues faced, and approaches taken, across Norfolk.

Accountability

Those receiving funding are required to report back to the Health & Wellbeing Board meeting in July 2014 answering the following questions:

- Which strategic priority(ies) or goal did you seek to address and why and what impact were you able to achieve?
- How were communities empowered to influence and lead on improving their own health and wellbeing?
- How did you use the funding to commission/build the capacity of the community and third sector to contribute to the achievement of health and wellbeing outcomes?
- How were local partners/local health partnerships involved in shaping and deciding on how the funding would be used?

Minimum Terms and Conditions
In addition, the following minimum terms and conditions apply:

1. There must be an improvement within this financial year, in one or more of the priorities identified in either the Joint Health & Wellbeing Strategy 2013-14 or the developing Joint Health & Wellbeing Strategy 2014-17
2. All funding must be spent by 31 March 2014 - any underspend will be returned to the HWB for re-allocation
3. The organisation in receipt of the funding will put in place all necessary arrangements to ensure that the funding is appropriately spent
4. Funding cannot be used to pay for the commissioning of or provision of services and/or interventions that have already been funded
5. Funding can only be spent for the benefit of the Norfolk population.

Time scales and reporting

- By the end of this financial year the funding must be allocated to community led health improvement projects in Norfolk
- The funding must either spent by those projects or there is a clear plan for the spend in place
- The fund holders (those organisations that received the funding from NCC) are expected to bring a report on spend, project progress and outcomes achieved to the H&WB meeting in July 2014

3. Arrangements for the allocation of funding

The Chair and Vice -Chairs considered a number of options, including holding a central 'pot' or allocating the monies to smaller geographical areas, and a method for deciding the share of funds.

Localisation, sub-county, of activity to support the implementation of the Joint Health & Wellbeing Strategy 2013 -14 was considered to be key as was the need to move quickly to reach the point when the funds could start to be used. It was agreed that:

- The funding is split on the basis of the Public Health (PH) Allocation formula - which builds in accepted national information on comparative health needs

- The funding will be allocated to city, district and borough Councils - to work with their local partners to commission activities in line with the aims and outcomes outlined above.

Allocation to City, District and Borough Councils, working with their local partners

Council	PH Allocation*
Norwich CC	£58,348
King's Lynn and the West BC	£52,142
Great Yarmouth BC	£40,745
North DC	£30,305
South DC	£33,408
Breckland DC	£41,354
Broadland DC	£33,408

*based upon city, district and borough council populations

4. Next Steps

Arrangements will be out in place for the funding to be transferred to City, District and Borough Councils as outlined above.

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

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Report to Health and Well Being Board
October 2013
Item No 9

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?

To receive an update on progress to the issues raised by the Winterbourne enquiry.

Key questions for discussion

Not applicable

Actions/Decisions needed

The Board needs to:

- Approve the terms of reference of the Steering Group
- Receive the report and note progress that is being made

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.

Action
The Board Is asked to:

- Approve the terms of reference of the Steering Group
- Receive the report and note progress that is being made

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, April and July this year. This report provides a further update on progress that is being made.

2 Progress Update

2.1 A project steering group has been set up in accordance with the direction given at the last Health and Well Being Board. The terms of reference of the steering group are attached for approval at Appendix 1. The first meeting of the group took place in September.

2.2 A small group of staff has been tasked by the steering group to ensure that the patients identified as eligible for stepping down into the community from private hospital provision are discharged into the community by June 2014. The steering group will receive regular reports of progress that is being made.

2.3 15 patients currently commissioned by Norfolk Clinical Commissioning Groups have been reviewed, two of the patients are already in the process of being discharged and the assessments show that a further 5 could be moved less restrictive care settings over the coming months. The remaining 8 patients are appropriately placed at this time.

2.4 The NHS England Area Team for specialised commissioning have assessed the Norfolk patients for whom they commission services and it is considered that 8 patients can be moved to less restrictive care settings over the coming months.

2.5 Work has begun on developing the Joint Strategic plan that needs to be in place by April 2014. The steering group has approved a model for the Norfolk plan which will include links to national best practice. The draft plan will be brought to the Health and Well Being Board for approval prior to publication.

2.6 A template has also been developed to ensure that the review of all Norfolk social care out of county placements will follow the new guidance

2.7 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.

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 be undertaken with the families and social care and health agencies. The group that has been set up to oversee this work will ensure that the required resources are deployed to enable this work to be completed by the timescale.

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 when the draft Joint Strategic 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 The Board Is asked to:

- Approve the terms of reference of the Steering Group
- Receive the report and note progress that is being made

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

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Winterbourne View Joint Strategic Plan Steering Group

Terms of Reference

1. Philosophy

Transforming Care: A national response to Winterbourne View requires an end to all inappropriate placements by June 2014, so that every person with a learning disability and/ or Autism with complex needs and challenging behaviour, receives the right care in the right place

2. Aims

The requirements of the Winterbourne View Concordat are fully implemented in Norfolk.

3. Function

- Monitoring the progress of the movement of patients to the most appropriate placement where it has been identified in the recent review programme that it is appropriate that they should move by June 2014.
- The approval of a clear and consistent process that will ensure that all those people who continue to require specialist in patient treatment are closely monitored and receive appropriate and excellent services in the least restrictive care setting and that effective discharge plans are developed in good time so that they are able to move on when treatment finishes.
- The approval of a clear and consistent process when new referrals are received.
- The production of a Joint Strategic Plan by April 2014 which will include innovative commissioning proposals that will prevent people being admitted to specialist in patient services unless it is absolutely necessary

4. Membership

- Chair – Director of Community Services
- Joint Commissioner for Adults with Learning Disabilities (Vice Chair)
- Integrated Mental Health and Learning Disabilities Commissioning Manager
- NCC Assistant Director, Safeguarding
- NCC Head of Social Care, Norwich Locality
- CEO Healthwatch
- Service user/ Advocacy Organisation
- Independent Sector Provider Organisation
- Public Health representative
- Child Health Commissioner

- East of England Specialist Commissioning representative
- Hertfordshire Partnership Foundation Trust representative
- Mental Health and Learning Disabilities Commissioning Board (Learning Disabilities Clinical Lead)
- Norfolk Community Health and Care Strategic Health Lead
- Health East: Great Yarmouth and Waveney MH/LD Programme Board representative
- Continuing Health Care representative
- Voluntary sector representative

Deputising should be arranged when principal members are absent

5 Meetings

- Notes and Agenda – support will be provided by Mental Health and Learning Disabilities Joint Commissioning Team
- Venue: County Hall
- Frequency: Bi monthly until January 2014 when meetings will be monthly if required.

6 Reporting

The Steering Group reports directly to the Norfolk Health and Well Being Board

7. Review

These terms will be reviewed and revised as required

MINUTES OF THE HEATHWATCH NORFOLK BOARD
HELD ON MONDAY 08 JULY 2013
AT 14:00 – ROWAN HOUSE, HETHERSETT

PRESENT

Nick Baker
Jon Clemo
Diane DeBell (Interim Chair)
Graham Dunhill
Moira Goodey
Pa Musa Jobarteh
Mary Ledgard
Fiona Poland
Julia Redgrave

OFFICERS IN ATTENDANCE

Alex Stewart
Chris Knighton
Chris MacDonald
Andy Magem
Sam Revill

1 APOLOGIES FOR ABSENCE AND INTRODUCTIONS

Apologies for absence were received from Joanna Hannam, Louise Cumberland and Mark Ganderton. It was noted that Mark Ganderton was attending a Healthwatch England "Training the Trainers" event and will report back to the board.

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

3. MINUTES OF THE MEETING HELD ON 30 APRIL 2013

The Board requested a slight amendment to item 6.4 to reflect the Board's 'support to the proposal to meet the total cost to provide permanent governance arrangements as outlined in the bid from Norfolk Rural Community Council accepted by the Shadow Healthwatch Norfolk Board.'. Alex Stewart agreed to make the amendments and for the minutes to be published on Healthwatch Norfolk website.

The Board noted that it was appropriate and necessary for Jon Clemo, Chief Executive of Norfolk Rural Community Council, (as one of the two required Healthwatch Norfolk bank signatories) to jointly sign the cheque in payment of the invoice submitted by Norfolk Rural Community Council in response to the work identified above.

4. MATTERS ARISING

Equality Impact Assessments

The Board agreed to the officers taking up the offer from Norfolk County Council to provide EIA training

Safeguarding Adults Policy

Julia Redgrave advised that she now has feedback from Safer who offered their profuse apologies for the lengthy delay. There is some work to be completed by the Operations Manager as a result to ensure all Healthwatch Norfolk (HWN) policies are incorporated in the document. Julia also recommended that HWN should become members of Safer. Julia will forward the relevant documentation to HWN office.

5. ITEMS FOR DECISION

5.1 Report following Board Away Day Resolutions

Alex Stewart introduced the paper in terms of the way forward.

Mary Ledgard suggested that reference should be made to commissioners as well as providers which was accepted.

In response to a query regarding HWN's involvement with a number of committees in Norfolk, Alex Stewart confirmed this is work in progress and that he is shortly to attend the CCG Chief Operating Officer meeting and that HWN will adopt a common approach to engagement with all CCGs. Alex Stewart reminded the Board of the forthcoming volunteer induction events and Mary Ledgard offered to attend the event in Kings Lynn.

John Clemo expressed concerns that the Overarching Operating Framework was too broad. Similarly Moira Goodey felt the framework lacked sufficient functionality to define HWN's focus areas and Julia Redgrave sought clarity as to the precise nature of the board's agreement if they were to approve the framework.

Alex Stewart urged that the framework should be seen in the context of the whole and clarified that operational decisions could not be presented to the board before the Overarching Operating Framework was approved.

In order to mitigate the broad scope of the framework Mary Ledgard requested an appendix of projects currently undertaken by Healthwatch Norfolk be added to the Report. In addition to this Diane DeBell requested that the framework be condensed to a highlight report on one side of A4.

Graham Dunhill and John Clemo requested that the framework be converted to a business plan to be presented to the board at a later date, thereby safeguarding against any resource implications as a result of approving the report.

Nick Baker requested that future reports presented to the board provide clear distinctions between what was initially presented to the board, the changes that were made and what was eventually signed-off.

Alex Stewart urged the board to commit to the framework and assured that greater detail would follow.

RESOLVED

The board formally approved "The Next Steps" as set out in section 4.0 of the report on Away Day Resolutions (Agenda Item 5.1):

Objectives – The Board resolves that:

a) The vision, mission, values and strategic objectives as set out in the report are adopted

Overarching Operating Framework – The Board resolves that

a) The Overarching Operating Framework be adopted in order to help further the strategic direction of HWN (+2 appendix items stipulated by the board above).

Communications – the Board resolves that:

a) the plan presented at the Away Day on the 5th June be implemented
b) an indicative budget of £17,050 be earmarked for 2013/14
c) a report be brought back to the Board in November 2013 detailing lessons learnt and achievements made

The Use of Interns – the Board resolves that

a) An options appraisal is provided by the Research and Analysis Manager to Board Members detailing what an intern or group of interns may be undertaking on HWN's behalf
b) Interns will be paid and details of payment will be included within the Options Appraisal
c) In the event that a decision is required in between Board Meetings, the Board will accept an emailed paper and a consensus decision will be provided within 5 working days of the paper being sent out
d) An indicative budget of £30,000 be earmarked for 2013/14

The Use of Volunteers – the Board resolves that:

a) Officers actively recruit a bank of volunteers
b) A Board Member will undertake to work with volunteers in a selected CCG geographical area
c) Induction and training be provided for the volunteers with immediate effect
d) An indicative budget of £15,000 be earmarked for 2013/14

Financial Standing Orders - the Board resolves that:

a) The Policy relating to Financial Standing Orders be adopted
b) The Policy be reviewed on an annual basis with the Board

Staff Handbook and Expenses Policy – The Board resolves that:

a) The Staff Handbook and Expenses Policy be adopted
b) The Staff Handbook and Expenses Policy be reviewed on an annual basis

Appointment of HWN Chair – The Board resolves that:

a) Mr Armstrong is formally elected as Chair of Healthwatch Norfolk
b) That the position be remunerated – currently £7,500 per annum
c) That for the period of 2013/14, Mr Armstrong be remunerated on a per annum pro rata basis

5.2 Protocols and Policies Requiring Board Ratification

Chris MacDonald confirmed that these protocols and policies were written in accordance with Healthwatch England guidelines (where available) and are subject to at least annual review by the board.

A) Volunteering Protocol

Mary Ledgard sought clarification on use of the word “internships” on page 4 of the volunteer protocol. The board then discussed the utility of the term and it was agreed that the word would be removed.

John Clemo asked for a specific item to be added to pages 5-6 binding HWN Volunteers to work in within an agreed remit or focus area.

Julia Redgrave felt that pages 5-6 of the protocol set out an “us and them” mentality in a founding HWN document. It was requested that this section was redrafted to form universal principles for team working focused around the commitments “we” all make at HWN.

C) Customer Care Standards

John Clemo requested that standards relating to telephone and email correspondence committed HWN not simply to “acknowledge” but to “acknowledge and respond” to in order to set customer care standards rather than minimum contract requirements.

D) Code of Conduct

John Clemo asked that board accountability (section 3) be extended to include reference to HWN members and Alex Stewart agreed, asking to also include the Charities Commission and Companies House.

It was agreed that the exact Quorum (section 6) would be cross referenced with the Articles and amended accordingly by Chris MacDonald.

The board agreed a limit of £15 should follow reference to “gifts of minor value” (section 10). It was also agreed that if the CEO was to be offered any gifts or hospitality these would be reported to the Chair.

RESOLVED

The board ratified the following protocols and policies (subject to the completion of all amendments listed above under agenda item 5.2):

A) Volunteering Protocol
B) Travel and Subsistence Policy – Staff, Members and Volunteers
C) Customer Care Standards
D) Code of Conduct
E) Complaints Policy
F) Whistleblowing Policy

5.3 Board vacancy – provider representative

The board provider members present agreed in principle to the appointment of Roan Dyson as the 4th provider representative on the board.

RESOLVED

This was agreed subject to formal notification being sent to all consortium members which Chris MacDonald undertook to complete.

5.4 Articles of Association

Chris MacDonald advised the Board that the proposed amendments to the clauses of the Articles of Association were the result of in-depth consultation with HWN's solicitors who in turn had liaised with DoH and Healthwatch England. The amendments were therefore understood to represent the strongest possible application for charity status for HWN.

Alex Stewart encouraged the board to approve the Articles whilst emphasising the need to maintain a critical stance and guard against an institutionalised health focus.

The board acknowledged the cost implications of amending the Articles and returning them to the solicitors, along with the risk of failing to secure charitable status for a second time. However the board expressed concern regarding the exclusion of any reference to social care from the Articles of Association.

RESOLVED

The board resolved that HWN would contact the solicitors and be clear that a reference to social care is required alongside health in the Articles of Association. The board conceded that if the solicitor did not believe the articles could be amended in this way, then this would be relayed to the board individually when signing the required papers at a later date.

5.5 Change of registered office address

RESOLVED

Change of registered office address formally approved by the board

5.6 Re-ratification of co-opted Board Members

RESOLVED

Fiona Poland, Pa Musa Jobarteh, Nicholas Baker and Julia Redgrave re-ratified as co-opted board members.

6. ITEMS FOR INFORMATION AND DISCUSSION

6.1 Board feedback from attended events

Mary Ledgard and Chris Knighton reported on the Healthwatch England National Conference. Mary Ledgard highlighted the key areas covered at the conference and relayed that a national Healthwatch project on complaints may require a contribution from HWN. Chris Knighton supported Mary's comments and added that Andy Burnham's commitment to Healthwatch was a positive indication of cross-party support.

The Interim Chair thanked Mary Ledgard and Chris Knighton for attending the event and for their reports.

6.2 Update on tenders for priority projects

Chris Macdonald reported to the board on the status of HWN's four priority projects; Complaints Handling, Enter and View, Access to Services and CAMHS.

Alex Stewart emphasised that there were lessons to be learned from the Internal Tender Policy and emphasised the need for a review of the policy at the end of September 2013.

RESOLVED

The board encouraged HWN to seek final confirmation of the remaining consortium bid for the priority CAMHS project. If this bid was not suitable the board was in agreement that a full research proposal should be completed and put out to tender.

6.3 Staff Reports

In response to the Operations Manager's report Nick Baker sought further clarification of HWN's liabilities (if any) in relation to the pending TUPE cases and asked that Healthwatch England were kept informed of any developments.

Moira Goodey and Julia Redgrave requested that staff reports be moved to the top of the agenda at the next board meeting.

John Clemo emphasised the importance of all HWN staff attending early board meetings but requested that this practice remain under review for the long term.

6.5 Updated risk log

Nick Baker asked that the risk log is updated to include further possible mitigations in relation to the pending TUPE claims. Nick Baker urged HWN to contact Healthwatch England and Norfolk County Council to inform them of the current status of the TUPE claims and outline the risks posed to HWN.

6.6 General Correspondence

Alex Stewart informed the board that he would be writing to Norman Lamb in order to clarify HWN's decision to hold board meetings in private.

Norfolk County Council
at your service

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH ON 20 JUNE 2013 AT 10.00AM

Present:

Mr C Aldred	Norfolk County Council
Mr J Bracey	Broadland District Council
Mr D Bradford	Norwich City Council
Mr M Carttiss (elected Chairman during the meeting)	Norfolk County Council
Mrs J Chamberlin	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Mrs A Claussen–Reynolds	North Norfolk District Council
Dr D Crawford	Norfolk County Council
Mrs M Fairhead	Great Yarmouth Borough Council
Mr B Hannah	Norfolk County Council
Miss A Kemp	Norfolk County Council
Mr R Kybird	Norfolk County Council
Dr N Legg	South Norfolk District Council
Mr G Sandell	King's Lynn and West Norfolk Borough Council
Mrs M Somerville	Norfolk County Council

Also Present:

Dan Roper	Norfolk County Council Cabinet Member for Public Protection
Bev Spratt	Local County Councillor for Dickleburgh
Roy Reynolds	North Norfolk District Councillor for Fakenham North Ward
Mark Taylor	Chief Executive North Norfolk Clinical Commissioning Group (Lead for Mental Health Commissioning in Norfolk)
Samantha Revill	Healthwatch Norfolk
Lorraine Rollo	NHS Gt Yarmouth and Waveney CCG
Debbie Wade	Manager of the Dickleburgh Branch Surgery of the Church Hill GP Practice, Pulham Market
Debra Conner	Deputy Divisional Manager, Elective Division, James Paget University Hospitals NHS Foundation Trust
Pauleen Pratt	Divisional Chief Nurse for Surgery, Queen Elizabeth Hospital, NHS Foundation Trust
Peter Wightman	Interim Director of Commissioning, NHS England, East Anglia Area Team
Fiona Theadom	Contract Manager, NHS England, East Anglia Area Team
Andrew Hopkins	Deputy Chief Executive, Norfolk and Suffolk NHS Foundation Trust
Patrick Marney	A member of Dickleburgh and Rushall Parish Council

1(a) Election of Chairman

Resolved (unanimously)

That Mr M R H Carttiss to be elected Chairman of the Committee for the ensuing year.

(Mr M R H Carttiss in the Chair)

1(b) Election of Vice-Chairman

Resolved (unanimously)

That Mr J Bracey be elected Vice-Chairman of the Committee for the ensuing year.

2(a) Apologies for Absence

There were no apologies for absence.

2(b) Change of Committee Membership-- Mrs M Somerville replaces Mrs A Thomas

It was noted that since the despatch of the agenda papers, Mrs M Somerville had replaced Mrs A Thomas as a Member of the Committee.

3. Minutes

The minutes of the previous meeting held on 11 April 2013 were confirmed by the Committee and signed by the Chairman.

4. Declarations of Interest

There were no declarations of interest.

5(a) Urgent Business

There were no items of urgent business

5(b) Chairman's Announcements

The Chairman welcomed to the meeting the newly appointed Members and those Members who were returning to the Committee following the County Council election in May 2013.

The Chairman said that in order to make the most effective use of NHS Officer time he would be looking to keep the Committee to its timetable, even if this meant that on occasion discussion was curtailed.

6 Norfolk Health Scrutiny

The Committee received a presentation from Maureen Orr, Scrutiny Support Manager (Health) about Health Scrutiny powers that had been delegated to the Committee and about health scrutiny within Norfolk in general.

In reply to questions, the Health Scrutiny Manager said that the County Council needed to be notified before the Committee could make a referral to the Secretary of State for Health. She added that the statutory guidance on the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 had not yet been published. A summary of the regulations would be included in the Member briefing note in due course.

7 Report of the Norfolk and Suffolk Joint Scrutiny Committee on Radical Redesign of Mental Health Services

The Committee received a suggested approach from the Scrutiny Support Manager (Health) to the report of the Norfolk and Suffolk Joint Scrutiny Committee on Radical Redesign of Mental Health Services which completed its work before the County Council election on 2 May 2013.

The Committee received evidence from Mark Taylor, Chief Executive, North Norfolk Clinical Commissioning Group (Lead for Mental Health Commissioning in Norfolk) and Andrew Hopkins, Deputy Chief Executive, Norfolk and Suffolk NHS Foundation Trust. The report was presented by Michael Chenery of Horsbrugh, a Member of the Committee and the Vice Chairman of the Joint Committee.

In the course of discussion, the following key points were noted:

- Michael Chenery of Horsbrugh said that the Clinical Commissioning Groups (CCGs) and the Norfolk and Suffolk NHS Foundation Trust (NSFT) had accepted the recommendations of the Joint Committee.
- The witnesses said that transitional funding for dementia assessment beds in the King's Lynn area had been pledged for a further three months, however, Chase Ward at Chatterton House was due to close at the end of June 2013, following the formation of Community Dementia Intensive Support Teams.
- The NSFT was developing Dementia Intensive Support Teams to work with patients in their own homes and to prevent the need for hospital admission.
- For people in West Norfolk who could not be cared for at home, the NSFT was working with residential and nursing home providers in the area to ensure that appropriate specialist advice was available to support people with mental health difficulties.
- The witnesses added that there would be a small number of patients who would require a specialist NHS assessment, mainly for dementia, and that this assessment would be provided in the Norwich area.
- Members commented that the NSFT had to be able to meet the demand for its redesigned services before mental health beds were taken out of the system.
- In reply to questions, the witnesses said that the NSFT had not been contracted to provide services for those within the Prison Service, or for those with drug and alcohol problems; these specialist services were outside the remit of the Joint Committee.
- The Committee noted that an NHS Working Group, with stakeholders, would be formed to examine whether mental health services in the Thetford area should be organised according to a Norfolk or a Suffolk mental health service model.
- The Committee shared the concerns of the British Medical Association

(BMA) Local Negotiating Committee about the consultation process which had not involved service users, carers and other significant stakeholders.
- Members said that the NSFT needed to coordinate its plans with those of all other public sector, third sector and independent sector organisations and recognised that this would require very careful planning by the NSFT during the transitional period.
- The witnesses said that Officers from the lead CCG met with officers of the NSFT at least on a monthly basis to review NSFT performance.
- There was a small group of GPs in all of the CCG areas who advised on how mental health services were operating.
- The single assessment route could lead to savings. Previously, there had been complex assessment routes and some patients had undergone more than one assessment.

The Committee noted the report and the fact that the CCGs and the NSFT would return to the NHOSC on 5 September 2013 to present a timetable for their decision-making processes and for the necessary consultations with the Committee.

The Committee asked that the NSFT provide a copy of the terms of reference for the stakeholder working group on the service operating model for Thetford which could be shared with Members.

8 Forward Work Programme

The Committee agreed the list of items on the current Forward Work Programme subject to:

- Ambulance turnaround times at the Norfolk and Norwich Hospital being moved from 5 September 2013 to 28 November 2013 meeting.
- Stroke Services being added to the agenda for 5 September 2013.

The Committee asked to receive information on the following subjects in the Member Briefing Note:

- NHS 111
- The report on the CQC Inspection of the Norfolk and Norwich Hospital on 11 April 2013 (when published).
- Availability of health checks at GP surgeries in Norfolk

Members also raised subjects with a public health connection that could potentially be looked at by other scrutiny panels (which would initially be looked at by the Chairmen's Liaison Meeting):

- Childhood obesity and the link with exercise
- Services for children with asthma and the rate of admissions to hospital
- Extended drug and alcohol services.

9 Norfolk Health Overview and Scrutiny Committee – Appointments

The Committee received a report about appointments to joint committees and other roles that could be taken on by Members.

The Committee agreed the following:

(I) Great Yarmouth and Waveney Joint Health Scrutiny Committee

The Committee did not support the proposed revisions to the terms of reference for the Great Yarmouth and Waveney Joint Health Scrutiny Committee (GY and WJHSC). The Committee considered it more important to appoint Members who could best serve on the GY and WJHSC rather than to appoint Members who only came from the geographical area. The Committee agreed that the existing terms of reference should stand and that the GY and WJHSC should be asked to look at them in late 2013 or in early 2014 and to make any recommendations for change to NHOSC and Suffolk at that stage. It was further agreed that Suffolk County Council should be informed of this decision and the reasons for it.

(ii) To make the following appointments:

(a) Great Yarmouth and Waveney Joint Health Scrutiny Committee

Mr J Bracey
Mr M Carttiss
Michael Chenery of Horsbrugh
Mrs M Fairhead
Mr B Hannah

(b) Liver Resection Services Joint Scrutiny Committee

Michael Chenery of Horsbrugh
Miss A Kemp
Mrs M Somerville
Substitue – Dr N Legg

(c) North Norfolk CCG

Mr B Hannah
Substitute – Mr J Bracey

(d) South Norfolk CCG

Dr N Legg
Substitute – Mr R Kybird

(e) Great Yarmouth and Waveney CCG

Mrs M Fairhead

(f) West Norfolk CCG

Michael Chenery of Horsbrugh
Substitute – Miss A Kemp

(g) Norwich CCG

Mr D Bradford
Substitute – Mrs M Somerville

(h) James Paget University Hospitals NHS Foundation Trust

Mrs M Fairhead
Substitute - Mr C Aldred

(i) Norfolk Community Health and Care NHS Trust

Mrs J Chamberlain
Substitute – Mrs M Somerville

(j) Norfolk and Norwich University Hospitals NHS Foundation Trust

Dr N Legg
Mrs M Somerville

(k) Norfolk and Suffolk NHS Foundation Trust

Mr D Crawford

(l) The Queen Elizabeth Hospital NHS Foundation Trust

Mr G Sandell
Mrs A Claussen-Reynolds

10 Same Day Admissions At Norfolk's Acute Hospitals

The Committee received a suggested approach from the Scrutiny Support Manager (Health) to an update on the implementation of recommendations concerning same day admissions that had been accepted by the Norfolk and Norwich, Queen Elizabeth and James Paget Hospitals in October 2012.

The Committee received evidence from Debra Conner, Deputy Divisional Manager, Elective Division, James Paget University Hospitals NHS Foundation Trust and Pauleen Pratt, Divisional Chief Nurse for Surgery, Queen Elizabeth Hospital NHS Foundation Trust.

The witnesses explained the updates that had been provided for the benefit of the Committee and were set out in Appendices A and B to the report.

The Committee noted the responses from the Queen Elizabeth and James Paget Hospitals and agreed to invite representatives from the Norfolk and Norwich to attend at a later date.

11 Report on NHS England East Anglia Area Team's Response to the Application to Close Dickleburgh Branch Surgery

The Committee received a suggested approach from the Scrutiny Support Manager (Health) to a report from NHS England East Anglia Area Team about its response to an application from Churchill GP Practice, Pulham Market to close its Dickleburgh Branch Surgery.

The Committee received evidence from Bev Spratt, the local County Councillor for West Depwade (which includes Dickleburgh), Debbie Wade, Practice Manager for the Dickleburgh Branch Surgery, Peter Wightman, Interim Director of Commissioning, NHS England East Anglia Area Team, Fiona Theadom, Contract Manager, NHS England East Anglia Area Team and also from Patrick Marney a member of Dickleburgh Parish Council.

In the course of discussion the following key points were noted:

- The Dickleburgh Parish Council was the owner of the Dickleburgh building on which the Dickleburgh branch surgery was situated, which was leased to the Churchill Surgery at Pulham Market.
- Mr Spratt said that the Churchill Surgery had made their decision to close the Dickleburgh branch surgery in isolation; they had delayed informing the public or their representatives (the Parish Council), conducted no meaningful consultation, and had avoided meeting with local representatives.
- It was suggested by the local County Councillor and by a Member of the Dickleburgh Parish Council that the Parish Council and/or other public bodies including South Norfolk Council might have been able to fund improvements at the branch surgery in order for it to have remained open.
- Debbie Wade, Practice Manager for the Dickleburgh Branch Surgery said that an unannounced inspection from the Care Quality Commission in 2012 had found the Dickleburgh building to be in one of the worst conditions of any of the GP surgeries in Norfolk. She estimated that there would be a considerable capital cost to bring the building up to standard. In the opinion of Debbie Wade this was money that could be best spent at the Churchill Surgery.
- Debbie Wade added that two of the three surgery partners had decided to leave the Dickleburgh branch surgery before the decision was made by the Churchill Surgery to close the branch surgery and invest in the facility at Pulham Market.
- It was noted that NHS reorganisation and delays within the County Council in the formation of political leadership and in the formation of Committee membership had meant that the Committee was not consulted about the closure of the Dickleburgh Branch Surgery.

The Committee noted the report and that decision to close the Dickleburgh Branch Surgery had been taken in advance of the meeting.

The Committee recommended that the Churchill GP Practice undertake further discussions with the local community with a view to establishing to their satisfaction the transport arrangements for people travelling from Dickleburgh to the Pulham Market Surgery and for providing home visits for those unable to travel.

The Committee concluded at 1.15 pm.

Chairman

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Norfolk County Council
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NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH ON 5th SEPTEMBER 2013

Present:

Mr C Aldred	Norfolk County Council
Mr J Bracey	Broadland District Council
Mr D Bradford	Norwich City Council
Mr M 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
Mr B Hannah	Norfolk County Council
Miss A Kemp	Norfolk County Council
Dr N Legg	South Norfolk Council
Mrs M Somerville	Norfolk County Council

Substitute Member Present:

Mr A Wright for Mr G Sandell

Also Present:

Fiona Theadom	Contract Manager, NHS England East Anglia Area Team
Linda Hillman	Consultant in Dental Public Health, Anglia and Essex Team – Public Health England
Nick Stolls	Secretary of Norfolk Local Dental Committee
Mark Taylor	Chief Executive, North Norfolk Clinical Commissioning Group (Lead CCG for Mental Health Commissioning)
Dr Penny Ayling	Clinical Lead on Mental Health Commissioning for North Norfolk CCG
Andrew Hopkins	Acting Chief Executive, North and Suffolk NHS Foundation Trust
Jonathan Fagge	Chief Executive, Norwich Clinical Commissioning Group (Lead Commissioner for Acute Services from the N &N)
Dr Jonathan Wilson	Deputy Medical Director and one of the Clinical Leads for the Service Strategy, North and Suffolk NHS Foundation Trust
Kevin James	Chair of Norfolk & Suffolk NHS Foundation Trust Service User Council
Beth Jones	Member of the Public
Ann Baker	Norfolk Strategic Partnership for Older People
Professor Krishna Sethia	Medical Director, Norfolk and Norwich University Hospitals NHS Foundation Trust
Chris Cobb	Director of Medical and Emergency Services, Norfolk and Norwich University Hospitals NHS Foundation Trust
Esther Aldred	Member of the Public
Bill Adams	Member of the Public
Emily Arbon	NHS Anglia CSU
Deborah Gihawi	Norfolk County Councillor
Emma Corlett	Norfolk County Councillor

Hazel Fredericks	West Norfolk Older Peoples Forum
Patricia White	NCH&C
Jane Webster	Norfolk Community Health and Care
Lou Chapman	Norfolk County Council
Alex Stewart	Healthwatch Norfolk
Laura Scholefield	NSFT
Deborah Wooller	NCH&C

1. Apologies for Absence

Apologies for absence were received from Mr D Crawford, Mrs M Fairhead, Mr R Kybird and Mr G Sandell.

The Committee agreed to send their best wishes to Mr Gary Sandell who was unwell and to wish him well in his recovery.

2. Minutes

The minutes of the previous meeting held on 20 June 2013 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

There were no declarations of interest.

4. Urgent Business

There were no items of urgent business.

5. Access to NHS Dentistry

The Committee received a suggested approach from the Scrutiny Support Manager (Health) to a report from NHS England and written comments from the Norfolk Local Dental Committee about access to dentistry in Norfolk, an issue which had last been considered in January 2012.

The Committee received evidence from Fiona Theadom, Contract Manger, NHS England East Anglia Area Team, Linda Hillman, Consultant in Dental Public Health, Anglia and Essex Team – Public Health England and Nick Stolls, Secretary of the Norfolk Local Dental Committee.

In the course of discussion, the following key points were noted:

- From 1st April 2013 commissioning responsibility for all NHS Dental Services had passed from the former Primary Care Trusts to NHS England. This function was discharged by NHS England's Local Area Teams and Norfolk was covered by the East Anglia Area Team based at Fulbourn in Cambridgeshire.
- Fiona Theadom said that the next step for the Area Team was to put together an oral health needs assessment for East Anglia which was due to be completed by the end of 2013. She said that the aim of this document would be to support and inform decision making in the next round of Dental

Service Commissioning and to provide the basis for the comprehensive strategy of local oral health improvement.

- It was acknowledged by all the witnesses that there had been a delay in setting up the East Anglia Area Team and that a number of organisational issues had yet to be resolved.
- Nick Stolls said that the Area Team had been slow in putting together its organisational arrangements for Norfolk, and the Norfolk Local Dental Committee had been unable to have any meaningful links with the fledgling Area Team from its inception in October 2012 until it had been formally established in April 2013. He said that during that time there had been significant staffing concerns for Norfolk, and that two key posts had not been filled. In the opinion of Mr Stolls, the changes and the way in which they had been introduced had put back improvements in NHS Dentistry in Norfolk by at least 12 months.
- Mr Stolls went on to say that many of those working for the East Anglia Area Team had previously worked for the Cambridgeshire and Peterborough PCTs and the Norfolk Local Dental Committee lacked the personal contact that it had once had. He said that where in the past there had been 8 PCT Managers in Norfolk who could be approached on dental issues there was now only one Senior Manager for dental services in the county.
- Mr Stolls said that there were no guarantees that when the East Anglia Area Team completed its oral health needs assessment that funding for NHS dental services in Norfolk would not be lost to dental health services elsewhere in East Anglia. Members expressed concern about any potential loss of funding for meeting Norfolk's dental health needs.
- Fiona Theadom said that those members of staff that had been taken on by the East Anglia Team were for the most part very experienced and that there were still some vacancies to be filled. She said that by taking on a area based approach there could be benefits in terms of training for dental staff and in the provision of some specialised dental services. Fiona Theadom added that the Area Team recognised that there were a number of issues around the provision of NHS Dental Services in the King's Lynn area that had to be carefully addressed.
- Members spoke about the importance of the Area Team building up a good working relationship with Norfolk Healthwatch. Members also spoke about the importance of maintaining and monitoring good dental services for children of all ages and in particular for Looked After Children, as well as for vulnerable people generally.
- Nick Stolls said that he had been asked to assist a Task and Finish Group on dental health services for vulnerable people that had been established nationally and Fiona Theadom added that she would let the Scrutiny Support Manager for Health have a copy of the information that she had submitted to this Group.

It was agreed that NHS England East Anglia Area Team (EAAT) should be asked to provide:

Information as to what happens to EAAT financial surpluses in the year and whether these were retained by EAAT for use in the following year or were returned to NHS England in Leeds. It was noted that there had been surpluses in the annual dentistry budget in Norfolk for several years.

It was further agreed that Linda Hillman and Fiona Theadom should be asked to

provide:

A copy of the work done on dental health for Looked After Children and of the information presented to the Task and Finish Group on dental health services for vulnerable people that has recently been established nationally (which then could be forwarded to Jenny Chamberlin as Chairman of Children's Service Overview & Scrutiny Panel and elsewhere in the County Council as deemed appropriate).

A copy of the East Anglia oral health needs assessment when it was ready.

The Committee agreed to look at access to NHS dentistry again sometime in 2014.

6. Radical Redesign of Mental Health Services

The Committee received a suggested approach from the Scrutiny Support Manager (Health) to an update report from NHS North Norfolk Clinical Commissioning Group (currently the Lead Commissioner for Mental Health Services in Norfolk) and Norfolk and Suffolk NHS Foundation Trust setting out a timetable for decision-making regarding changes to mental health services that were outlined in the Trust's Service Strategy 2012/16, along with a timetable for consultation regarding substantial changes.

The Committee received evidence from Mark Taylor, Chief Executive, North Norfolk Clinical Commissioning Group (Lead CCG for Mental Health Commissioning), Dr Penny Ayling, Clinical Lead in Mental Health Commissioning for North Norfolk CCG, Andrew Hopkins, Acting Chief Executive, Norfolk and Suffolk NHS Foundation Trust, Dr Jonathan Wilson, Deputy Medical Director and one of the Clinical Leads for the Service Strategy, North and Suffolk NHS Foundation Trust and Kevin James, Chair of Norfolk and Suffolk NHS Foundation Trust. The Committee also heard from a long term service user and from Ann Baker of the Norfolk Strategic Partnership for Older People.

During the course of discussion, the following key points were noted:

- Members expressed concern about the impact changes in Mental Health Services was having on staff morale and asked what steps were being taken by the NHS to address this issue.
- In reply, Andrew Hopkins said that the NSFT was well aware of the importance of maintaining staff morale at a time of significant organisational change. He said that the NSFT was planning to introduce a new staff well being strategy which would be locally based. The NSFT was working with the CCG to ensure that any areas of concern about quality and performance were properly addressed.
- Mark Taylor said that the CCG and the NSFT intended to consult about changes to mental health service in the West and East localities.
- In West Norfolk a new community based service model for older people would be piloted which aimed to reduce the use of traditional in-patient beds and to provide more care and assessment in people's own homes.
- The new strategy aimed to avoid dementia sufferers being moved to care homes when they could still be treated in their own surroundings.
- There were beds in the Swaffham area that could be accessed where necessary.
- Andrew Hopkins said that the changes where likely to see a 20% reduction

in staffing levels. He also said that there were areas of excellence in mental health services in Norfolk: patient recovery from mental illness and the provision of a youth service were areas of service delivery that were being examined nationally as best practice for use elsewhere in the country.

- It was noted that there were historically different levels of spend on Mental Health Services across Norfolk.
- It was pointed out that an increase in the number of unexpected deaths in the West Norfolk community was being examined by the CCG and the NSFT. The number of serious incidents had risen from 3 in 2012 to 5 in 2013, however, no noticeable trends in the causes of these incidents had been detected.
- A long term service user spoke to the Committee about how service users had a unique contribution to make in that they were experts by experience in addition to any other skills qualities and life experiences that they had to offer. She said that for many of the service users who were in the most need of help having their own care co-ordinator who understood their personal circumstances was essential and yet some service users did not have such a person that they could turn too. She said that she knew of several service users who were concerned about the changes that were taking place and that they wanted to be kept more informed about how the changes would impact on them.
- Mark Taylor said that he would be happy to speak with the service user after the meeting about how she might be able to get more involved in shaping mental health services should she wish to do so.
- Mr Hopkins said that the Trust Board took the issue in involving service users very seriously. He said that every two to three months a service user was invited to attend the Board to share their experiences with Board Members.
- Kevin James said that the User Council made sure that the views of patients, their carers and others were sought and that they were taken into account in the planning of mental health services. He said that one of the issues that was being closely examined was that of establishing a Recovery College where (using a education model, aimed at getting service users back into the community) courses were provided for service users,
- Andrew Hopkins agreed to provide information about any proposals or plans to change the location of the services that were currently based at 80 St Stephens, Norwich, including Outreach Services.

It was noted that the Committee would receive consultation by the CCG's and the NSFT on proposed changes to Mental Health Services in West Norfolk in Spring 2014. It was also noted that the Committee would receive an update on changes to services in the central Norfolk area at a future meeting.

7 Stroke Services in Norfolk

The Committee received information regarding Stroke Services in East, Central and West Norfolk and were asked to consider whether to establish a Scrutiny Task and Finish Group to examine county-wide services in detail.

The Committee received evidence from Jonathan Fagge, Chief Executive, Norwich Clinical Commissioning Group (the Lead Commissioner for Acute Services from the N&N), Professor Krishna Sethia, Medical Director, Norfolk and Norwich University Hospital NHS Foundation Trust and Chris Cobb, Director of Medicine

and Emergency Services, Norfolk and Norwich University Hospital NHS Foundation Trust.

All the witnesses spoke in favour of the Committee setting up a Task and Finish Group to examine the issue of Stroke Services in Norfolk.

It was agreed that the following Members should be appointed to serve on a Task and Finish Group to examine Stroke Services in Norfolk in detail:

Mr John Bracey
Michael Chenery of Horsbrugh
Dr Nigel Legg
Mrs Margaret Somerville
Mr Tony Wright

It was also agreed there should be one co-opted Member from Healthwatch Norfolk (in a non voting capacity).

It was further agreed that the Task and Finish Group would develop terms of reference for approval by the Committee for 10 October 2013.

8 Forward Work Programme

The Committee agreed the list of items on the current Forward Work Programme with the addition of "Quality of Services at the Queen Elizabeth Hospital" being added to the agenda for 10 October 2013.

The meeting concluded at 1pm.

Chairman