Health & Wellbeing Board

Date: **Wednesday 17 April 2013**

Time: **10am**

Venue: **Edwards Room, County Hall, Norwich**

Membership	Substitute	Representing
Cllr Yvonne Bendle		South Norfolk Council
Stephen Bett	Jenny McKibben	Norfolk's Police and Crime Commissioner
Harold Bodmer		Director Community Services
Cllr Bill Borrett		Leader, Norfolk County Council
Sheila Bremner		Area Director, National Commissioning Board East Anglia
Dr Jon Bryson	Ann Donkin	South Norfolk Clinical Commissioning Group
Lisa Christensen		Director Children's Services
Pip Coker		Voluntary Sector Representative
Dr Ian Mack	Sue Crossman	West Norfolk Clinical Commissioning Group
Dr Anoop Dhesi	Mark Taylor	North Norfolk Clinical Commissioning Group
Richard Draper		Voluntary Sector Representative
Andy Evans		Great Yarmouth & Waveney Clinical Commissioning Group
Cllr Angie Fitch-Tillet		North Norfolk District Council
Anne Gibson		Acting Managing Director, Norfolk County Council
Cllr Shelagh Gurney		Cabinet Member, Community Services, Norfolk County Council
Joyce Hopwood		Voluntary Sector Representative
Lucy Macleod		Interim Director of Public Health
Cllr Elizabeth Nockolds		King's Lynn and West Norfolk Borough Council
Cllr William Nunn		Breckland District Council
Dr Chris Price		Norwich Clinical Commissioning Group
Cllr Andrew Proctor		Broadland District Council
Alex Stewart		Chief Executive, Healthwatch Norfolk
Cllr Mike Stonard		Norwich City Council
Cllr Alison Thomas		Cabinet Member, Children's Services, Norfolk County Council
Cllr Bernard Williamson		Great Yarmouth Borough Council
ACC Gareth Wilson		Norfolk Constabulary

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

A g e n d a

1	**Election of Chair**	**Committee officer**	
2	**To Receive Apologies and Details of any Substitute Members Attending**		
3	**Minutes** To confirm the minutes of the Shadow Health and Wellbeing Board meeting held on 9 January 2013.		**(PAGE 5)**
4	**To Receive any Items of Business which the Chairman Decides should be Considered as a Matter of Urgency**		
5	**Forward Plan and Work Programme 2013/14**	**Debbie Bartlett**	**(PAGE 13)**
6	**Norfolk Joint Health and Wellbeing Strategy – Responding to the Priorities** Report by the Head of Planning, Performance & Partnerships and the Interim Director of Public Health, Norfolk County Council	**Debbie Bartlett/ Lucy Macleod**	**(PAGE 29)**
7	**Community-led Health Improvement Programme – Update Report 2012-13** Update Report by the Interim Director of Public Health, Norfolk County Council	**Lucy Macleod**	**(PAGE 73)**
8	**Voluntary Sector Engagement Project – Update Report, March 2012-March 2013** Report by the Head of Operations, Voluntary Norfolk	**Linda Rogers**	**(PAGE 79)**
9	**Health and Wellbeing Board - Budget Report** Report by the Head of Planning, Performance & Partnerships	**Debbie Bartlett**	**(PAGE 87)**
10	**The Francis Inquiry and the new Quality Assurance system (Discussion paper)** Report by the Head of Planning, Performance & Partnerships	**Debbie Bartlett**	**(PAGE 91)**
11	**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 105)**
12	**Funding Transfers from the NHS for Adult Social Care** Report by Director of Community Services, Norfolk County Council	**Harold Bodmer**	**(PAGE 125)**

13 For Information:

- Follow the link to the relevant section of the Report to Council 25 March 2013 establishing the Health & Wellbeing board
- Follow the link to NCC's Rules for Committee meetings and the link to the Code of Conduct - *which will apply to all members of the Board and will include the requirement for declarations of interest at meetings*

- **Meetings dates for 2013 (all start at 10:00):**

  - **10 July**
  - **23 October**

Chris Walton
Head of Democratic Services
County Hall
Martineau Lane
Norwich NR1 2DH

Date Agenda Published: 10 April 2013

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Norfolk County Council
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Shadow Health and Wellbeing Board
Minutes of the meeting held on Wednesday 9 January 2013 at County Hall

Present:

David White (in the Chair) Chief Executive, Norfolk County Council (NCC)

Yvonne Bendle	South Norfolk District Council
Harold Bodmer	Norfolk County Council
Sheila Childerhouse	NHS Norfolk & Waveney
Lisa Christensen	Norfolk County Council
Pip Coker	Voluntary Sector
Sue Crossman	West Norfolk CCG
Dr Anoop Dhesi	North Norfolk CCG
Ann Donkin	South Norfolk CCG
Richard Draper	Voluntary Sector
Angie Fitch-Tillett	North Norfolk District Council
Kate Gill	NHS Great Yarmouth and Waveney CCG
Dr Jenny Harries	NCC/ NHS Norfolk & Waveney
Joyce Hopwood	Voluntary Sector
Dr Ian Mack	West Norfolk CCG
Jenny McKibben	Deputy Police and Crime Commissioner
Elizabeth Nockolds	Borough Council of King's Lynn & West Norfolk
Dr Chris Price	Norwich CCG
Andrew Proctor	Broadland District Council
Mark Taylor	North Norfolk CCG
Mike Stonard	Norwich City Council
Patrick Thompson	Local Involvement Network (LINk)
Gareth Wilson	Norfolk Constabulary

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

1 Apologies

Apologies were received from Stephen Bett (J McKibben substituting), Sheila Bremner, Andy Evans (K. Gill substituting), Chris Francis, John Fuller (Y. Bendle substituting), Shelagh Gurney, Derrick Murphy, William Nunn, Dr Jon Bryson, Cath Robinson, Alison Thomas, Bernard Williamson.

2 Minutes of the Shadow Health and Wellbeing Board meeting held on 24 October 2012.

The minutes of the Shadow Health and Wellbeing Board (H&WB) meeting held on 24 October 2012 were agreed as a correct record and signed by the Chairman.

3 Matters Arising

There were no matters arising.

4 Norfolk Joint Health and Wellbeing Strategy

(a) Responding to the Priorities.

The report (4a) by the Head of Planning, Performance and Partnerships, NCC, was received by the Board. It outlined progress that had been made to improve understanding of the priorities that had been agreed at the last meeting of the H&WB. The report also considered one priority in two of the categories for approaching the priorities as follows:

- Mental Health and Employment - **Investigate and Report**
- Healthy Eating and Weight Management - **Commissioning Assurance**

A third priority around unplanned/emergency care and admissions, which was in the **Watching Brief** category, had not been outlined in the report but was the subject of a presentation to the Board by the Director of Public Health. (Refer to the presentation named *Improving Unscheduled Care*, attached to the minutes as Appendix A).

The Board were invited to review and comment on the process that had been adopted to work on the priorities and whether work should continue on all the priorities this basis. The Board were also asked to review and comment on the discussion points and conclusions that had been noted, together with any possible actions identified.

The following points were noted during the ensuing discussion:

- During the discussion of the priority around unplanned care/emergency admissions the question of reporting lines arose and role of the Board as against the role of health scrutiny was raised. It was noted that, whilst the Norfolk Health Overview and Scrutiny Committee's focus was generally on whether things were working effectively, the Health and Wellbeing Board was operating at a strategic level and its focus was more on tackling the 'upstream' issues, driving integration and using its collective 'reach' to escalate issues to achieve better service outcomes. However, it was also recognised that there was some potential for overlap and that roles and relationships between the Board and the scrutiny function were still being explored.

- The NHS Commissioning Board's new Quality Premium was raised as something which might present an ideal opportunity for the Board to work on collectively. The Quality Premium was for improvements in the quality of the services commissioned by CCG's and it involved all CCGs in identifying a mixture of national and local priorities, with the three local priorities needing to be aligned with the local priorities in the Joint Health and Wellbeing Strategy.

- During the discussion on the initial conclusions of the investigation of the priority around mental health and employment, the Board noted the sheer

scale of the issues and breadth of the impact on the wellbeing of Norfolk's population.

- There was a discussion about mental health issues in the broader context of the wider social issues, the climate of change, the services in place, etc, and it was agreed that it would be helpful to look at the wider determinants of good mental health and wellbeing. This would be both from the perspective of what Board members could do, as policy makers and commissioners, as well as what Board members could do as employers of over 42,000 people.

- It was agreed that a one-off task and finish group would be convened on this and the results fed back to the Board.

- The commissioning assurance work on healthy eating and weight management outlined the commissioning arrangements for the 4 - tier model of services and interventions to promote healthy weight management, as they have developed across Norfolk.

- The Board recognised the direct links between on healthy eating and weight management and other priorities, such as mental health.

- It was suggested that as part of the next stage of development, some work should be done with schools, looking at both of these priorities from the preventative approach. The focus could be, for example, the extent and impact of the healthy schools programme in relation to mental health and healthy eating/weight management.

Resolved

The Board agreed the next steps for the priorities as outlined in the report.

The Board also agreed that the process for managing and responding to the priorities within the agreed categorisation was working well and should be continued for the rest of the priorities.

4(b) Responding to the Priorities – opportunities for CCG's to update on the local perspective.

North Norfolk CCG presented a report (4b) entitled Developing a Health Improvement Strategy for North Norfolk and Rural Broadland. The report set out the progress which had been made in developing a Health Improvement Strategy and Action Plan, flowing from the Health and Wellbeing Board's emergent priorities, which had been agreed at the last meeting.

The following verbal updates were also received:

- Norwich CCG would producing a Health & Wellbeing Strategy, which was in the final stages of development and included direct linkages to priorities in the Norfolk H&WB Strategy. A "Healthy Norwich"

campaign was being launched in February 2013 which would include pledges from various organisations.

- South Norfolk CCG recognised the priorities in the Norfolk H&WB Strategy and the issues involved, and arrangements were being set up for development of a local strategy.

- West Norfolk CCG has an established programme of working with local partners and priorities had been shared with stakeholders at an earlier stage. They have a local executive forum which is currently looking at dementia care and seven-day working across all agencies. They would be working towards a joint strategy, whilst looking at the blocks that prevented strategies from working.

- NHS Great Yarmouth and Waveney CCG confirmed that they have a System Leadership Partnership in place, which is an established multi-agency group. The H&WB's priorities were well received by the Partnership which was driving the work around integration.

Resolved
The Board noted the reports and the updates provided by the CCGs and supported the work that was being undertaken.

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

The report (5) by the Director of Community Services was received by the Board. The report outlined the main findings of the Winterbourne enquiry, gave details of the current position within Norfolk, outlined the implications of the recommendations being made to the H&WB and the next steps that would be required.

The Director drew the Board's attention to the government's key actions, which were as follows:-

- By Spring 2013, the department would set out proposals to strengthen accountability of boards of directors and senior managers for the safety and quality of care which their organisations provided.

- By June 2013, all current placements would be reviewed, everyone in hospital inappropriately would move to community-based support as quickly as possible, and no later than June 2014.

- By April 2014, each area would have a joint plan to ensure high quality care and support services for all people with learning disabilities or autism and mental health conditions or behaviour described as challenging, in line with best practice

- As a consequence, there would be a dramatic reduction in hospital placements for this group of people

- The Care Quality Commission would strengthen inspections and regulation of hospitals and care homes for this group of people, including unannounced inspections involving people who use services and their families

- A new NHS and local government-led joint improvement team would be created to lead and support this transformation.

During the ensuing discussion the following points were made:

- A detailed action plan would be developed and that a key role for the H&WB would be in actively overseeing the implementation of it.

- That a significant issue for Norfolk was as the host authority for people placed within the area by other Authorities.

- Reporting hate crimes and issues arising from them was an important part of the strategy.

Resolved

The Board noted the report and agreed that a further report, together with an action plan, should be brought back to the next meeting.

6 NHS Transfer Funding for Social Care 2013-14

The report (6) by the Director of Community Services was received by the Board. The report outlined the funding available to Norfolk County Council and proposals on how this should be spent by the local authority to support local health outcomes.

The Director of Community Services advised the Board that the grant settlement had only very recently been received and that they were three main funding streams;

- NHS Funding for transfer to Adult Social Care, with a requirement that the spending should be agreed at the Health and Wellbeing Board.

- Funding would be allocated to support reablement in every area with CCGs required to agree local allocations with local authorities.

- Spending would be allocated to local authorities for Winter Pressures for 2013-14 with a requirement for agreement with local CCGs.

The report proposed that the additional funding from 2013-14 be used for the following purposes:-

- To contribute to maintaining patient flow through the acute care sector to the community by increasing the availability of domiciliary and

residential care packages

- To contribute to improving hospital discharge arrangements by ensuring seven day per week availability of social care assessment capacity

- To phase in the mental health savings required in the Big Conversation

- To invest in a data management system to allow commissioners to analyse activity and cost across health and social care to improve integration and a whole system approach to the local health economy

During the ensuing discussion the following points were noted:-

- The increased allocation of transferred funding was positive news and the emphasis on increased integration made sense.

- It was important to ensure that lower level, lower cost prevention services were not overlooked when allocating funding, as these smaller services often allowed independent living to continue.

Resolved

The Board agreed to support the proposals in principle and that the finalised proposals should be brought to the April meeting for sign-off.

7 A Local Healthwatch for Norfolk

The report (7) by the Interim Chair of the Healthwatch Norfolk Shadow Board was received by the Board, and in her absence, was presented by the Head of Planning, Performance & Partnerships, NCC. The report updated the Board on the progress which had been made since the last meeting.

During the ensuing discussion the following points were noted:

- Data protection issues relating to membership transfer were being addressed.

- A strong message was given that the Local Healthwatch was not just aimed at adults and this was a good opportunity to make sure the focus was on children and young people as well.

Resolved
The Board noted the report.

8 Norfolk's Health and Wellbeing Board – Transition from Shadow Board to Statutory Committee

The report (8) by the Head of Planning, Performance and Partnerships, NCC, was received by the Board. The report outlined the Shadow Board's terms of reference and current membership to provide an opportunity for the shadow board to consider whether changes were required.

The current membership and Terms of Reference from the shadow year were reviewed by the Board and a wide-ranging discussion ensued.

Members agreed that although it was clearly a large group, and it would not be practicable to look to increase it, the organisations currently involved brought a breadth to the discussion, which was important to maintain, and provided the Board with the necessary influence and collective 'reach', for example, to be effective in unblocking or problem-solving system-wide issues.

During the discussion the following points were made:-

- The role of the Board was strategic, to steer and give direction but not to get into operational details – that would be for discussions outside of the meeting, involving the key people concerned whether or not they are on the Board

- The terms of reference should be strengthened to reflect the clear intent of the Board, for example in terms of accountability around integration.

- The wording of the terms of reference needed the appropriate degree of 'activeness' but that that most important going forward would be how individuals take on their responsibilities as a member of the H&WB and work together as a Board to fulfil its functions, for example, around strategic oversight.

- This continued to be a rapidly developing agenda and there was still a lack of clarity in many areas, but that as H&WBs became fully functioning they were likely to receive more responsibilities from the Government. Key right now was that partners were building a culture of working together, in readiness for the flexibility and responsiveness that would be needed.

Resolved

The Board concluded that, as it moved into its statutory stage, the membership should continue as before and be monitored on an ongoing basis. It was noted that task and finish groups could be set up, made of smaller groups of members, to consider more specific issues as necessary.

It was agreed to remove no. 1, 7 and 9 from the terms of reference for the

shadow year as they related to activities specific for the shadow year, and to look to strengthen no. 8.

9 H&WB Development

The Board noted a “whole systems scenario planning event” would be held on 4 February 2013 at Hethel Engineering Centre, which they were all urged to attend.

10 Any Other Business

Pip Coker raised the reforms to the welfare system and the potential impact that the proposed changes could bring, including the wider social consequences in areas such as mental health and the general wellbeing of vulnerable people and families which in turn could impact on health.

The Board noted work that had been previously undertaken by the Norfolk Community Advice Network and that the network would convene a further discussion, identify actions and report back.

The Director of Community Services advised the Board that a bid was being made for capital funding from the recently set up specialised housing fund operated by the Department of Health as part of the Building a Better Future strategy; if successful housing would be developed in Bowthorpe for service users with dementia. The bid involved Norwich City Council, Norwich Clinical Commissioning Group and NCC commissioners, and the deadline for submission was 18 January.

Resolved

The Board agreed to support the bid.

As it was the last meeting of the shadow Board, Members were thanked for their input and attendance.

The next meeting will be held on:

Wednesday 17 April 2013 at 10am in the Edwards Room, County Hall.

The meeting closed at 11.50am.

Chairman

Report to Norfolk Health and Wellbeing Board

17 April 2013
Item 5

Forward plan and Work Programme 2013/14

Report by the Head of Planning, Performance and Partnerships

Summary
The Norfolk Health & Wellbeing Board is meeting for the first time as a statutory committee. As the Board moves from its shadow form into its formal, statutory mode, it is considered helpful to construct a forward plan and work programme to provide a clear structure to the work of the Board for the coming year and to ensure it fulfils its statutory responsibilities. This paper provides an outline forward plan for consideration by the Board.

Action
The Board is asked to:

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

1. Background

1.1 At its last meeting, the Board discussed and agreed Terms of Reference. These are attached, as amended at the January meeting, for information. (Appendix B). Also attached is the operating framework agreed last year (Appendix C).

1.2 The Terms of Reference are consistent with the legal responsibilities arising from the Health and Social Care Act 2012 which gives Health and Wellbeing Boards the following duties:

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

2. Rationale for a forward plan

2.1 As the Board now moves out of shadow and into statutory mode, it was felt helpful to construct a forward plan and work programme for the Board to give clear structure to the work of the Board for the coming year and to ensure it fulfils its responsibilities.

2.2 A draft plan is attached (Appendix A) and the following should be noted:

- The plan covers key issues associated with the Board's duties and terms of reference. It does not preclude including other relevant issues on Board agendas.

- The plan is, not surprisingly, formulated in greater detail for the forthcoming meetings, and less populated for later meetings. This will change and develop as the cycle of meetings goes forward

- The plan indicates key lead responsibilities, and suggests mechanisms – outside of the Board in some cases – to ensure action takes place.

- The plan suggests some standing items, and some annual items. The latter will need to be timetabled as appropriate

- The plan needs to be flexible. It is proposed to review and update the plan at each meeting

3. Key elements of the draft forward plan

Joint Strategic Needs Assessment

3.1 The information and intelligence brought together in the JSNA forms a critical foundation for decision making on health and health care. The shadow board recognised that the real value of JSNA was not the production of a document but in promoting a way of working that improves analysis of health and health care data to help commissioners make good decisions, and helps all partners round the H&WB table marshal and target their efforts to make the maximum difference to residents' health and wellbeing.

3.2 During the shadow year, the JSNA has undergone significant development. Additional information and analysis has been carried out, much of it for localities – including a suite of district council profiles and CCG profiles. Follow this link to the JSNA.

3.3 It is proposed that the Board formally reviews the JSNA annually, and the first such review of its effectiveness as a planning and commissioning tool is scheduled for July.

Pharmaceutical needs assessment

3.4 Health and Wellbeing Boards take on the responsibility for these assessments from Primary Care Trusts. The assessments are intended to provide information to help the National Commissioning Board assess if, when and where new pharmacies are needed for their area. The first Pharmaceutical Needs Assessment has to be completed by 2015 and will have required public consultation.

3.5 The work programme proposes that initial work to assess the current robustness of the pharmaceutical needs assessment is led by public health in discussion with the Local Commissioning Board, and a report brought back to the July meeting. This will inform subsequent scheduling.

Health and Wellbeing Strategy

3.6 In the shadow year, the Board oversaw a process to identify a set of priorities which formed a one-year strategy for the Board. There have been regular discussions on the priorities at the Board, and later on this agenda is a further update. We have always recognised that the one-year strategy has been a pragmatic response, and mainly built on existing work and priorities.

3.7 With a stronger sense of overall purpose for the Board, and stronger local partnerships, it is proposed that 2013/14 adopts a twin track approach – continuing monitoring and challenge around existing 11 priorities, while working towards a refreshed 3 year strategy which will run from 2014/2017.

3.8 The forward plan proposes a sub-group to scope and steer the Board's strategy for 14-17 with discussions for the full board in July and October.

Commissioning plans

3.9 Clinical Commissioning Groups are required to produce 'plans on a page'. These follow a common set of headings and demonstrate key health and health care commissioning priorities. In addition, in May, CCGs are required to publish prospectuses for their residents and patients.

3.10 The forward plan proposes that in July CCGs lead a discussion at the Board on progress against their commissioning priorities, with particular emphasis on how they contribute to the priorities of the health and wellbeing strategy.

Health and social care integration

3.11 In 2012, the shadow board reviewed the approach to the integration of health and social care in Norfolk, and endorsed a set of principles for integration. The Board recognised the strong foundation from which we are working, with Norfolk's health and social care system hosting one of the Department of Health's Integrated Care Pilots, involving six pilot sites, based around GP surgeries.

3.12 The Board has a duty to encourage integrated working between commissioners of health and social care services, and it is proposed that progress and priorities are considered at the July meeting.

Community led health improvement

3.13 The shadow board has been clear that its remit and goals should be as much about improving the determinants of health, as the NHS services themselves. Strong local partnerships between district councils and Clinical

commissioning Groups are developing which provides leadership at a local level of improving health.

3.14 The shadow board has agreed to support this approach by pump-priming a programme to expand Healthy Towns and Ageing Well initiatives – proven to bring about benefits for localities. An update on this is at item 7 on this agenda.

4. Ways of working

4.1 The Board has always been clear that it should not add layers of unnecessary bureaucracy to an already complex health and social care landscape. For this reason, we have not set up a formal sub-structure, preferring instead to work through local partnerships, and other commissioning structures already established, or being set up.

4.2 However, the Board did recognise that there would be a need for one-off task and finish groups, or short-term working groups, set up under the auspices of the Board to take forward issues outside of the formal meetings, and this draft forward plan includes proposals for some such groups.

5. Action

5.1 The Board is asked to:

- Agree the draft forward plan, taking into account the notes set out in section 3

- Agree the establishment of working groups, as outlined in the draft forward plan

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

Appendix A

Draft forward plan, Health and Wellbeing Board April 2013 to April 2014

Meeting	Title and content	Lead officer	Mechanism
July	**Joint Strategic Needs Assessment update** Board to consider the impact to date of the Joint Strategic needs Assessment and to make recommendations about changes, additions as a result	Director of Public Health	DPH to establish task and finish group with range of representation. Task and finish group makes recommendations to Board
	Pharmaceutical Needs Assessment Interim report for the Board to assess the current robustness of the pharmaceutical needs assessment and agree next steps	Director of Public Health in discussion with Local Area Director for National Commissioning Board	Paper to Board
	In-year monitoring on Health and Wellbeing priorities. CCGs use 'plans on a page' to feedback progress on relevant priorities.	Head of Planning Performance and Partnerships (NCC) with CCGs	Paper to Board
	Accountability framework – a set of performance and quality measures for the Board	Head of Planning Performance and Partnerships (NCC)	Workshop of performance leads from H&WBB organisations shape a develop framework for consideration by the Board
	Health and Wellbeing strategy 2014-17 Board to consider approach towards 3-year health and wellbeing strategy. This will include engagement strategy with local residents	Head of Planning Performance and Partnerships (NCC) Director of Public Health	Proposal to establish a sub-group under the auspices of the Health and Wellbeing Board to scope approach for consideration by the full Board

	Health and social care integration - Paper on progress and priorities	Director of Community Services	Paper to Board
October	**Health and Wellbeing Strategy** Board to consider initial priorities for health improvement and health care commissioning for 14-17. This should include priorities for joint commissioning, and goals for integration between health, social care, and other public sector responsibilities	Head of Planning Performance and Partnerships (NCC) Director of Public Health	Sub-group to co-ordinate and oversee the work outside of the main Board in line with agreed approach.
	Community led health improvement Board to consider impact to date of initiatives, and next steps	Director of Public Health	Paper to Board
January 2014	**Commissioning priorities** Board to consider commissioning intentions of CCGs and how they 'fit' with H&WBS priorities	Director of Public Health CCG Chairs	To be agreed
	Voluntary sector engagement project – a report on the outcomes and impact of the project which is commissioned by the Health and Wellbeing Board	Head of Planning Performance and Partnerships (NCC)	Paper to Board from Voluntary Norfolk

Annual items to be timetabled

Director of Public Health Annual Report; Annual Report of Local Healthwatch.

Standing items

Norfolk Health Overview and Scrutiny – minutes. This will ensure that the Board picks up and considers any appropriate issues raised by scrutiny

Healthwatch minutes. This will ensure the Board is able to pick up and consider any appropriate issues arising from Local Healthwatch

APPENDIX B

Health and Wellbeing Board Terms of Reference 'shadow' year 2012/13

Aim

The Norfolk Health and Wellbeing Board will lead and advise on work to improve the health and wellbeing of the population of Norfolk by providing strategic leadership of, and oversight for, the commissioning across the NHS, social care and public health.

Purpose is to:

1. Lead the development, with Norfolk County Council and Norfolk's Clinical Commissioning Groups, of the Joint Strategic Needs Assessment (JSNA)

2. Lead the development, with Norfolk County Council and Norfolk's Clinical Commissioning Groups, of the Joint Health and Wellbeing Strategy (JHWS)

3. Speak up for Norfolk, championing the health and wellbeing needs of the people of Norfolk at a local, sub-regional, regional and national level and challenging central government policy where it conflicts with locally identified priorities

4. Lead and encourage a broad base of partners outside of formal health, public health and social care settings to tackle the wider determinants of health and wellbeing

5. Influence and support commissioners of health and wellbeing services to act in line with the evidence-based findings of the JSNA, and to highlight where commissioning is out of step with best evidence

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

7 Promote the sharing of good practice and learning across the Norfolk health system.

APPENDIX C

Report to Norfolk Shadow Health and Wellbeing Board
July 18th 2012
Item No: 5

An operating framework for the Health and Wellbeing Board
Chief Executive Norfolk County Council

Summary
This paper proposes an operating framework for the Norfolk Health and Wellbeing Board, based on the Kings Fund scenarios, which were discussed at the last Board meeting. The paper sets out what the Board can do to achieve a 'systems leadership' approach and outlines the potential challenges.

Recommendation
The Board is asked to consider the report and agree the operating framework for the Health & Wellbeing Board in Norfolk.

1. Background

1.1 Health and Wellbeing Boards have three main functions:

- to assess the needs of their local population through the joint strategic needs assessment process
- to produce a local health and wellbeing strategy as the overarching framework within which commissioning plans are developed for health services, social care, public health and other services which the board agrees are relevant
- to promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate.

1.2 The NHS Operating Framework for 2012/13 describes health and wellbeing boards as central to the new system and states that they will 'provide local systems leadership across health, social care and public health'. In addition, the Department of Health has also confirmed that it sees 'health and wellbeing boards acting as one of the engines of integration in the reformed system with the ambition of improving local care'

1.3 At the first meeting of the shadow board, we considered some scenarios, developed by the King's Fund as part of policy research into how Health and Wellbeing Boards might and could develop. In summary these were:

Scenario 1 'towards system leadership' was a Board which was setting its own agenda; debating and discussing the big health and health care issues and providing leadership across the whole system

Scenario 2 'strategic co-ordination' was a Board which worked on the common areas of agreement, and avoided the areas of disagreement

Scenario 3 'passive engagement' is a Board which picks up where a previous health partnership (or local strategic partnership) left off. Board meetings are dominated by sharing of existing plans which are rubber stamped. People enjoy the opportunity to network but the Board becomes irrelevant in an unfolding crisis of funding and service failure.

1.4 There was a collective view that this Board wanted to operate at Scenario 1.

2. Operating framework

2.1 The diagram at Appendix 1 provides a suggested operating framework which begins to apply the key features of scenario 1. What follows is a commentary for discussion on that framework.

3. What the Board will do

3.1 **Convene all commissioners.** The Health and Wellbeing Board is the single place where all the commissioners of health and social care come together:

- CCGs – commissioning the vast majority of health care for Norfolk people, including acute care, community services, mental health services, ambulance services and continuing health care.
- National Commissioning Board – commissioning primary care services for Norfolk people, and some specialist health care services for rare conditions and diseases
- Public health – commissioning public health prevention programmes, health protection, public health services e.g. sexual health, smoking cessation,
- Social care – commissioning services and care for children, families and adults

3.2 Together we are spending around £1.4bn a year of public money. Whilst specific commissioning decisions are not going to be made at the Health and Wellbeing Board, it is right that commissioners test their thinking with each other, with other public sector partners, and with representatives of patients and residents.

3.3 **Test, challenge commissioning.** The Health and Wellbeing Strategy will provide the overall 'big picture' for health and wellbeing improvement for Norfolk residents. As agreed at the last meeting, the strategy will not be a formal written document, prepared by a policy team and presented to the Board. It will be the collation of contributions which will answer the following questions:

a) What is the context for Norfolk and its communities? (economic, social and financial)
b) What principles and or values are we using to decide priorities?

c) What are the top commissioning priorities for improving and sustaining the health and wellbeing of residents in Norfolk, both pan-Norfolk and by CCG area?
d) What do Norfolk people think about our priorities?
e) What are the top commissioning priorities for improving and sustaining health care for patients in Norfolk, both pan-Norfolk and by CCG area?
f) What actions – collectively and as individual organisations – will partners in the health and wellbeing board take during 2013/14 to address these identified priorities?
g) How will we collectively and individually account for our actions?

3.4 In testing and challenging commissioning, the role of this Board is not to directly manage the commissioning activity of any of those bodies, nor can this Board 'veto' any commissioning plans. However, the Board can expect all commissioning plans of the above to be in line with the Health and Wellbeing Strategy, and will expect to give a formal opinion on commissioning plans as to whether they have taken proper account of the health and wellbeing strategy. There may be a role for the Board in challenging national priorities which are impressed on commissioners, where these might conflict or not align with the local picture of need and priorities.

3.5 **'Whole systems thinking'.** The King's Fund report highlights that over the next decade and beyond, the NHS, social care and related services face the enormous challenge of responding to the needs of increasing numbers of people with long-term conditions and an ageing population; this at a time when the NHS leaves behind the substantial real-term funding increases of the past to face a productivity gap of £20 billion, and local government faces an overall reduction of 26 per cent over the next four years. Both trends require a radical shift from a model of care based predominantly on acute hospitals towards a more preventive approach that promotes self-care and is much more personalised and co-ordinated around the needs of the individual.

3.6 The Health and Wellbeing Board will need to be the place in Norfolk where this overall shift is tested and developed. It will need a 'whole systems' approach because of the complexity and interdependency of different factors. Applying the principles of whole systems thinking to this and other issues, will draw in all partners and illuminate where and how a different way of working or a switch of resources could make a difference. It avoids the temptation to commentate and sympathise with other partners' challenges, and instead identifies the practical contribution other partners can make.

3.7 For example, the prevalence of dementia is increasing with implications for many of the services that collectively we provide. Are we geared up for this; how are we adapting our services so they are more dementia friendly?

3.8 It is envisaged that the Board will facilitate one-off task and finish working groups – or other mechanisms – to work through a small number of complex issues which have multiple inter-dependencies, drawing in partners beyond Board membership.

3.9 **Broker and drive integration.** Elsewhere on this agenda is a position statement about health and social care integration to date, and some suggested priorities for integration. The Board will want to promote and accelerate integration where this makes sense for patients, so it is likely that this Board will have papers and discussions about specific integration projects, about any blockages, and constraints.

3.10 This will need to involve providers and we will need to think about how the provider voice around integration is reflected on this Board. The Board will want to look at and push for integration not just between health and social care, but with other parts of the public sector. For example, integration with housing providers, with leisure and recreation, regeneration and economic development.

3.11 **Driving health and well-being improvement for Norfolk residents.** Members of the Shadow Board have already indicated the importance they place on the Board directing much of its collective effort towards tackling health inequalities. As well as the needs identified through the Joint Strategic Needs Assessment, the Board will want to look at the assets that communities, organisations and individuals have to help build resilient, health communities as well as treat and prevent illness. The Board has a crucial leadership role in addressing the structural, material and relational barriers to individuals and communities achieving their potential

4. Accountability

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

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

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

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

5. Underpinning information and principles

5.1 Patient and citizen voice and perspective will be critical to the effectiveness of the work of the Board. Elsewhere on this agenda is some initial thinking about engagement, and the principle of "Is this good enough for me and my family?" will need to be a recurring test and question when evaluating and testing commissioning intentions.

5.2 During its developmental year, the Board affirmed the value of good evidence and best practice to inform thinking and decision making.

6. Challenges

6.1 **Identifying critical issues for collective action.** It is likely that the critical issues for the Board will be obvious and clearly identified. However, there is a risk that there will not be a consensus and partners will 'drift' away if their particular concerns are not seen to be central to the work and focus of the Board.

6.2 **Sub-structures.** As discussed at the April Shadow Board meeting, there is a myriad of partnerships, groups, fora whose work overlaps, complements and probably at times duplicates. Given the context, challenges and suggested operating framework, there are some critical relationships between this Board and other existing or newly emerging groups which need to be maintained or enhanced. In particular, the Board will want to establish a relationship with the following new structures which have been established as part of the reforms:

- Norfolk NHS Systems Leadership Group, or East, West and Central groups
- Commissioning Boards for Acute, mental health, community
- Clinical networks
- 'Local' office for the National Commissioning Board

6.3 In addition, there are existing partnerships whose role and remit is established, and there would be merit in clarifying the relationship with the Board and those partnerships going forward. In particular:

- Norfolk Children's Trust Joint Commissioning Group
- Norfolk Older People's Strategic Partnership
- County Community Safety Partnership (will need to take into account new Police Commissioner)
- New Anglia - Local Enterprise Partnership
- Joint Health Social Care and Voluntary Sector Strategic Forum

6.4 It is proposed that discussions between respective leads from these – and other relevant groups – take place with a view to bringing a report to the next Board meeting, setting out relationships and links.

6.5 **Influence, not authority.** We have already reflected that Health and Wellbeing Boards are not top-down decision making bodies. Their authority will come from being seen to speak with one voice on the most pressing

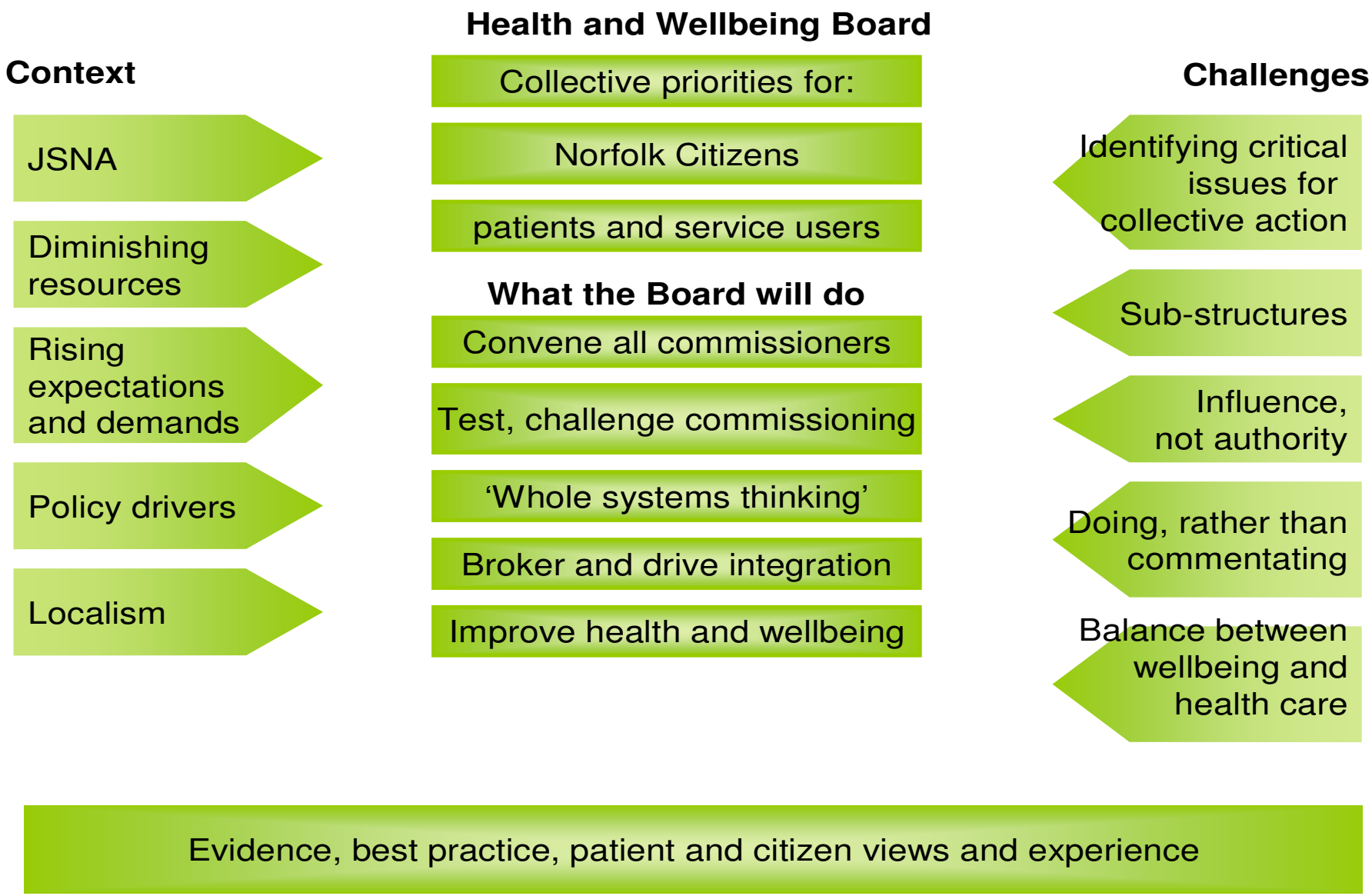
improvement and transformation issues that affect residents and patients, and being willing to hold each other to account for action and behaviour which gets in the way of improvement. We need to be realistic that such a way of working takes time to develop, and there are no quick fixes.

6.6 **Doing rather than commentating.** On a very basic level, this means avoiding having lots of items 'for information' that come to the Board and operating in line with the scenario 3 as set out above. It means that the Board may want to broker discussions between different organisations outside the normal Board business; it may want to take discussions/papers through decision-making forums of partners; it may want to delegate action on specific issues to existing boards or partnerships.

6.7 **Balance between wellbeing and health care.** The potential scope of issues the Board could work on is vast – stretching from wider determinants of health right through to patient pathways for specific common conditions. The financial pressures on the NHS and social care may also become a significant issue for the Board squeezing out consideration of more community based health improvement and 'upstream' work.

7. Recommendation

7.1 The Board is asked to consider the report and agree the operating framework for the Health & Wellbeing Board in Norfolk.


Health and Wellbeing Board
Context
JSNA
Diminishing resources
Rising expectations and demands
Policy drivers
Localism
Collective priorities for:
Norfolk Citizens
patients and service users
What the Board will do
Convene all commissioners
Test, challenge commissioning
'Whole systems thinking'
Broker and drive integration
Improve health and wellbeing
Challenges
Identifying critical issues for collective action
Sub-structures
Influence, not authority
Doing, rather than commentating
Balance between wellbeing and health care
Evidence, best practice, patient and citizen views and experience

Report to Norfolk Health and Wellbeing Board

17 April 2013
Item 6

Norfolk Joint Health and Wellbeing Strategy – responding to the priorities

Report of Head of Planning, Performance and Partnerships

Summary
This paper summarises the progress that continues to be made with work to deepen our understanding of the issues behind the priorities that have been agreed by the members of the Health and Wellbeing Board. It works through the priorities on alcohol and smoking, both of which have been considered using the Commissioning Assurance approach. The paper then outlines a series of conclusions and discussion points for the members of the Board to consider.

Appended to this paper is a copy of the Norfolk Joint Health and Wellbeing Strategy 2013/14, which consolidates the work of the Health and Wellbeing Board to date, for Board members to note. This paper also outlines a proposal for the development of a three-year strategy to run from April 2014.

Recommendation
The Norfolk Health and Wellbeing Board review and comment on:

- Progress that has been made to date on the 11 priorities
- The discussion points that have been noted on the priorities for alcohol and smoking and the possible actions that have been identified
- The proposal for the development of a three year strategy to run from April 2014.

1. Background

1.1 At the last meeting of the shadow Health and Wellbeing Board on 9 January 2013, Board members considered three of the 11 priorities in greater depth, using an agreed three tier methodology. These were Healthy eating and weight management (commissioning assurance), Mental health and employment (investigate and report) and Unplanned/emergency care and admissions (watching brief). The Board members then agreed that this methodology be developed further and work on the remaining 8 priorities continue.

1.2 The priorities on alcohol and smoking are considered in this paper and an update is given on the progress that is being made with work on the remaining 6 priorities.

2. Priorities – update on progress

2.1 Following on from the last meeting of the Health and Wellbeing Board on 9 January 2013 when 3 priorities were considered by the Board, the priorities for alcohol and smoking have been reviewed using the commissioning assurance approach. Reports have been completed by the Anne Louise Schofield of the Norfolk Drug and Alcohol Partnership and by Dr Augustine Pereira, Consultant in Public Health Medicine. These are appended (Appendix 1 and 2) to this report for consideration by members of the Board.

2.2 Work is also underway on the remaining 6 priorities. The progress that has been made to date is as summarised below:

- Dual diagnosis - Commissioning Assurance – under review by lead commissioners for mental health services in NHS Norfolk and Public Health
- Support frail elderly people living independently - Investigate and Report – under review by lead commissioners for adult health and social care
- Carers of older people and carers of people with long term conditions - Investigate and Report – workshop held on 5 April 2013
- Young carers - Investigate and Report – initial investigation completed, validation with Children's Trust Joint Commissioning Group and Public Health to be undertaken
- Creating good developmental and learning outcomes for all children and young people - Watching Brief – under review by the Children's Trust Joint Commissioning Group
- Improving Access to Psychological Therapies (IAPT) – Watching Brief - under review by lead commissioners for mental health services in NHS Norfolk and Public Health – consideration of a broader priority around mental wellbeing.

2.3 It is anticipated that work on the remaining 6 priorities will brought to a conclusion in advance of the October 2013 meeting of the Board.

2.4 The Health and Wellbeing Board has a responsibility to prepare a Joint Health and Wellbeing Strategy. The Norfolk Joint Health and Wellbeing Strategy 2013/14 is appended (Appendix 3) to this paper for the members of the Board to note. It is a consolidation of the work that has been undertaken by the Board to date to identify the issues that it will focus on and how it will respond to them. The Strategy for 2013/14 provides an overview of the development of the Health and Wellbeing Board, roles and responsibilities, the context of health and wellbeing in Norfolk, the priorities for action, how they will be tackled and how we will know that we are making a difference.

2.5 It is proposed that the next Norfolk Joint Health and Wellbeing Strategy cover the three years from April 2014. It is also proposed that the Strategy is developed by a sub-group of the Board.

3. Conclusions

3.1 The conclusions and recommendations specific to the priority on alcohol are summarised below. The full detail is available in the report in Appendix 1.

- NHS figures indicate that alcohol related harms are increasing steadily year on year among adults in Norfolk, with the greatest harm happening in the more urban areas of the county
- Barriers to service access include geographical issues of a rural county, stigma and motivation to change
- Holistic, multi-agency working needs to continue and further develop (at both county and locality levels), to ensure that effective strategic and operational approaches to reducing alcohol related harms are supported, particularly in terms of meeting related needs including mental health, employment and housing
- There is a clear role for Individual partner agencies in reducing alcohol related harms in Norfolk, for example through the delivery of alcohol identification and brief interventions and by looking at their approaches to alcohol related needs within their workforce

- Commissioners of wider services to take account of and embed clear expectations of providers in relation to their role in identifying alcohol related harms and responding effectively
- It is recommended that N-DAP present six monthly updates on strategy implementation to the Health and Well-being Board.

3.2 The conclusions and recommendations specific to the priority on smoking are summarised below. The full detail is available in the report in Appendix 2.

- Smoking levels are rising across Norfolk and our rates of Smoking in Pregnancy remain high
- Reduction in smoking prevalence and reduction of smoking uptake can only be achieved through systematic and comprehensive Tobacco Control (as demonstrated by the FRESH model)
- There is a clear role for individual partner agencies in improving health and reducing health inequalities by contributing to the smoking cessation and tobacco control agenda
- Progress has been made in setting up the Norfolk Tobacco Control Alliance, which will co-ordinate the local response and link in with regional work
- The Health and Wellbeing Board is requested to consider who would be able to act as a lead on and advocate for reducing smoking in Norfolk, highlighting the Tobacco Control Agenda and influencing strategic partners across the health and wellbeing agenda.

4. Recommendations

4.1 The Norfolk Health and Wellbeing Board review and comment on:

- Progress that has been made to date with the work to understand the issues behind the priorities that have been agreed by the members of the Health and Wellbeing Board

- The discussions points and recommendations that have been noted on the priorities for alcohol and smoking and the possible actions that have been identified

- The proposal for the development of a three year strategy to run from April 2014.

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Alcohol misuse

1. Why this was identified as a priority by the health and wellbeing board?

1.1 The issue of alcohol misuse was specifically identified by the West Norfolk CCG, although all 5 CCGs highlighted priorities where alcohol misuse was a significant contributory factor.

1.2 In our prioritisation matrix, this specific issue scored highly (11 out of a possible 12) because it promotes healthy lifestyles, is a problem that no one has been able to tackle, strengthens investment in prevention and early intervention, promotes integration, aligns with outcomes frameworks, reduces health inequalities, tackles a major issue for the long term health and wellbeing of the County, draws upon a strong evidence base, provides value for money, promotes equality and diversity and results in measurable and sustained improvements in the health and wellbeing of the people of Norfolk.

1.3 The Board agreed that this fell into its categorisation of 'commissioning assurance', because it was felt that there was a need to analyse and review relevant commissioning plans to assure itself that there are the right commissioning structures in place to ensure that effective interventions – based on good evidence of what works – are being implemented.

2. Commissioning assurance report on alcohol misuse

The following commissioning assurance report has been written by Anne-Louise Schofield, Norfolk Drug and Alcohol Action Team Strategy Manager.

1.0 Overview

1.1 Alcohol misuse and alcohol related problems, especially binge drinking and alcohol related liver disease, are major public health concerns. Rising alcohol consumption and the increasing incidence of cirrhosis is seen across all ages and sections of society. Excessive drinking causes accumulating harm in long-term ways, contributing to liver and kidney disease, acute and chronic pancreatitis, heart disease, high blood pressure, depression, and strokes. Alcohol is now the second biggest risk factor for cancer after smoking.

1.2 NHS figures indicate that alcohol related harms are increasing steadily year on year among adults in Norfolk. The latest Local Alcohol Profile for England (LAPE) shows that the greatest harm is happening in the more urban areas of the county (Norwich, Great Yarmouth and King's Lynn and West Norfolk), even when population numbers are accounted for. Overall figures for Norfolk usually remain well below the national average but this is because low levels of harm in certain areas such as Broadland and South Norfolk are masking the higher levels occurring in other areas of the county, such as Great Yarmouth, where they were double the national average in some measures.

2.0 Prevalence

2.1 The Norfolk Drug and Alcohol Action Team (DAAT) on behalf of the Norfolk Drug and Alcohol Partnership (N-DAP) complete yearly substance misuse needs assessments encompassing drugs and alcohol and more recently provide locality (based on CCG area) supporting assessments. Full copies of the reports will be available on www.nordat.org.uk and on Norfolk insight.

2.2 Adults:

- 4% of the population are 'higher risk drinkers'
- 0.1% have a severe dependence on alcohol

Norwich district has a significantly higher rate of binge drinkers than usually seen, 24% binge drink, compared to 17% in Norfolk on average.[1]

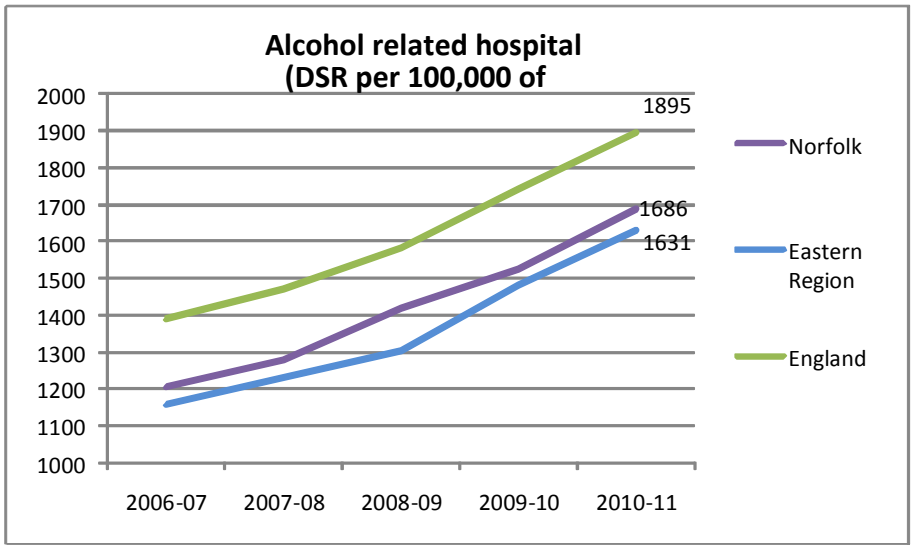
	Number in Norfolk	**Estimated local healthcare costs**
Abstainers	76,150 (15% of people)	
Higher risk drinkers Drink at very heavy levels which significantly increases the risk of damaging their health and may have already caused some harm to their health	21,803 (4% of drinkers)	£6.8m per year
Increasing risk drinkers Drink above the recommended levels which increases the risk of damaging their health	89,368 (14% of drinkers)	£28m per year
Lower risk drinkers Drink within the recommended alcohol guidelines	508,569 (82% of drinkers)	£8.2m per year

- There were 105,565 alcohol-related admissions in Norfolk in 2010/11, including:

	Number in Norfolk	**Estimated Cost**
A&E (accident & emergency) admissions	61,297	£7m
Inpatient admissions	20,465	£31.4m
Outpatient admissions	23,803	£4.6m

- The rate of alcohol-related hospital admissions in Norfolk continues to rise year-on-year. There was a 10% increase alcohol related hospital admissions in Norfolk last year, compared to only an 8% increase nationally**.**
- The 55-74 age group are responsible for the most alcohol related hospital inpatient admissions

[1] NWPHO (2012) *Local Alcohol Profiles England*. North West Public Health Observatory on behalf of Public Health Observatories in England: http://www.lape.org.uk/



2.3 Young People: N-DAP in conjunction with the Matthew Project completed a survey in February 2012 of just over 1,000 young people aged between 12 and 18 (although most were 15 or 16 [70%]). The survey found that:

		National Average [2] [3]	Norfolk average[4]
Drinking	Have experienced being drunk at least once	80%	51%
	Drinking every day or every week		9%
Smoking	Have tried smoking tobacco	35%	37%
	Smoking every day or every week	7%	7%
Drug Use	Tried cannabis	12%	19%
	Tried Class A	3%	5%

Between 2008/09 and 2010/11 there were 161 alcohol related hospital admissions of under 18 year olds in Norfolk. This gives a rate of is 33 per 100,000 of under 18s; this rate has dropped over the last few years and is statistically significantly lower than the average rate for England (56 per 100,000 young people). However two districts in Norfolk have seen this rate increase over the last two years (Great Yarmouth and King's Lynn & West Norfolk).

2.4 Older People: About a third of older people with drinking problems develop them for the first time in later life.

3.0 Related Needs and Harms

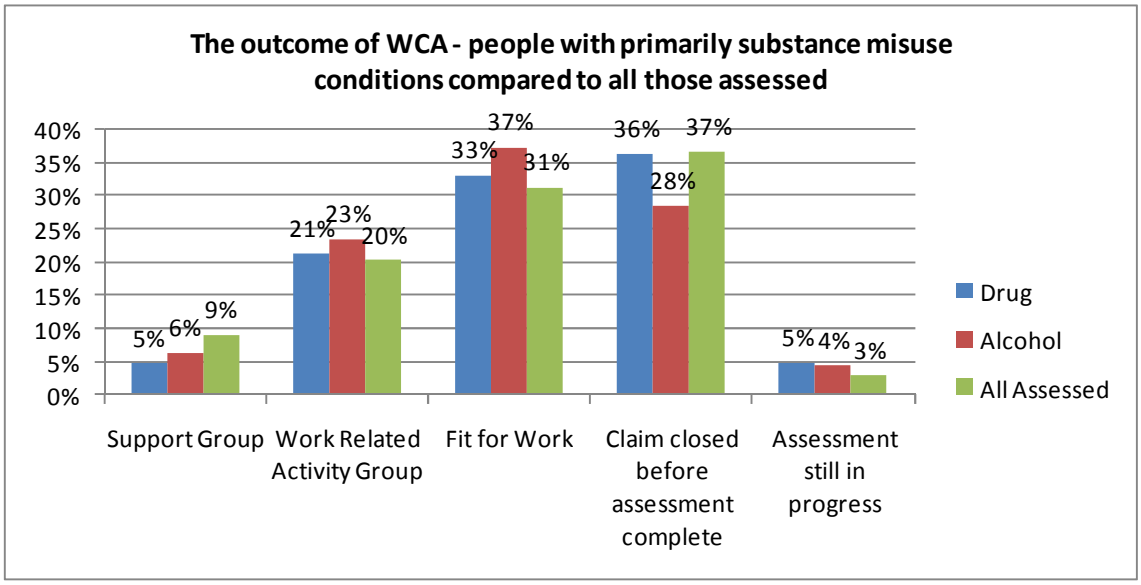
3.1 Housing - A recent study into Multiple Exclusion Homelessness (MEH) found that 70% of those surveyed had experienced problems with substance misuse. It concluded that first stage in becoming MEH is often substance misuse, with 19 being the median age for

[2] Bremner, P. et al (2011) *Young People, Alcohol and Influences* http://www.jrf.org.uk/publications/young-people-alcohol-and-influences
[3] Fuller, E. (2011) *Smoking, Drinking and Drug Use Among Young People in England in 2010* http://www.ic.nhs.uk/pubs/sdd10fullreport
[4] N-DAP (2012) *Young People in Norfolk, Drugs and Alcohol: Survey 2012*. All Norfolk data in this section is taken from this survey, for full report see: *http://www.nordat.org.uk/CSS/resources/research.html*

homeless people to begin to get involved with heavy alcohol and drug use.[5] 18% of people in alcohol treatment had identified accommodation needs at treatment start.

3.2 Employment - It is estimated that up to 17 million working days are lost each year due to the effects of alcohol. Alcohol-related harm costs an average organisation with 200 employees around £37,634 per annum.[6] Department for Work and Pensions (DWP) data shows that for new claimants of Employment Support Allowance of the alcohol group 6% are placed in the support group (therefore are entitled to ESA and exempt from mandatory work related activity) and a higher rate found fit for work (37%).

Only 26% of alcohol clients in treatment are in paid employment. People with a severe alcohol dependency are a group that is vulnerable to the impact of changes to the disability benefit system. Treatment services report spending an increasing amount of time helping clients to deal with problems with their benefits and to appeal Work Capacity Assessment (WCA) decisions.



3.3 Mental Health - 17% of clients in drug and alcohol treatment in Norfolk are also receiving mental health services (724 people). 44% of mental health service users either reported drug use or were assessed to have used alcohol at hazardous or harmful levels in the past year. This is 6,500 people in Norfolk.

3.4 Fire and road traffic accidents - Problematic use alcohol is linked to an increase risk of experiencing a fire at home. Often caused by people drinking alcohol and then falling asleep whilst cooking or smoking. Research from Scotland suggest that 17% of fires are linked to impairment due to suspected alcohol and/or drugs use as a contributory factor.[7] Norfolk has a rate of 2.07 per 100,000 people dying from land transport accidents due to alcohol, this is higher than the Eastern region average of 1.38 per 100,000 and the national average of 1.30 per 100,000.

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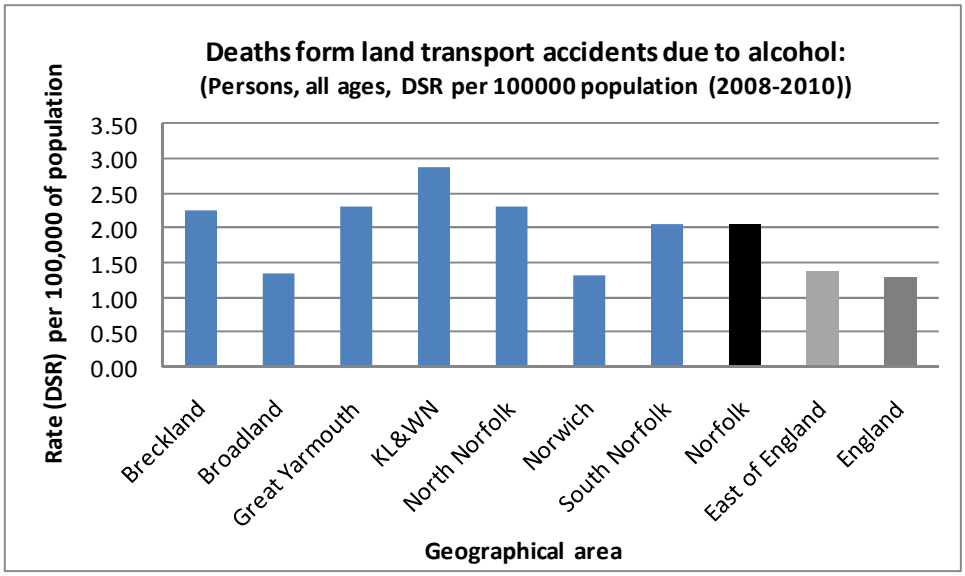
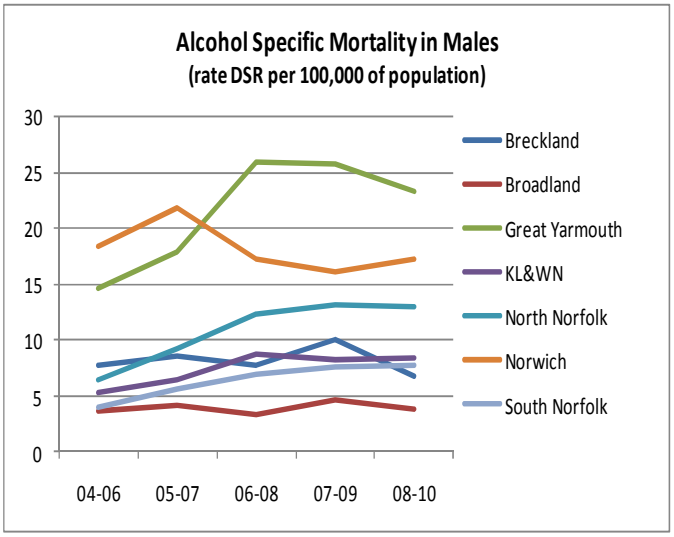
[5] JRF (2011) *Tackling homelessness and exclusions: Understanding complex lives*
[6] Alcohol Policy UK (2011) *Alcohol and the Workplace?* http://ranzetta.typepad.com/files/alcohol-at-work_-prevention-of-alcohol-costs-at-work-2011-briefing.pdf
[7] The Scottish Government (2012) *Fire Statistics Scotland.* National Statistics Scotland



3.5 Deaths - The overall number of alcohol specific deaths[8] in Norfolk was 150 over the two year period 2008/10 (most recently available data). The rate has remained steady over the last five years at 11 per 100,000 of the population (DSR).[9] This is above the average rate for the region (9 per 100,000) and below the rate of the average for England (13 per 100,000).[10] The rate fluctuates drastically across the county**:**



3.6 Crime and anti-social behaviour - Alcohol is the most significant contributory factor in incidents of violence in Norfolk and 'drunk and rowdy' behaviour accounts for the largest proportion of ASB reported to the police (23% of all reports). Data from Norfolk Constabulary suggests a substantial amount of domestic offences and almost a quarter of sexual offences in Norfolk in are linked to alcohol. Peak days for alcohol related crimes are Saturday and Sunday and peak times are between 23:00 and 02:00 with nearly a third of all offences occurring between these three hours. This is clearly linked to the night time economy.

3.7 Children families and safeguarding - It is estimated that of the 250,000 young people (0-19 years old) in the UK 6% are living with dependant drinkers. 61% of alcohol clients in treatment in 2010/11 had children. Findings of a national survey of social workers found that they believed that on average around 50% of the clients they worked with had issues

[8] Alcohol specific deaths" are those directly attributable to alcohol including alcohol-related liver disease and alcohol overdose
[9] DSR refers to 'Directly Standardised Rate. The observed mortality rates for the population in a certain area will depend to some extent on the ages of the people in that area. Age standardisation facilitates comparisons across geographical areas by controlling for differences in the age structure of local populations.
[10] NWPHO (2012) *Local Alcohol Profiles England*. North West Public Health Observatory on behalf of Public Health Observatories in England: http://www.lape.org.uk/

relating to drug and alcohol use.

4.0 Strategy and Planning

4.1 The Governments Alcohol Strategy (March 2012) and along side this the National Drug Strategy[11] set out the objectives and national approach to talking alcohol related harms and dependence. In line with this N-DAP have set in place a framework for the development and implementation of county and locality driven strategy and action planning with the following aim:

"To prevent and reduce drug and alcohol-related harms, to individuals, families and communities in Norfolk"

4.2 Consultation on the draft county strategy objectives to meet this aim has been completed and final objectives are being prepared for agreement.

4.3 Alongside the county work two areas (Norwich and Great Yarmouth and Waveney) are in the final stages of finalising locality strategies. These strategies support the draft county objectives. Within both areas working groups are being set up to drive forward action planning and ensure effective join up and governance arrangements between locality and county working.

4.4 The aim is for similar locality focused approaches to be developed that cover the whole county.

5.0 Commissioning

5.1 The commissioning of services to support and meet the needs of those affected by or dependant on alcohol is taken forward by the NCC DAAT on behalf of the Norfolk Drug and Alcohol Partnership. Within this partnership the Board has commissioning executive responsibilities and is supported by the N-DAP Joint Commissioning Group (JCG).

5.2 Since Autumn 2010 N-DAP has embarked on a project to redesign and procure its adult drug and alcohol treatment system. The project has enabled the development a whole systems approach to drug and alcohol treatment in Norfolk, which combines community and prison non-clinical provision and will see alcohol treatment being fully developed across all elements of service provision and a much more robust approach to the performance and quality management of alcohol interventions.

5.3 From April 2013 the responsibility of health improvement in relation to alcohol will become part of public health's roles and responsibilities and Directors of Public Health will see the commissioning and oversight of drug and alcohol treatment services as a core part of their work. This will need to continue to be taken forward through local partnership approaches, which ensure that services meet local needs including those relating to criminal justice services.

6.0 Are we meeting need?

6.1 Over the last year (2011/12) 4,368 adults received structured drug and alcohol treatment in Norfolk, 42% for alcohol problems. There are a number of peer led, abstinence based support groups in Norfolk. There are 33 AA groups that meet in 23 venues across Norfolk; however some more rural areas of the county do not have local groups.

6.2 There are some areas of the county where there lower levels of service provision. Broadland and South Norfolk have similar population sizes to Breckland, but far lower numbers of alcohol clients in treatment.

6.3 Barriers to service access include: geographical issues of a rural county, stigma and motivation to change. The barriers identified are consistent with a study completed five

[11] Drug Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life. HM Government (2010).

years ago. People feel services are too geared towards Opiate and Crack Using (OCU) clients and need to be more attractive to alcohol clients.

6.4 There are specific issues for the treatment of older people with alcohol related needs. It may be that they do not feel traditional specialist alcohol services are suitable for them and are more likely to rely more on primary health care, like their GP.

6.5 There is an identified need for greater provision for designated supported housing for people with substance misuse issues in Norfolk in order to ensure that people can be matched to the right type of accommodation for their stage in the recovery journey (in particular, a need to abstinence based supported housing).

6.6 There are no dedicated services for younger children (eleven and below) who are affected by parental substance misuse. There is some anecdotal evidence of Early Years projects and children's centres supporting children aged five and under, but it is less clear what is available for children aged between six and eleven. Consideration needs to be given as to how support for children within this age group is developed and implemented across the county.

6.7 N-DAP have supported the implementation of alcohol brief interventions for a number of years through the funding and delivery of alcohol brief intervention training. However it is not possible to assess how many brief interventions are being delivered and the quality of this.

6.8 Stigma needs to be addressed as it is a barrier to accessing help and there is an opportunity for this service to raise the profile of this issue and therefore begin to reduce stigma.

7.0 What can partners do?

7.1 Holistic, multi-agency working needs to continue and further develop (at both county and locality levels), to ensure that effective strategic and operational approaches to reducing alcohol related harms are supported, particularly in terms of meeting related needs including mental health, employment and housing.

7.2 Individual partner agencies need to take on board and be accountable for their role in reducing alcohol related harms in Norfolk, for example through the delivery of alcohol identification and brief interventions and by looking at their approaches to alcohol related needs within their workforce.

7.3 Commissioners of wider services need to take account of and embed clear expectations of providers in relation to their role in identifying alcohol related harms and responding effectively. Including ensuring that this element of provision is supported by training and staff development and assured through performance governance and quality assurance mechanisms.

8.0 Discussion Points

8.1 What more needs to be done in order to make the provision of alcohol brief interventions a reality in a wide range of Norfolk support services?

8.2 How can we ensure that community and family focused approaches to reducing alcohol related harm are developed and supported across Norfolk?

8.3 How can individual agencies help to reduce alcohol related hospital admissions?

9.0 Recommendations

9.1 It is recommended that N-DAP present six monthly updates on strategy implementation to the Health and Well-being Board.

Smoking and Tobacco Control

1. Why this was identified as a priority by the health and wellbeing board?

1.1 The issue of smoking was specifically identified by Norwich CCG and Public Health. Also, this issue runs through the priorities identified by Children's Services and is increasingly an issue for adult health and social care.

1.2 In our prioritisation matrix, this specific issue scored highly (11 out of a maximum score of 12) because it promotes healthy lifestyles (EPIC), requires collective action, strengthens investment in prevention and early intervention, tackles a problem that no one else has been or is able to tackle, aligns with outcomes framework, reduces inequalities, tackles a major issue for the long term health and wellbeing of the County, draws upon a strong evidence base, provides value for money, promotes equality and diversity, and results in measurable, sustained improvements to the health and wellbeing of the people of Norfolk.

1.3 The Board agreed that this fell into its categorisation of 'commissioning assurance', because it was felt that there was a need to analyse and review relevant commissioning plans to assure itself that there are the right commissioning structures in place to ensure that effective interventions – based on good evidence of what works – are being implemented.

2. Commissioning assurance report on smoking and tobacco control

2.1 The following commissioning assurance report has been written by Dr Augustine Pereira, Consultant in Public Health Medicine.

Overview

2.2 The issue of Tobacco control, specifically reducing the number of children and young people who start smoking and increasing the number of people who stop smoking was identified by the Public Health Directorate at Norfolk County Council as a priority for the following reasons:

- Smoking remains the single biggest cause of preventable premature death in Norfolk
- It is also the single biggest contributor to life expectancy gap between most and least deprived quintiles in society
- Tobacco control involves a wide range of partners and requires co-ordinated activity on behalf of those partners to bring about improvements
- A lot is known about the theme, with national and local evidence including previous studies and work by both Norfolk and Great Yarmouth & Waveney PCTs.

Public Health Outcomes Framework (PHOF*)*

2.3 Reducing smoking rates within the communities will have an impact on six Public Health Outcomes Framework[1] indicators and they are listed below:

- Low birth weight of term babies

- Smoking status at time of delivery
- Smoking prevalence in adults (over 18)
- Smoking prevalence 15 year olds (placeholder)
- Mortality from Cardiovascular disease
- Mortality from Respiratory disease.

2.4 In addition it also contributes to two indicators corresponding to the overarching outcomes:

- Healthy life expectancy
- Differences in life expectancy and healthy life expectancy between communities.

Table 1 - further detail on the indicators specifically related to smoking.

Indicators	Description	Data Source	National Ambitions
1. Smoking status at time of delivery	Number of maternities, number of mothers recorded as smoking at delivery and number of mothers recorded as not smoking at time of delivery.	Data collected by acute hospital trust	To reduce rates of smoking throughout pregnancy to 11 per cent or less by the end of 2015 (measured at time of giving birth).
2. Smoking prevalence – aged 15years old	National estimates of the proportions of young people aged 11 to 15 who smoke	Recorded by a series of surveys of secondary school children in England.	To reduce rates of regular smoking among 15 year olds in England to 12 per cent or less by the end of 2015.
3. Smoking prevalence – aged 18 years +		Integrated Household Survey (IHS) at a locality level. (Yearly survey not in real time)	To reduce adult (aged 18 or over) smoking prevalence in England to 18.5 per cent or less by the end of 2015, meaning around 210,000 fewer smokers a year.

Tobacco Control Standards

2.5 The Marmot Review published in 2010 stated that "tobacco control is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups" [2].

2.6 The report "Healthy Lives, Healthy People: A Tobacco Control Plan for England" [3] describes the national standards that can help augment tobacco control at the regional and local level. The standards described in the report are given below:

- Stopping the promotion of tobacco
- Making tobacco less affordable
- Effective regulation of tobacco products
- Helping tobacco users to quit
- Reducing exposure to second-hand smoke
- Effective communications for tobacco control
- Information and intelligence
- Protecting tobacco control from vested interests.

Smoking Prevalence

2.7 There are approximately 10 million adults who smoke cigarettes in UK i.e. 21% of adult men and 20% of adult women. The highest smoking prevalence is among 20 -24 years old in women (29%) and 25-34 years old in men (28%)[4].

2.8 The Norfolk smoking prevalence is showing an increasing trend since April 2010. The smoking prevalence in the Norfolk area is currenlty higher than the East of England and England averages. (ssee figure 1 and figure 2), The smoking prevalence in the Broadland area is signficantly low as compared to the Norfolk average, however, there were no siginficant difference found in other Norfolk localities. (figure 4)

Figure 1: Smoking Prevalence (Integrated household survey)

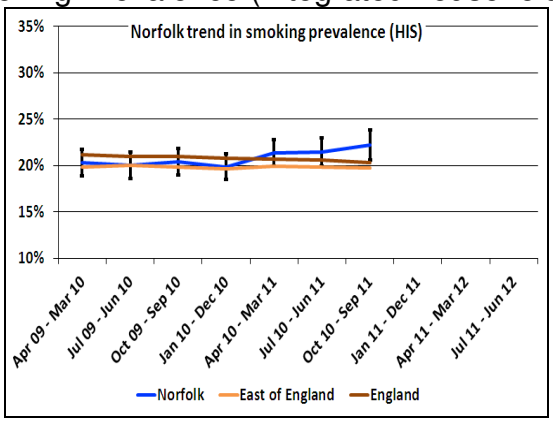
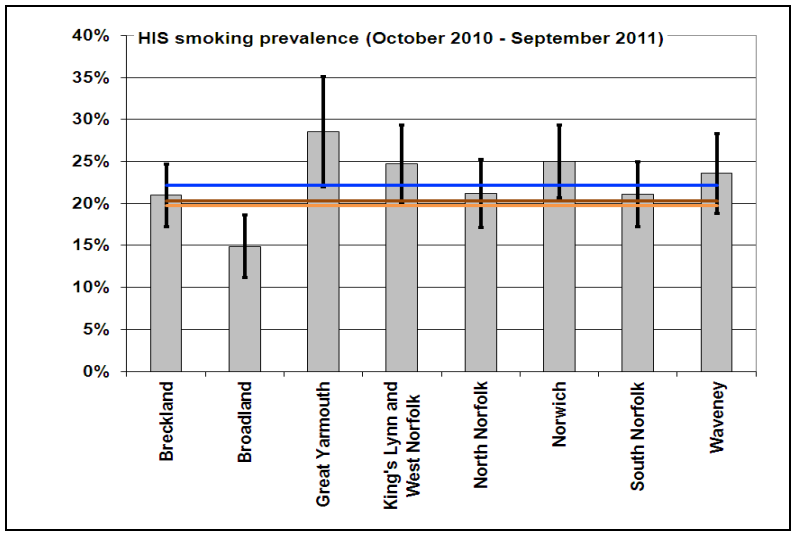


Figure 2: Smoking Prevalence (HIS), Norfolk Local Authorities



Mortality Secondary to Smoking

2.9 Smoking is one of the biggest causes of preventable deaths in the UK. “Smoking is the biggest cause of health inequalities in the UK accounting for half the difference in life expectancy between richest and poorest. Not smoking can allow people to leap the health gap, with the poorest non-smokers typically having a substantially longer life than the richest smokers”. [5]

2.10 “As a whole the districts of Great Yarmouth and Norwich have rates higher than the national average and the rest of the districts in Norfolk have rates lower than the national average. Only the district of Great Yarmouth has a rate higher than the national average

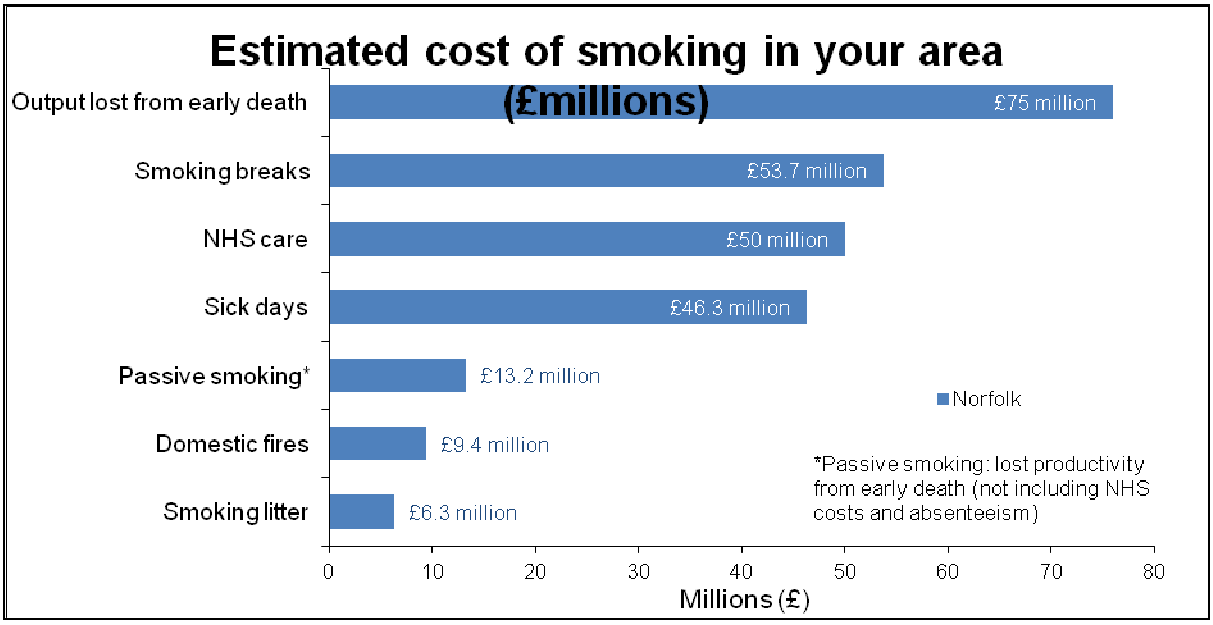
and the rest of the districts in Norfolk have rates lower than the national average, most significantly so." [6]

Smoking impact (Cost) in Norfolk

2.11 Smoking costs the National Health Service (NHS) £2.7 billion a year for treating conditions caused by smoking. 1,400 people per year in Norfolk die from smoking attributed diseases and there are about 8,000 smoking related hospital admissions[7].

2.12 The estimated output lost from early deaths in Norfolk is £75 million. The total cost to the NHS care of smoking in Norfolk is £50 million[8]. (Figure 3)

Figure 3 Estimated cost of smoking in Norfolk

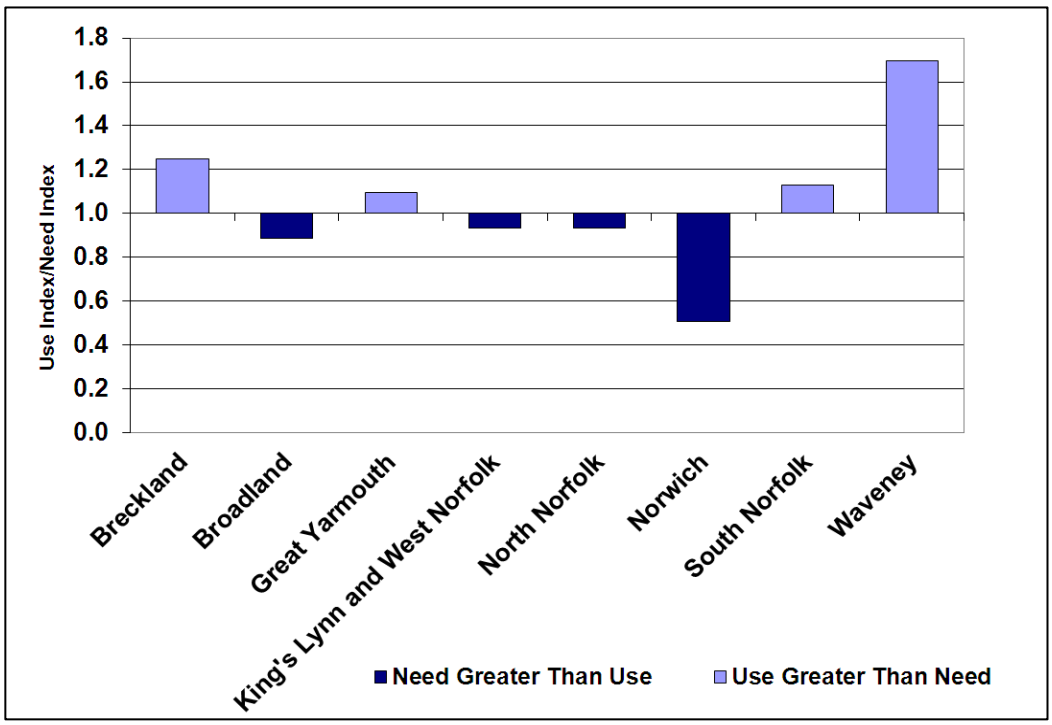


Stop Smoking Services- Needs Analysis

2.13 While every smoker that quits is a good thing more can be done to target areas where smoking prevalence is high. For Norfolk local authorities Norwich needs to recruit more smokers into the Stop Smoking Service. If the service was being utilised by smokers in a local authority in accordance with need then the Use Index /Need Index would be about 1.

2.14 In the case of Norwich this is about 0.55 indicating that the stop smoking service is not being used in accordance with need. The need in Norwich is generally high but the use of the stop smoking service is generally low. The need in Great Yarmouth is generally high and the use of the stop smoking service is generally high.

Figure 4: Comparing stop smoking service use and need in 2010/2011



Evidence Based Approach

2.15 The government's white paper "Healthy lives, healthy people: a tobacco control plan for England" provides an action framework at national, regional and local level. The interventions discussed include smoking bans, restricting advertising and placement, workplace smoking cessation interventions, reducing tobacco smugglings, individual counselling, self-help materials, nicotine replacement therapy and social support. Local authorities and other partners can supplement national action by[9]:

- Educating and informing people (especially children and young people) about the risks of smoking
- Preventing access to illegal cigarettes and ensuring compliance with legislation on tobacco displays
- Ensuring there is access to local advice and services for those who want to quit smoking.

2.16 Norfolk Public Health Directorate is using the best available evidence for commissioning services to prevent the uptake of smoking among children and young people and to help individuals who are already smoking to quit. The NICE guidelines and the examples of best practice models which are commissioned across England to tackle tobacco control (below) have informed the commissioning of services.

2.17 The National Institute of Clinical Excellence (NICE) has developed evidence based guidelines/ pathways to help commissioners make informed commissioning decisions. The NICE "Smoking Prevention and Cessation Overview" pathway covers interventions and action plans to prevent children and young people from taking up smoking and to help everyone who already smokes to quit. Smoking cessation interventions are generally considered very cost-effective, regardless of the targeted audience, the

strategies to identify and recruit ideals or the type of intervention offered. [10] . A number of the key NICE guideline links are given below.

- Brief interventions and referral to stop smoking services - NICE public health guidance 1 (2006) (http://guidance.nice.org.uk/PH1)
- Workplace interventions to help people stop smoking - NICE public health guidance 5 (2007) (http://guidance.nice.org.uk/PH5)
- Preventing children and young people from starting to smoke – (http://guidance.nice.org.uk/PH14)
- Quitting smoking in pregnancy and following childbirth - (http://guidance.nice.org.uk/PH26)
- Smoking Cessation Services- NICE public health guidance 10 (2008). Smoking cessation services.
- School-based interventions to prevent smoking. NICE public health guidance 23 (2010)

2.18 There is some evidence that using regional approaches for tobacco control is more effective and beneficial. One example is an approach adopted by the North East of England (FRESH). Here in Norfolk, we will be adopting a 'CleaR approach' provided by ASH. The training on model implementation is provided by the ASH.

Best Practice Models for Tobacco Control across England:
Fresh[11]:
"Fresh was the UK's first dedicated regional programme set up in the North East of England to tackle the worst rates of smoking related illness and death in the country. As a result, the North East has had the biggest drop in smoking in England from 29% in 2005 to 21% of people in 2011."

CleaR: Excellence in Local Tobacco Control[i] by "Action on Smoking and Health" [12]
"CLeaR is a new approach to improving local tobacco control, specially designed for councils in England as they take on their new responsibilities for public health". The member councils will get support and training in self-assessment and ultimately a peer assessment from colleagues, expert in tobacco control and the CLeaR model.

Social Norms

2.19 Norfolk Public Health directorate has invested in a social norms work to promote smoking quits. The Social Norms Project seeks to realise behavioural change by aligning perceptions with reality. It does this by presenting individuals with the information they need to make fully informed decisions about how they fit in with those around them.

2.20 The pressure in adolescence to fit in with peer groups can be a powerful influence on behaviour; driving individuals to act in accordance with what they perceive as normal. This perception is often distorted by media portrayals that focus on the sensational and the controversial. In showing that the lifestyles of a minority do not reflect those of the majority of their peers, we can reduce the pressure felt by young people to conform to a misguided understanding of what is normal behaviour.

2.21 The process of the Social Norms Project begins by surveying young people anonymously about their own behaviour as well as their beliefs about the behaviour of others. The responses can then be used as a powerful educational tool in showing the difference between widely held perceptions and reality. With the collated data, young

people can then be engaged in designing their own educational campaigns that are relevant to their peer groups.

2.22 The effectiveness of this approach has been demonstrated and documented by the "father of social norms marketing," Professor H Wesley Perkins. The approach is based on his theoretical formulations and development, evidence for which can be found on the following website: http://www.socialnorm.org/. For a Social Norms guide see www.normativebeliefs.org.uk/Guidebook.pdf

Commissioning Partners

Norfolk Public Health Directorate

2.23 Norfolk Public Health Directorate currently spends £2.5 million pounds on commissioned NHS Stop Smoking Services from a number of different providers. The aim is to provide a high quality, flexible and accessible service for the people of Norfolk. The figure includes prescribing costs and excludes the cost for the Waveney element of the service provided in Great Yarmouth and Waveney. During the year 2013-14, a negotiated settlement for the cost of this service for Waveney will be implemented. We have budgeted for the service based on aspirational targets as illustrated below and the actual spend will depend on the number of smokers supported to quit by the service. The average cost per quit is in the region of £374 to £478 and varies by target group we are trying to reach out to.

2.24 The core Specialist Services (Smokefree Norfolk and GYW Stop Smoking Service) are currently commissioned from Norfolk Community Health and Care (NCH&C) and East Coast Community Healthcare (ECCH). Within the contract is a responsibility for providing training, mentorship, communication, health promotion and delivering the annual quit target. There is also a requirement that the Services reach key target groups within the population- e.g. pregnant smokers, BME, routine and manual smokers, young people, mental health.

2.25 Currently, 102 of our GP Practices are signed up to deliver a stop smoking service as are 106 out of 170 Pharmacies. We also commission Services from the community sector (Keystone Trust, Matthew Project) and Health Trainers.

2.26 In addition, we also work with Norfolk Trading Standards and the Local Pharmaceutical Committee on Tobacco Control activities.

2.27 Outlined below are the annual aspirational quit targets for Norfolk, broken down by district council and CCG:

Area	**Target**
Norfolk	**7140**
Clinical Commissioning group	
NHS North Norfolk CCG	1063
NHS Norwich CCG	2084
NHS South Norfolk CCG	1711
NHS West Norfolk CCG	1276
NHS Great Yarmouth and Waveney CCG	2189
Local Authority	

Breckland	1022
Broadland	812
Great Yarmouth	1005
King's Lynn and West Norfolk	1116
North Norfolk	615
Norwich	1720
South Norfolk	849
Waveney	1184

2.28 The 4-week quitters are smokers who remain quit 4 weeks after setting a quit date and giving up smoking. The aspirational 4-week quit targets are calculated based on registered population from April 2012, integrated household survey prevalence data (2011/12), MSOA estimated prevalence, and a target of 50 quits per /1000 smokers (8324 across Norfolk and Waveney).

2.29 The Commissioning for Quality and Innovation (CQUIN) payment scheme is a mechanism for improving the services we commission from NHS providers. The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

2.30 We are currently negotiating a CQUIN for NCH&C. It is likely that this will include incentive for Smokefree Norfolk to create invoices for other Providers, thereby reducing Commissioner Administration time, providing clear payment schedules and giving assurance of data validity.

Environmental Health and Trading Standards

2.31 NICE recommends[13] that local authorities should ensure environmental health and trading standards services prioritise tobacco control and enforce legislation on tobacco in accordance with their statutory role and best practice. This includes conducting and auditing test purchases, providing training for retailers and prosecuting those who break the law.

Clinical Commissioning Groups

2.32 Clinical Commissioning Groups as membership organisations have a unique role to play to promote smoking cessation service among their member practices. The evidence is strong on the impact smoking cessation and tobacco control can have on health inequalities. In fact this is the single most important intervention to help CCGs reduce their health inequalities and improve population health. CCGs also have a responsibility to ensure that health improvement activities are an integral part of the healthcare services they commission. In particular, brief interventions in secondary care and maternity care.

2.33 `Progress on health outcomes will be measured against the NHS Outcomes Framework and the Public Health Outcomes Framework. CCG activity will play an important part in improving both outcomes frameworks.

2.34 General Practice plays a vital role in successful Stop Smoking Services. We know that a good service will have a huge impact on preventative healthcare, conferring benefits to the service User, their families, communities and wider Health Economy.

2.35 The GP's role in Smoking Cessation is well documented. A well placed intervention from a respected healthcare professional, with offer of pharmacotherapeutic support and referral greatly increases the likelihood of an individual making a quit attempt.

2.36 Primary Care has a guaranteed support from Public Health and the Specialist Stop Smoking Service. By working together, we can support practices to support their patients in a clinically effective way which will directly benefit the Patient, Practice, CCG and local population.

Norfolk Healthy Norfolk Schools

2.37 The key issue which undermines progress in reducing smoking prevalence among young people are availability, affordability and perceived attractiveness of tobacco. Local Healthy Schools, Healthy Child and Healthy Further Education programmes all provide frameworks in which to deliver interventions to children and young people.

Tobacco Control Alliance

2.38 The Norfolk Tobacco Control Alliance is the central hub for tobacco control work in the county. In the past, support for and engagement in the Norfolk Tobacco Control Alliance have been limited and not necessarily a top priority for key partners. This was highlighted by the previous Director of Public Health, Dr Jenny Harries, in her report to the shadow Health and Wellbeing Board on 18 July 2012.

2.39 Over the past 9 months, members of the Norfolk Tobacco Control Alliance undertook a review of their roles and responsibilities and the first meeting of the renewed Alliance took place on 4 April 2013.

Norfolk Tobacco Control Alliance

Reshaping/ restructuring

2.40 The Norfolk Tobacco Control Alliance had been functioning on limited capacity for the last year due to some funding/resource issues. Norfolk Public Health Directorate has recognised Tobacco Control as an important work stream and so support has been put in place. Dr. Augustine Pereira, a Consultant in Public Health Medicine, as the Senior Responsible Officer for Tobacco Control and Smoking cessation activity across Norfolk will be responsible for setting up the alliance. Vicki Wash, an Advanced Public Health Officer, will be providing the support to commission evidence based interventions across Norfolk and Waveney. Ali Naqvi, a Public Health Officer, will be managing the day to day running of the Norfolk Tobacco Control Alliance Network.

Models of approach

2.41 There is some evidence that using regional approach for tobacco control is more effective and beneficial. The example is an approach adopted by the North East of England (FRESH). Here in Norfolk, we will be adopting a "CleaR approach" commissioned by ASH. All training on how to implement the model is provided by ASH. We will be sending our Public Health Consultant, Public Health Officer and Trading Standards Officer to attend this training.

NCC Communications - Becoming Part of Tobacco Alliance

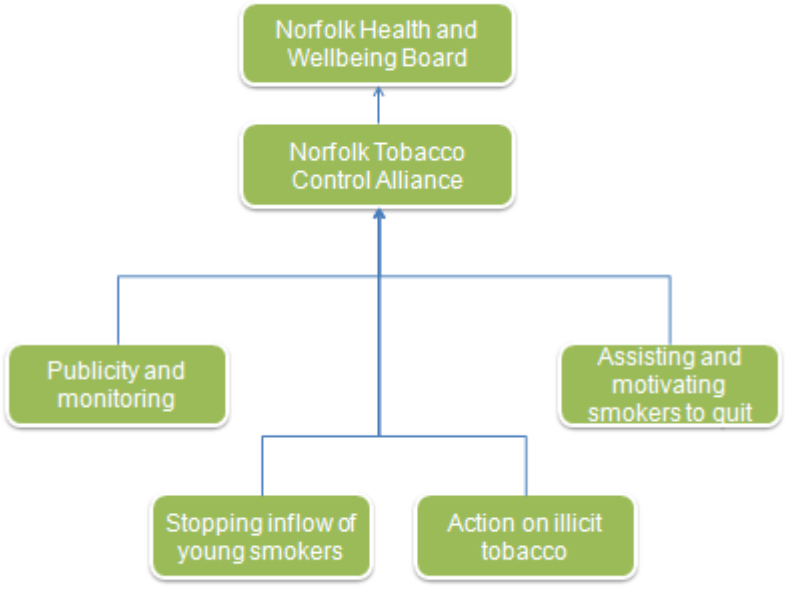
2.42 The NHS East Midlands Public Health Team recently commissioned a piece of work around the role of Communications in Tobacco Control and the minimum set of standards expected within a Tobacco Alliance. The Norfolk and Waveney Public Health department has been working closely with Norfolk County Council Communications Department to ensure that a robust Communications Plan is in place for the coming year.

Norfolk Trading Standards

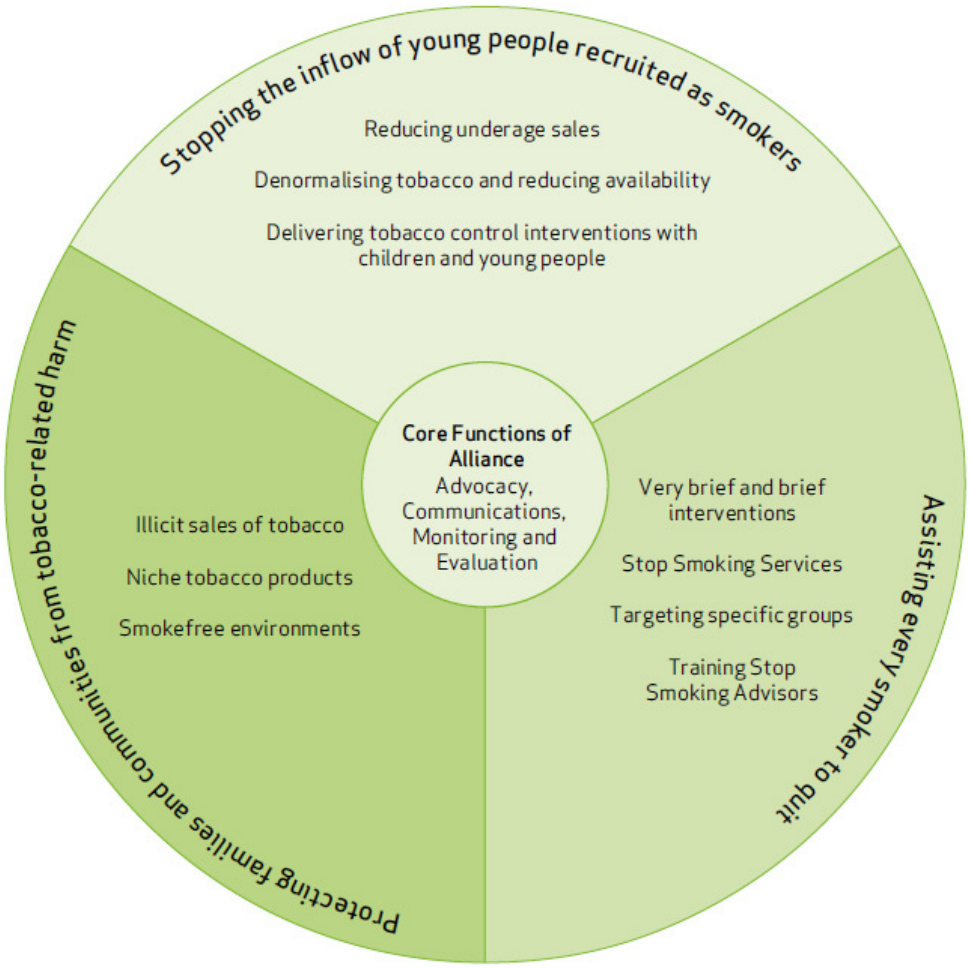
2.43 Norfolk Trading Standards will play an important role in the running of the Tobacco Control Alliance in Norfolk. There has been some restructuring taking place in the Norfolk Trading Standards Department. They will have an individual team whose remit is focussed on stopping the illicit tobacco trade and preventing the sale of tobacco products to those who are underage. Public health is currently in discussions with Trading Standards, to have robust systems and methodologies in place for capturing and evaluating the Trading Standards activity data.

Report from first meeting of Tobacco Control Alliance held on 4 April 2013

2.44 The Norfolk Tobacco Control Alliance met for the first time following a period of inactivity on 4 April 2013. The partnership reviewed the Terms of Reference and agreed on a proposed structure with reporting arrangements to the Health and Wellbeing Board as outlined below. It decided to set up four key workstreams looking at: publicity and evaluation; stopping inflow of young smokers; assisting smokers to quit; and protecting families and communities from tobacco related harm.



2.45 The core functions within each workstream are broadly as outlined in the figure below and will be discussed at the next meeting of the Tobacco Control Alliance in July.



2.46 The leadership for each workstream has been agreed as follows:

Workstream	Lead
Publicity and monitoring	James Dunne - NCC Comms
Stopping Inflow of Young Smokers	Adele Godsmark - School Health partnership Advisor
Action on Illicit Tobacco	Maureen Cleall - Trading Standards
Assisting and motivating smokers to quit	Vicki Wash – NCC Public Health

2.47 The Tobacco Control Alliance will meet on a quarterly basis and all the workstreams will report to the Tobacco Control Alliance through the Tobacco Control Coordinator Ali Naqvi. The Alliance decided on an approach to discuss its vision and strategy at its next meeting and develop the partnership approach to delivering the strategy.

2.48 It was proposed that the members of the Alliance would revisit the appointment of the Chair in the initial year of operations. In the interim, the Chair would be Dr Augustine Pereira.

2.49 The Health and Wellbeing Board is requested to consider who would be able to act as a lead on reducing smoking in Norfolk, highlighting the Tobacco Control Agenda and influencing strategic partners across the health and wellbeing agenda.

3. Discussion

3.1 Transition matters and gaps and opportunities identified

- We are in a time of transition, and as Public Health moves towards an Outcomes Framework within Local Authority, the Stop Smoking/Tobacco Control work-stream will be expected to deliver reduction in prevalence of smoking. This means that from April 2013, the SHA Quitter Target will disappear. NHS Midlands and East have recommended that the 50 quits per 1000 smokers is retained, but as yet reporting mechanisms are unknown.
- Regional Public Health Staff are moving to Public Health England, but there is no dedicated Tobacco Control Post, meaning that the Services will lose an experienced Regional Co-ordinator and the benefits that Regional Co-ordination confers. Public Health England has yet to define their offer of support to the local Public Health Teams, and it is unlikely that the Department of Health will be able to liaise on a local level. This presents a serious risk to the Services. Whilst no-one would argue that Smoking Cessation is not a valuable intervention, the Services need to "sell" themselves in a new arena.
- There is also the issue of Waveney provision. Funding has gone to upper tier local authorities, meaning that Waveney funding has gone to Suffolk County Council. Councils must work together to protect Services which serve the public's best interest.
- With Public Health now in Local Authority, it is an opportunity to work with colleagues on the wider determinants of behaviour, and to denormalise tobacco use through legislation, enforcement and prevention.
- Our priority groups remain a concern. Smoking levels rising across Norfolk and our rates of Smoking in Pregnancy remaining high.
- NICE have recently closed a consultation on Harm Reduction. Future guidance is likely to have a huge impact on the way we deliver Stop Smoking Services.

3.2 Reducing Prevalence

- Reduction in smoking prevalence and reduction of smoking uptake can only be achieved through systematic and comprehensive Tobacco Control (as demonstrated by the FRESH model).
- There is little evidence for the efficacy of delivering Stop Smoking support in schools, and the tactics used to scare young people into never starting smoking has been unsuccessful. Stop Smoking Services should be available to young people wanting to stop smoking, with most forms of NRT licensed for aged 12 year plus.
- The Norfolk Public Health Team (in association with Suffolk County Council, the NHS and Voluntary Sector) is developing a Social Norms approach to reducing risk taking behaviour.

3.3 Key points to consider

The Health and Wellbeing Board is requested to consider the following:

- Note the progress in setting up the Norfolk Tobacco Control Alliance and agree the reporting arrangements suggested by the Alliance
- Note the appointment of Chair, leads of Workstreams and coordinator of the Norfolk Tobacco Control Alliance
- Make a recommendation on Health and Wellbeing Board Champion for the Norfolk Tobacco Control Alliance
- Discuss the role of various partners to improve the health and reduce health inequalities by each partner contributing to the smoking cessation and tobacco control agenda.

4. References

[1] Improving outcomes and supporting transparency, part 1: A public health outcomes framework for England, 2013–2016

[2] Tackling tobacco Lessons from the Reducing Health Inequalities through Tobacco Control Programme Contents. http://ash.org.uk/files/documents/ASH_737.pdf

[3] Healthy lives, healthy people: a tobacco control plan for England, 2011. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124917

[4] Action on Smoking and Health [online] accessed in January 2013 http://www.ash.org.uk/files/documents/ASH_93.pdf

[5] Nottinghamshire County Council, 2012. Tobacco control and Nottinghamshire: Report to the Health and Wellbeing board. [online] accessed in January 2013 LINK

[6] Action on Smoking and Health http://ash.org.uk/localtoolkit/cllr-briefings.html

[7] Action on Smoking and Health [online] accessed in January 2013 http://www.ash.org.uk/files/documents/ASH_95.pdf

[8] Action on Smoking and Health [online] accessed in January 2013 www.ash.org.uk/localtoolkit/docs/Reckoner.xls

[9] The National Institute of Clinical Excellence, [online] accessed in January 2013. http://publications.nice.org.uk/tobacco-phb1/what-can-local-authorities-achieve-by-tackling-tobacco#public-health-policy-and-indicators

[10] The National Institute of Clinical Excellence, [online] accessed in January 2013. http://pathways.nice.org.uk/pathways/smoking

[11] http://www.freshne.com/

[12] Action on Smoking and Health, [online] accessed in January 2013. http://www.ash.org.uk/CLeaR

[13] The National Institute of Clinical Excellence, [online] accessed in January 2013. http://publications.nice.org.uk/tobacco-phb1/what-nice-say

Appendix 3

Norfolk Joint Health and Wellbeing Strategy 2013/14

Introduction

One of the key responsibilities of the Health and Wellbeing Board is to prepare a Joint Health and Wellbeing Strategy. This is what we set out to do with the identification of a set of 11 priorities to work on during the first year of the operation of the Board. The focus upon these priorities has enabled the Board to better understand how it will work and add value to the new system of health, social care and public health in Norfolk. It is acknowledged that further work is required to develop a strategy that articulates the varied health and wellbeing needs across Norfolk and the response of the Board to them. During the course of this year the Board will have the opportunity to look again at the priorities, as the new system enters its first year of operation, and draw upon a wider and more inclusive range of data, information and intelligence to identify the areas of focus for April 2014 onwards.

Roles and responsibilities

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

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

The Act also specifies the minimum required membership of the Health and Wellbeing Board, as the Leader of the upper tier local authority, Directors of Public Health, Children's Services and Community Services, CCGs, and Local HealthWatch. Locally, additional members have been included to help ensure that a broad range of health, social care and public health commissioners and providers are engaged. The membership of the Health and Wellbeing Board in Norfolk is available on the Norfolk County Council website.[1]

The legal responsibilities of the statutory Board members focus upon engagement, cooperation, sharing data, developing and having regard to the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy. For CCGs, these responsibilities also include duties to review how far they have aligned with and help implement the Joint Health and Wellbeing Strategy, involvement of the Board in the annual CCG commissioning plan, promoting service standards, innovation, patient involvement and reducing inequalities. [2]

During the shadow or developmental phase of the Board, members have sought to identify the key roles and responsibilities of the Board above and beyond the legal powers and duties. To date, the members of the Health and Wellbeing Board have agreed that they will not:

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[1] Norfolk County Council Cabinet 23rd January 2012, Item 12, 'NHS Reforms and Norfolk County Council - Next steps towards establishing a Health and Wellbeing Board, and implications of legislation for scrutiny and Local HealthWatch'.

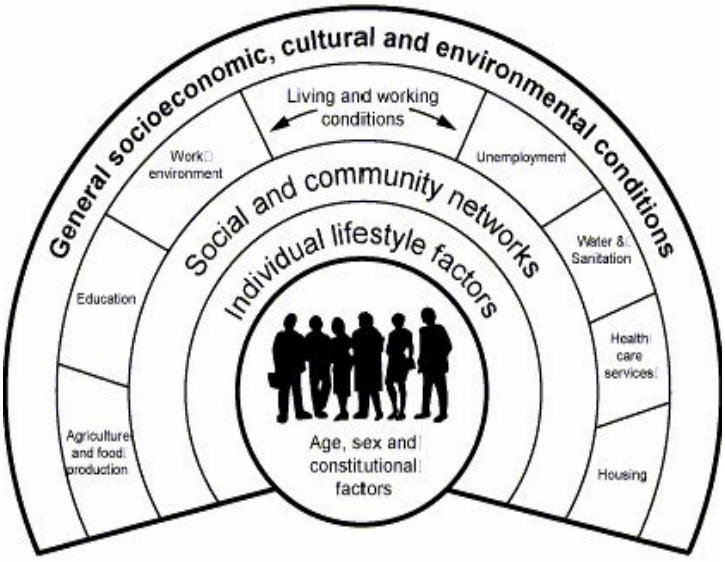
[2] DH (2013) Statutory guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

- Make commissioning decisions, manage commissioning activity, veto commissioning plans, or arbitrate contract disputes
- Agree operational solutions or do operational planning
- Provide 'expert views' on clinical issues or make decisions about prescribing issues.

The context for health and wellbeing in Norfolk

Dahlgren and Whitehead

Health and wellbeing is impacted upon by a range of individual, societal and environmental factors. Some of these are within the control of an individual, such as lifestyle choices, and some are not, such as crime or air pollution. Dahlgren and Whitehead (1991) identified these determinants, as outlined in the diagram below: [3]



The Dahlgren and Whitehead model provides us a route into understanding the factors that affect the health of people in Norfolk.

Norfolk context

When we look at the Joint Strategic Needs Assessment and the annual Director of Public Health Report for Norfolk, it is apparent that although services for older people are a clear and increasing need in Norfolk, the proportion of children living in poverty is also of considerable concern as is the gap in life expectancy related to deprivation in some parts of the county. Tackling obesity and obesity related disease is a major priority for England as a whole and Norfolk is no exception. Other priorities in Norfolk include improving mental health and addressing and/or mitigating the impacts of deprivation and long term unemployment.

Some headline data is provided below and appended in Appendix 1. For more information about the health and wellbeing of people in Norfolk see the Norfolk Insight website - http://www.norfolkinsight.org.uk/.

Population - at the 2011 Census there were just under 858,000 people in Norfolk. The proportion of the population aged over 65 is substantially higher than elsewhere in the East of England and in England as a whole.

[3] Dahlgren and Whitehead (1991) 'Policies and strategies to promote social equity in health'.

Life expectancy - for both men and women is higher than the England average and overall life expectancy is 5.8 years lower for men in the most deprived areas of Norfolk than in the least deprived areas. There are some parts of the county, however, where this gap is significantly wider.

Avoidable deaths - Over the last 10 years, the overall death rate has fallen and early death rates from cancer and from heart disease and stroke have fallen and are better than the England average.

Obesity - An estimated 24.8% of adults in Norfolk are obese. Studies by the National Obesity Observatory (http://www.noo.org.uk/) show that obesity has increased across all social classes for men and women except for women of the professional social class. Obesity carries associated risks of developing conditions such as Diabetes, Stroke, CHD and Cancer. Over the next 25 years if trends continue then across Norfolk and Waveney it is estimated that there will be an additional 50,000 diabetics due to obesity and an additional 9,000 strokes due to obesity. This will impact on demand for services.

Smoking - 1,400 people per year in Norfolk die from smoking attributed diseases. 21.3% of adults smoke and smoking in pregnancy in Norfolk is higher than the England average.

Lifestyles - rates of sexually transmitted infections, smoking related deaths and hospital stays for alcohol related harm are lower than the England average. Levels of teenage pregnancy and alcohol-specific hospital stays among those under 18 are better than the England average.

Mental health - more people in Norfolk than the England average claim incapacity benefit / severe disablement allowance (IB/SDA) where there is a diagnosis for a mental illness. This is true for Great Yarmouth, King's Lynn and West Norfolk, North Norfolk and Norwich. Like long term unemployment IB/SDA is associated with increased premature mortality and reduced disability free life expectancy.

Deprivation - The average annual household income in Norfolk is around £30,900. However, almost 47,400 Norfolk residents live in areas which have been classified as being among the 10% most deprived in England and about 27,000 children live in poverty.

Skills - In general, the qualification levels of Norfolk residents aged 16-64 are lower than regional and national figures. The proportion of people in Norfolk with no qualifications is 13.0% (or 68,100 individuals) which is worse than the national figure of 11.3%.

Unemployment – in the year to September 2012, 25,200 people of working age were unemployed in Norfolk. Unemployment rates are lower than the averages for the East of England, 7.1%, and England, 8.1%.

Crime - for most people Norfolk is very safe. It has one of the lowest crime rates in England. The rate of total recorded offences per 1,000 population for Norfolk is 50, compared with 73 for England.

The members of the Health and Wellbeing Board are in an unique position to influence the key determinants of health and wellbeing as they represent local government, health, social care, public health, community safety, advocacy and both commissioners and providers of services. Together they employ an estimated 42,000 people and control multi-billion pound budgets.

Our priorities and how we decided on them

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

The Health and Wellbeing Board will work to:

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

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

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

The 12 principles adopted by the Board were used to identify its priorities for action. The principles were applied to the long-list of over 40 health, social care and public health priorities for the County, which resulted in a short list of 11. The result is the 11 priorities that now form the basis of the Joint Health and Wellbeing Strategy 2013/14 for Norfolk, as below.

1. **Alcohol misuse**. This is important because each year in Norfolk there are 300 alcohol related deaths, 20,000 alcohol related hospital admissions and about 4,400 alcohol related crimes. The average cost of an alcohol admission to hospital is over £700. Alcohol related hospital admissions cost Norfolk more than £14 million per year.

2. **Smoking**. This is important because 1,400 people per year in Norfolk die from smoking attributed diseases. Overall, smoking costs Norfolk an estimated £226m per annum whilst the estimated expenditure on Tobacco Control activity and interventions is £2.3m per annum.

3. **Healthy eating and weight management**. This is important because being overweight or obese is associated with an increasing risk of diabetes, cancer, and heart and liver disease among others – and the risks get worse the more overweight people become. In Norfolk, it is estimated that by 2020 over 50,000 people will have weight related diabetes. This means that by 2020 Norfolk will be spending over £26m on treating weight related diabetes. These costs do not take into account additional costs of knee replacement, other conditions (such as CHD, Stroke, liver disease, cancer), costs due to loss of work, and social care costs.

4. **Unplanned care/emergency admissions & preventing re-admission.** This is important because the treatment outcomes from unplanned/emergency care are poorer than when planned and people are at increased risk of re-admission/re-referral to hospital and/or community-based services. Each year in Norfolk, after having a fractured hip, there are about 125 emergency re-admissions within 30 days at a cost of about £740,000. There are also 13,500 Ambulatory Care Sensitive conditions admissions per year in Norfolk at a cost of more than £30m. Ambulatory care sensitive (ACS) conditions are chronic conditions that include congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension.

5. **Supporting frail elderly people living independently.** This important because community based services can help maintain older people in their homes for longer and then work out a planned transition into the health and social care services that they need. The average, annual cost of providing residential care for each person receiving that service is £23,868. This compares to £7,696 for Domiciliary Care, £2,704 for Day Care, and £5,304 for Direct Payments.

6. **Carers of older people and people with long term conditions.** This is important because there is estimated to be approximately 80,000 people in the county who have the responsibility of caring for a family member or friend with little or no support. Often these informal carers have health and social care needs of their own that go unmet.

7. **Improving Access to Psychological Therapies (IAPT).** This is important because people with mental health problems account for nearly 40% of people on incapacity benefit and a third of all GPs' time. Only a third of people with diagnosable depression and less than a quarter of those with anxiety disorders are in treatment. The average expenditure on mental health services in Norfolk per year is £146m.

8. **Mental health and employment.** This is important because the mental health of people who are not in work can deteriorate further and lead to significant financial and social problems. In Norfolk, as of May 2011, there were over 11,000 people of working age claiming Incapacity Benefit / Severe Disablement Allowance for mental health reasons.

9. **Dual diagnosis.** This is important because the complexity of issues makes diagnosis, care and treatment more difficult, with service users being at higher risk of relapse, re-admission to hospital and suicide. Care can be fragmented and people can fall down the cracks. In Norfolk, there is estimated to be 17,400 people with a dual diagnosis who are not currently in treatment services.

10. **Young carers.** This is important because children and young people who take on a significant caring role, usually to support family members, are less likely to do well at school, get a job and experience a varied social life when growing up. They are also more likely to suffer emotional stress, live in poverty and be socially excluded. In Norfolk and at any one time, services are working with 450 carers under the age of 18 years. National research has suggested that the number of young carers in the county may be anywhere from 2,000 to 12,000.

11. **Creating good outcomes for all children and young people.** This is important because children and young people who are supported and encouraged from an early age are more likely to realise their potential and lead an independent and healthy life. The Dame Clare Tickell Review, and subsequent OFSTED framework for early years assessment, identifies communication and language, physical development, and social and emotional development as the three prime areas of learning most essential for children's readiness for future learning and healthy development.

The priorities above are those where the Health and Wellbeing Board has identified that it can add value to work that is already underway. Therefore, there may be some areas of work that do not appear as a priority but are recognised as important or pressing.

In addition to the priorities identified above, the Health and Wellbeing Board will look at dementia, fuel poverty, housing and rural isolation to better understand what impact they have upon health and wellbeing in Norfolk.

Dementia – the prevalence of dementia in Norfolk is above the average for England and increasing. In 2010, there were estimated to be 13,236 people with dementia. It has been projected that this will rise to 24,204 by 2030. [4]

Fuel poverty – Households are considered by the Government to be in fuel poverty if they would have to spend more than 10% of their household income on fuel to keep their home in a satisfactory condition. In 2009 it was estimated that over 76,000 households in Norfolk were in fuel poverty. Fuel poverty generally affects households in the more rural areas although there are pockets in Great Yarmouth. [5]

Housing - Poor housing is associated with a wide range of health conditions, including respiratory infections, asthma, lead poisoning, injuries, and mental health. It is also associated with excess winter deaths. Poor quality housing can have a significant impact on the ability of children to do well at school and achieve their potential. This may be a result of increased absence from school due to sickness or lower levels of engagement at school.

Rural isolation - Norfolk is one of the most rural counties in England with 452,270 people living in rural areas, 53.2% of the total population. The three main causes of rural isolation have been identified as lack of income and employment, lack of access to transport and other services and lack of contact with, and help from, relatives, friends and neighbours. [6]

More detailed evidence grids have been produced for each of the priorities, as presented to the meeting of the Norfolk shadow Health and Wellbeing Board on 24 October 2013. [7]

How we will tackle them

As well as through the members of the Health and Wellbeing Board committing to reflect the aims and priorities of the Strategy in their respective strategies and plans, we can chose from a variety of different approaches and tools to improve outcomes in the 11 priority areas that have been identified.

Analysis and research – using the JSNA to understand the scale of the issue, the experience of care and the best practice responses. The JSNA will be formally reviewed, by the Health and Wellbeing Board, on a six monthly basis to ensure that it is working on the key issues for Norfolk.

Localisation – acknowledging that there are local variations in the levels of need and so the order in which different areas will tackle the 11 countywide priorities. There are opportunities for local activity, focussed around CCG and District Council areas. The annual 'Plan on a Page', published by the CCGs, highlights both the alignment with the work of the Board and the local variations in focus. [8]

Integration – fostering greater integration across the health, social care and public health system of service planning, commissioning and delivery.

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[4] Source: Public Health and Norfolk County Council (2011) Norfolk Dementia Needs Assessment.
[5] Norfolk Director of Public Health Report 2012
[6] Commission for Rural Communities (2006), Annual Report
[7] Norfolk shadow Health and Wellbeing Board (24 October 2012) Item 4(b) 'Joint Health and Wellbeing strategy development – next steps'. These can be accessed from the Norfolk Ambition website – www.norfolkambition.gov.uk.
[8] The 2013/14 'Plan on a Page' for the CCGs, that have been made available at the time of writing, are in Appendix 2 to this strategy document

Challenge and hold to account – evidence-led challenge of the way that we plan, commission and deliver services.

Prevent and intervene early – drawing upon the Marmot Review[9] of effective strategies for reducing health inequalities in the country.

Assets-based approaches – which build upon and strengthen local community assets like family and friendship networks, the local environment, existing volunteering, life-long learning, and political activism and participation

Behaviour change – the use of 'nudge' to create and embed 'healthy' defaults and choices as the norm.

A tiered approach

The Health and Wellbeing Board will look to add value to and not duplicate work that is already underway in the County on these priorities. To aid this, a three tier approach has been developed which tailors the level of involvement of the Board according to the scale of the problem that has been identified by an initial investigation. The tiers are 'watching brief', 'commissioning assurance' and 'investigate and report'.

Watching brief – this is where we feel there is currently sufficient focus and attention within the health and wellbeing system. At this stage, the Board could bring little added value, without stretching existing leadership capacity more thinly. However, if the situation changes and concerns were raised, then the Board could decide to take further action. The following have been grouped under this heading:

- Unplanned care/emergency admissions & preventing re-admission
- Frail elderly people living independently
- Creating good outcomes for all children and young people.

Commissioning assurance – this is where we feel there are the right commissioning structures in place to ensure that effective interventions – based on good evidence of what works – are being implemented. Through the Board's role in testing and challenging commissioning, it will specifically analyse and review relevant commissioning plans to assure itself that these issues are being addressed in an integrated way. The following have been grouped under this heading:

- Alcohol misuse
- Smoking
- Healthy eating and weight management
- Dual diagnosis.

Investigate and report – this is where we feel that further information is required, either to understand the issue or to provide clarity about the direction of travel. The following have been grouped under this heading:

- Carers of older people and carers of people with long term conditions
- Improving Access to Psychological Therapies (IAPT)
- Mental health and employment
- Young carers.

[9] Marmot Review (2010) 'Fair Society Healthy Lives'

How we will measure success

There are a range of Outcomes Frameworks for health, social care and public health that underpin the work of the Health and Wellbeing Board[10]. These frameworks have a wealth of different indicators to help understand the progress that is being made with the delivery of the outcomes. At this stage the Health and Wellbeing Board does not want to create an additional reporting burden by designing new indicators. Instead, it will use those that already exist.

Outlined over the page is a summary of some of the indicators that already exist that could be used to measure progress with the 11 strategy priorities.

Priority	**Indicator**[11]
Alcohol misuse	(PH) Alcohol-related admissions to hospital (CCG) Emergency admissions for alcohol related liver disease
Smoking	(PH) Smoking prevalence – adult (over 18s) (CCG) Under 75 mortality from respiratory disease
Healthy eating and weight management.	(PH) Excess weight in adults (PH) Recorded diabetes (CCG) Under 75 mortality from cardiovascular disease
Unplanned care/emergency admissions & preventing re-admission of people to hospital and/or health and social care services, post-intervention	(PH) Hip fractures in over 65s (CCG) Improving recovery from fragility fractures (ASC) Proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation services
Supporting frail elderly people living independently	(PH) Falls and injuries in the over 65s (PH) Excess winter deaths (CCG) Unplanned hospitalisation for chronic ambulatory care sensitive conditions (ASC) Permanent admissions to residential and nursing care homes
Carers of older people and people with long term conditions	(CCG) Helping people recover their independence after illness of injury (ASC) Carer reported quality of life
Improving Access to Psychological Therapies (IAPT)	(PH) Hospital admissions as a result of self-harm (CCG) Recovery following talking therapies (all ages)
Mental health and employment	(PH) Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness (ASC) Proportion of people in contact with secondary mental health services in paid employment
Dual diagnosis	(PH) Successful completion of drug treatment
Young carers	(PH) Pupil absence
Creating good developmental and learning outcomes for all children and young people	(PH) Children in poverty (PH) School readiness

[10] DH (2012) Adult Social Care Outcomes Framework 2013/14, DH (2013) A public health outcomes framework for England, 2013-2016, DH (2012) NHS Outcomes Framework 2012/13, DH (2012) CCG Indicator Set 2013/14

[11] PH denotes Public Health, CCG denotes Clinical Commissioning Group and ASC denotes Adult Social Care

What we have achieved so far

At the April 2012 meeting of the shadow Health and Wellbeing Board we set ourselves the task of being able to answer a series of questions relating to the development of the Health and Wellbeing Strategy.[12] These questions enable us, one year on, to assess how the development of the Strategy has progressed and what further work is required, as follows.

a) What is the context for Norfolk and its communities? (economic, social and financial)

   Response - this is readily available in both the Joint Strategic Needs Assessment and the annual Director of Public Health Report for Norfolk. A 6-monthly review of the JSNA is planned to help ensure that the Board is focussed upon the key issues for Norfolk.

b) What principles and or values are we using to decide priorities?

   Response - the principles have been agreed and applied in the identification of the priorities for the Board. [13]

c) What are the top commissioning priorities for improving and sustaining the health and wellbeing of residents in Norfolk, both pan-Norfolk and by CCG area?

   Response - priorities have been identified for the first year of Joint Health and Wellbeing Strategy but it is acknowledged that further work is required to look again at the priorities, as the new system enters its first year of operation, and draw upon a wider and more inclusive range of data, information and intelligence to identify the areas of focus for April 2014 onwards.

d) What do Norfolk people think about our priorities?

   Response - whilst the 11 priorities have come from a long list of commissioning priorities in Norfolk and so been subject to public consultation in their own right, there is a need to look at how the Board engages with Norfolk people about its work and the focus of its activity, particularly with the development of a three year strategy to run from April 2014. There is also an ongoing requirement to consider the work of the Board in the context of any adverse impacts on people with protected characteristics, as defined under the Public Sector Equality Duty.

e) What are the top commissioning priorities for improving and sustaining health care for patients in Norfolk, both pan-Norfolk and by CCG area?

   Response - priorities have been identified for the first year of Joint Health and Wellbeing Strategy but it is acknowledged that further work is required to look again at the priorities, as the new system enters its first year of operation, and draw upon a wider and more inclusive range of data, information and intelligence to identify the areas of focus for April 2014 onwards.

f) What actions – collectively and as individual organisations – will partners in the health and wellbeing board take during 2013/14 to address these identified priorities?

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[12] Norfolk shadow Health and Wellbeing Board (18 April 2012) Item 5 'Towards a Health and Wellbeing strategy for Norfolk'.

[13] Norfolk shadow Health and Wellbeing Board (24 October 2012) Item 4(b) 'Joint Health and Wellbeing strategy development – next steps'. These can be accessed from the Norfolk Ambition website – www.norfolkambition.gov.uk.

Response – to date we have worked through 5 of the 11 priorities identified for the first year of operation of the Board. The response to the conclusions and discussion points identified is beginning to shape how the Board, collectively and individually, will work together. The response to the priorities has been localised by the CCGs and the District Councils and a strong basis for local working established. It is anticipated that the approach of the Board to identified issues will evolve over the first year of its operation.

g) How will we collectively and individually account for our actions?

Response - some early work has been undertaken to understand how progress with the 11 priorities can be measured. Further work remains to be done to determine the most efficient means of doing this as there is a strong desire not to create another layer of reporting against performance management frameworks.

Overall, progress has been made over the past 12 months in answering most of these questions. However, more needs to be done, particularly in the areas of understanding the changing commissioning priorities for health care/treatment and the prevention ill health, the full range of actions that the members of the Health and Wellbeing Board can take, and then the means by which people are held to account for those actions.

Forward Plan

A plan of work to be undertaken over the next 12 months is being developed, which takes into account national requirements, local priorities and the need of the Health and Wellbeing Board to achieve and make a difference.

The Forward Plan will include key activities like: the 6 monthly review of the JSNA; the annual publication of the Director of Public Health Report for Norfolk; the annual review of the CCG commissioning Plans; and a formal review of the progress that we have made with the implementation of the Health and Wellbeing Strategy.

Raising concerns

The 11 strategy priorities are not a static list but a starting point. As the assessment of health, social care and public health needs in Norfolk changes, in the JSNA, and as the response to the priorities has an impact, so the priorities will change. It is envisaged that there will be a flow of work as issues are addressed by the Board and new ones are identified for consideration.

At this early stage, it is understood that the primary routes in to the Health and Wellbeing Board for any key issues around health and wellbeing will be:

- JSNA - ongoing review of evidence and formal review process twice yearly
- Public Health – health surveillance
- HealthWatch – service user intelligence
- Health Overview and Scrutiny – proposed changes to service configuration.

The National Commissioning Board may also have a role to play in the identification of national and regional priorities.

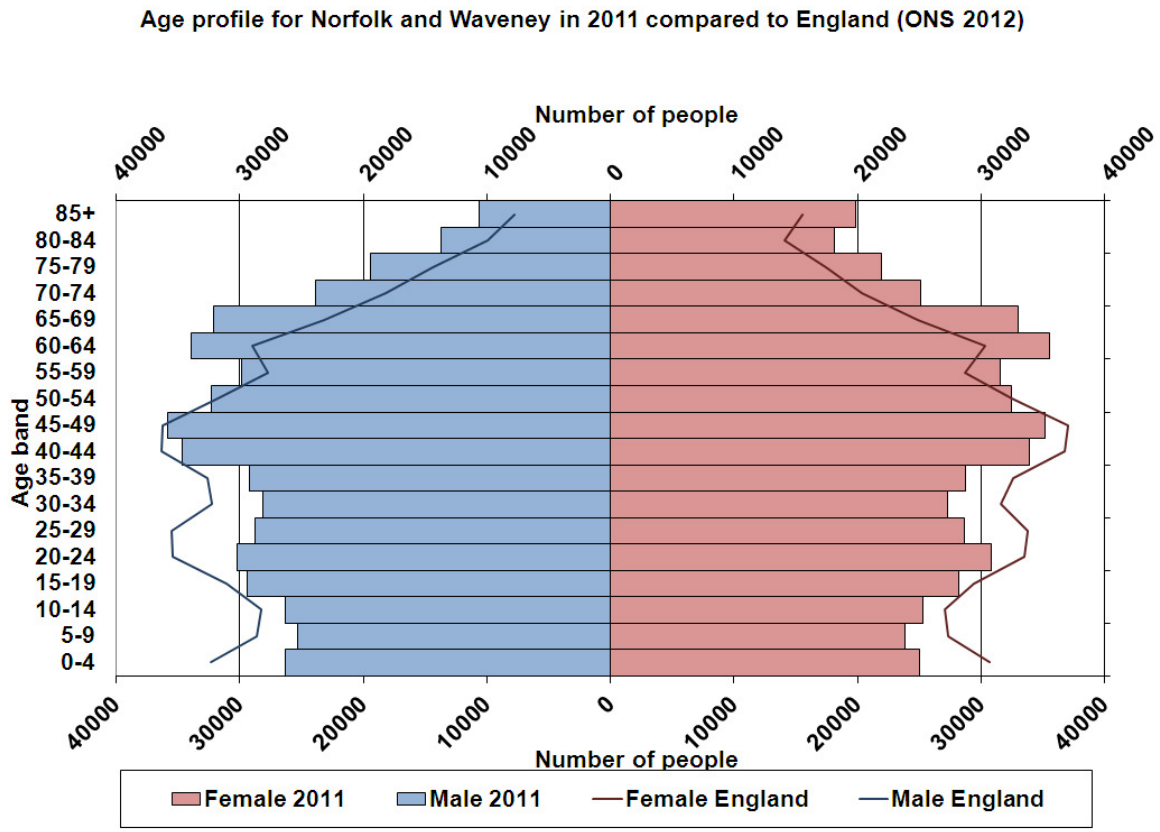
Equality Impact Assessment

The 11 priorities for action that the Health and Wellbeing Board has identified in this strategy have come from a long list of health, social care and public health commissioning priorities for the County. As a consequence they have already been subject to both public consultation and Equality Impact Assessments by those organisations.

The work that is underway in this first year of the Health and Wellbeing Strategy, to more fully understand what intervention is required by the Health and Wellbeing Board to improve outcomes in the priority areas, will result in some specific packages of work. The work packages will be subject to an Equality Impact Assessment, where a proposal, project, service change, strategy or contract is likely to have an adverse impact on people with protected characteristics as defined under the Public Sector Equality Duty.

Appendix 1 – Summary of Health and Wellbeing in Norfolk

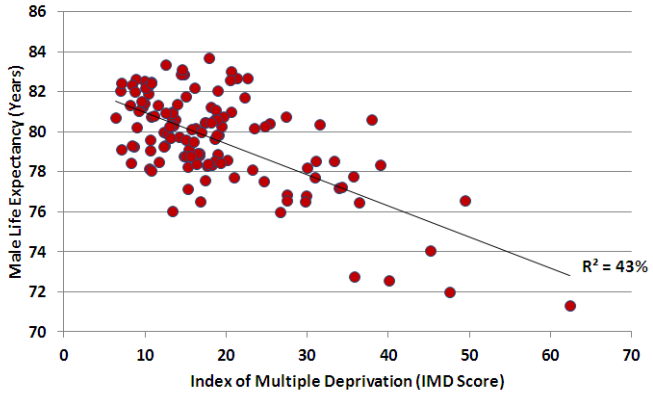
At the 2011 Census there were just under 858,000 people in Norfolk. The proportion of the population aged over 65 is substantially higher than elsewhere in the East of England and in England as a whole.

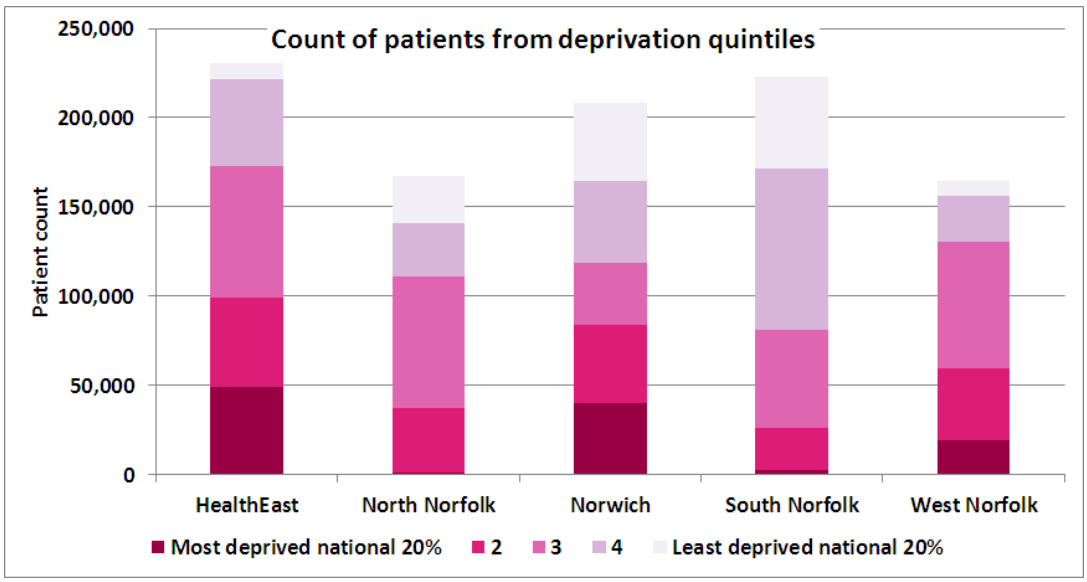


The health of people in Norfolk is generally better than the England average with lower than average levels of deprivation. However about 27,000 children live in poverty and the countywide picture tends to obscure more localised extremes. Great Yarmouth has the highest inequality in child poverty across Norfolk and contains both the area with the highest proportion of child poverty in the County (49%) and 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.

Deprivation is concentrated in the urban areas of Great Yarmouth, Norwich, King's Lynn and parts of Thetford. However, there are pockets of rural deprivation that are not necessarily captured at this geographic level. There is a clear association between deprivation and early illness and disability.

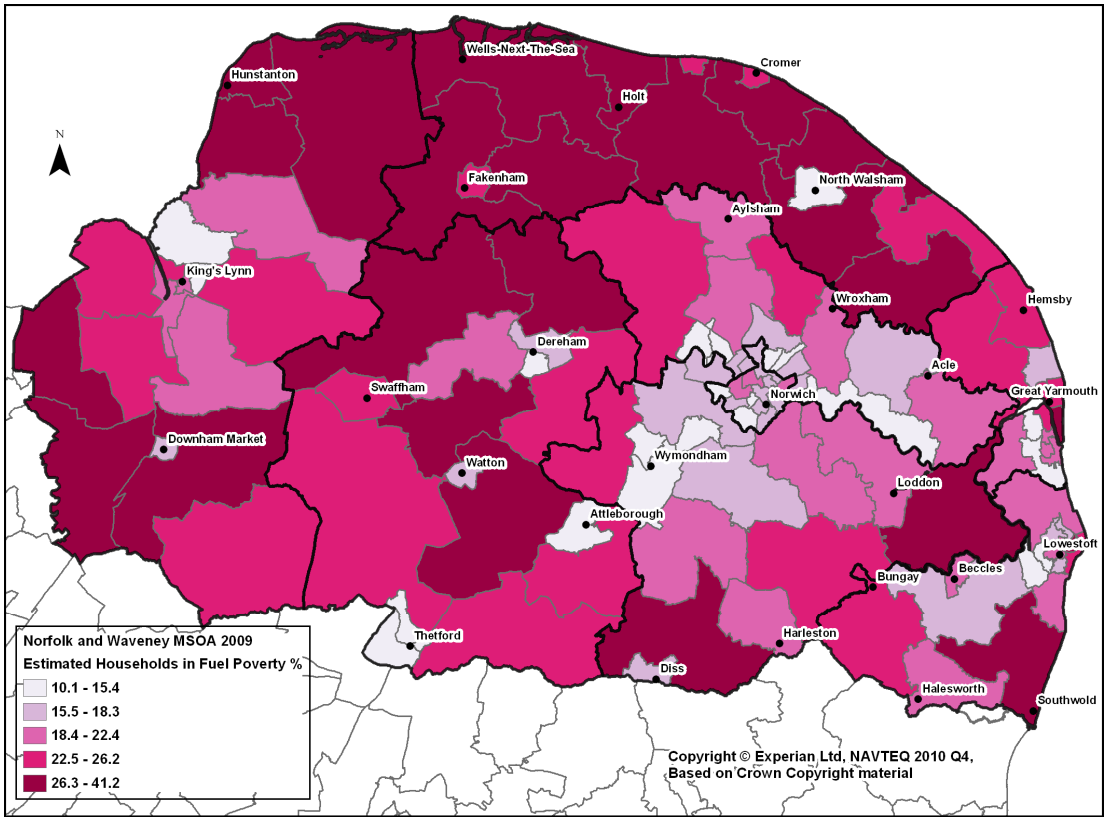
Association between deprivation and male disability free life expectancy at birth (1999 to 2003) for MSOAs in Norfolk and Waveney





Behaviours related to poor health, such as smoking, and low levels of physical activity are more common in deprived areas. The consequences of poverty are seen most clearly in the distribution of physical and mental illnesses and health status. For example, higher rates of male premature mortality, circulatory diseases, COPD and higher proportion of claimants for mental health related incapacity benefit.

Over 76,000 households in Norfolk are thought to be in fuel poverty. Fuel poverty generally affects households in the more rural areas although there are pockets in Great Yarmouth. For example over a quarter of households in North Norfolk are estimated to be fuel poor. Fuel poverty often affects older people and contributes to excess winter death rates and higher winter hospital admissions.



Life expectancy for both men and women is higher than the England average and overall life expectancy is 5.8 years lower for men in the most deprived areas of Norfolk than in the least deprived areas. There are some parts of the county, however, where this gap is significantly wider, up to 10 years difference for men.

Over the last 10 years, the overall death rate has fallen and early death rates from cancer and from heart disease and stroke have fallen and are better than the England average.

The proportion of overweight and obese children at Reception and Year 6 in Norfolk has remained relatively static over the last few years and is not significantly different from the England average. In Broadland and South Norfolk the proportion of children of healthy weight is significantly higher than the England average.

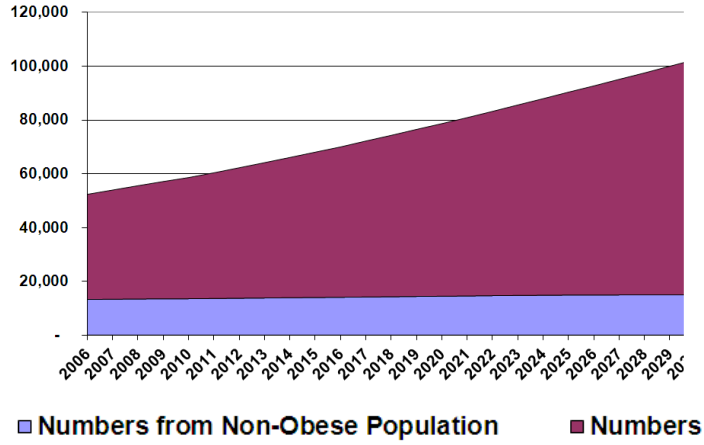
Foundation stage attainment in Norfolk is improving but not as fast as in England or the East of England. For Norfolk as a whole foundation stage attainment is significantly lower than the England average. Only in South Norfolk does the proportion of children classed as having a good level of development exceed the England average. The inequality in foundation stage attainment ranges from 22% in one area of North Norfolk to 79% for an area in Broadland. Levels of GCSE attainment are also worse than the England average.

Levels of teenage pregnancy and alcohol-specific hospital stays among those under 18 are, however, better than the England average.

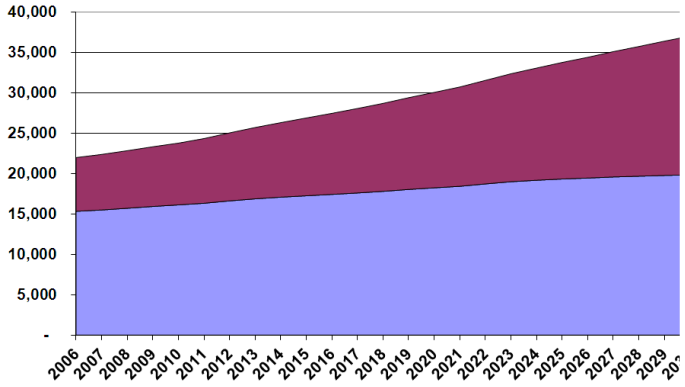
An estimated 24.8% of adults are obese, and the implications of this for the individuals concerned and for the provision of future services are extremely worrying. The two graphs below show the projected increase in two potentially disabling and sometimes fatal conditions associated with obesity.

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



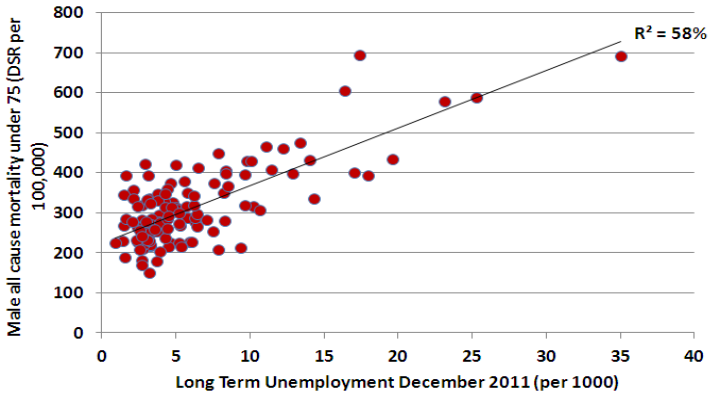
Studies by the National Obesity Observatory (http://www.noo.org.uk/) show that obesity has increased across all social classes for men and women except for women of the professional social class. Obesity carries associated risks of developing conditions such as Diabetes, Stroke, CHD and Cancer. Over the next 25 years if trends continue then across Norfolk and Waveney it is estimated that there will be an additional 50,000 diabetics due to obesity and an additional 9,000 strokes due to obesity. This will impact on demand for services.

Great Yarmouth is estimated to have the highest proportion of obese adults and Norwich the lowest.

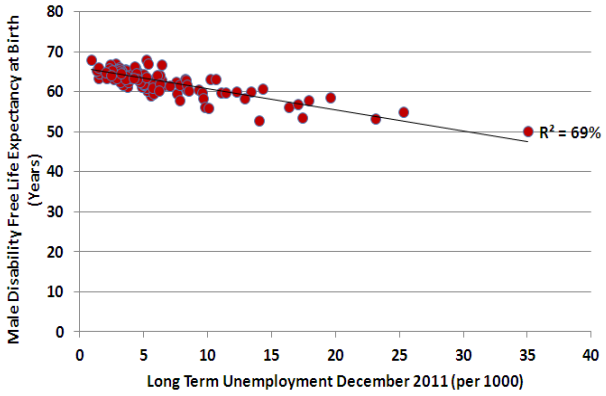
21.3% of adults smoke and smoking in pregnancy in Norfolk is higher than average.

At a time of economic recession, the health impacts of unemployment should be considered as there is a correlation between increased unemployment rates and increased early male death and disability. Long term unemployment for Norfolk as a whole is less than the England average, however in Great Yarmouth and Norwich it is higher. At a more local level long term unemployment is concentrated in the urban areas of Great Yarmouth, Norwich and King's Lynn with other pockets around Swaffam and Dereham. Reducing long term unemployment will improve health outcomes.

Association between male early deaths and long term unemployment



Association between male disability free life expectancy and long term unemployment



More people in Norfolk than the England average claim incapacity benefit / severe disablement allowance (IB/SDA) where there is a diagnosis for a mental illness. This is true for Great Yarmouth, King's Lynn and West Norfolk, North Norfolk and Norwich. Like long term unemployment IB/SDA is associated with increased premature mortality and reduced disability free life expectancy.

IB / SDA with diagnosis of poor 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 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

In summary, although services for older people are a clear and increasing need in Norfolk, the proportion of children living in poverty is also of considerable concern as is the gap in life expectancy related to deprivation in some parts of the county.

Tackling obesity and obesity related disease is a major priority for England as a whole and Norfolk is no exception. Other priorities in Norfolk include improving mental health and addressing and/or mitigating the impacts of deprivation and long term unemployment.

Appendix 1 – Clinical Commissioning Groups 'Plan on a Page' 2013/14

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

NHS
North Norfolk Clinical Commissioning Group

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

Our Five Priority Areas:

Older People

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

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

Mental Health

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

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

Planned Care

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

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

Unplanned Care

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

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

Children

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

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

We will deliver:

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

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

Key Risks:

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

We will manage these risks by:

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

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

OUR VISION

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

OUR 4 STRATEGIC GOALS

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

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

Strategic Plan on a Page for 2013-2014

NHS

Norwich Clinical Commissioning Group

KEY TRANSFORMATIONAL AREAS (QIPP)

Healthy Norwich

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

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

Urgent Care

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

Planned Care

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

Prescribing

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

Continuing Healthcare

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

Quality & Safety

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

KEY RISKS

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

RISK MITIGATION

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

South Norfolk CCG

Context	Vision	Aims	Strategies	QIPP Work-streams	Outcomes	Programmes	Initiatives include	Engagement	Governance
High incidence of long term conditions Ageing population Unhealthy lifestyles Health inequalities Variations in access to services Financial restraints and challenges	Delivering the highest quality integrated healthcare in order to improve the health and th Norfol	Promoting a safe and innovative approach to clinical commissioning, fully utilising local and challenge our processes	Fully integrated community health & social care teams	Frail older people £1.8 million efficiency saving	•Right care, right setting, right team •Improvement in patient reported outcomes •Increased % of patients who die in their preferred place of care	Integrating health and social care Integrated pathways of care Case management	•Frail & older people project (FOPP) •End of life/continuing care pathway improvement. •Reablement •Falls service review •Pathway and service integration	Patient and Public Engagement – 'Your Voice Portal', SNCCG Public Website, Patient and Public Groups, County Media Stakeholder Engagement – Voluntary Sector, Local Councils, MPs, Providers, Charitable Groups Member Engagement – Locality meetings, Website, Involvement in Pathway Development	Organisational Risk Register Monthly Performance Monitoring Programme Management Individual accountability
			Review referral rates, prescribing and outcomes to minimise unwarranted variation	Planned care and tackling variation £4 million efficiency savings	•Clinically effective, integrated pathways of care •Reduced variation in referrals •Reduced variation in access •Promotion of patient choice •Improve quality of referrals to hospital •Improve quality and value for money of hospital care	Redesigning care pathways Referrals management Prescribing practice Reviewing thresholds for surgical intervention	•MSK pathway review •Remodel audiology •Review pain, Upper GI, dermatology & T&O pathways •Access to community diagnostics •Prescribing incentive schemes		
				Emergency and urgent care £1.4 million efficiency savings	•Improved management of LTCs •Less reliance on acute sector •Reduced variation in access •Reduce variation in, and improve performance of providers	Reforming the urgent care system Avoiding unnecessary hospital admission(s)	•Reduce levels of cardiac hospital admissions •A&E attendance followed by zero length of stay •Chest pain diagnosis •Stroke service review •Local 111 service •Local out of hours		
			Promotion of healthy lives, well-being self management	Mental health	•Personalised budgets •Implement national dementia strategy	Improving management of dementia Improving access to psychological therapies	•Implement dementia strategy •Organic mental health pathway review •Review ADHD pathway •LD access		
				Women and children	•Reducing levels of childhood obesity •Improve children's	Tackling childhood obesity	•5 year health y weight strategy •Procure TOP local		

13/14 Plan on a page

NHS
West Norfolk Clinical Commissioning Group

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

Clinical Quality and Patient Safety.

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

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

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

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

Report to Norfolk Health and Wellbeing Board

17 April 2013
Item No 7

Community-led Health Improvement Programme

Report by the Interim Director of Public Health

Summary
This report summarises the progress made in setting up a community-led health improvement work programme based on two place-based approaches to health improvement - Healthy Towns and Ageing Well. The report outlines the two approaches, the key activity to date, governance arrangements and proposed action.

Action
The Health & Wellbeing Board is asked to:

- Comment on the approach and the 10 communities identified from the health evidence base
- Work with appropriate local partnerships to identify how and when to take forward either healthy town or ageing well initiative in that area
- Replace the steering group with a locality implementation group, to co-ordinate the roll-out of the programme

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.

1.2 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, the factors that impacted on their wellbeing, and to take the lead in identifying and implementing solutions.

2.3 It was agreed that this was an opportunity for the Board, in its role as system leader, to embrace the community-led health improvement model behind the two specific approaches, Healthy Towns, Ageing Well, and to seek to promote them and accelerate their implementation, where there was a need and appetite from the local community.

2.4 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 the County Council's allocation of 2nd homes monies, with the decision about the specific sum being for the Leader of the Council.

2. Healthy Towns and Ageing Well

2.1 The Community Led Health Improvement programme has drawn upon national evidence (National Institute of Clinical Excellence), research (a number of journal reviews), information from similar projects nationally and the lessons learnt from both respective County pilots (Ageing Well and Healthy Towns).

2.2 Norfolk's approach to 'Ageing Well' is based on the Older People's Strategy 'Living Longer, Living Well' which has a clear focus on prevention.

2.3 Ageing Well programme activities have already taken place in 3 very different Norfolk localities – Breckland, Great Yarmouth and Norwich, as part of a pilot in 2012. They were chosen because they represented a mix of rural, coastal town and city environments and varied in the degree to which they already had community-based initiatives in place.

2.4 Norfolk's approach to 'Healthy Towns' began after Thetford was selected as one of 9 areas to receive a share of £30million Department of Health investment in November 2008

2.5 The Thetford Healthy Town (THT) Programme devised a number of individual projects and schemes to meet the long term goals of the project. The key primary objective was to embed a healthy lifestyle in a rapidly growing town, by ensuring health is fully integrated into the growth plans and regeneration projects.

2.6 The secondary objective was to deliver a series of highly visible initiatives on the ground, within existing communities (which are very diverse, with a high migrant population) some building on good practice and other new initiatives, not only to encourage healthier lifestyles within existing communities in Thetford but to foster a town wide understanding and commitment to deliver, a community with healthy lifestyles at its heart.

2.7 To achieve these objectives, the programme delivery was centred around increasing the knowledge and the understanding of the Thetford community and their health needs and aspirations and to build on existing good practice in health promotion and the prevention of poor health outcomes using a community development approach.

2.8 The approach taken by both pilots is one of asset-based community development, community and stakeholder consultation / engagement and the development of key solutions and ideas, as described in further detail below:

a) Asset mapping:

- Individual people's assets (e.g. personal skills, experiences, time) relative to the local area, including health and ageing related discussions;
- Community assets (e.g. neighbourhood boards, community clubs, libraries, local amenities) within a locality.

b) Identifying key common or recurrent issues:

- Perceived community health problems, barriers to independence and wellbeing (gaps in provision, perceived and actual barriers).

- Other areas of concern or interest linked to health, wellbeing and ageing.

2.9 Developing good ideas, using the (individual and community) assets identified, to:

(i) Tackle the common issues / provide solutions

(ii) Facilitate Ageing Well and Healthy Communities in the localities identified.

(iii) Setting up of local community based groups to support the health and ageing well agenda and to develop and promote the good ideas and solutions developed.

2.10 The overall outcome the Community led Health Improvement programme is to deliver and maintain a community led outcome focused project which will be led and shaped by the localities we work with.

2.11 The programme, although having a standardised approach throughout the County, most importantly will take into account local consultation, community perceived health problems and work with local communities to develop solutions to improve these with the support and capacity of health improvement officer's intervolving around the local arrangements.

3. Evidence based approach to rolling out community-led health improvement

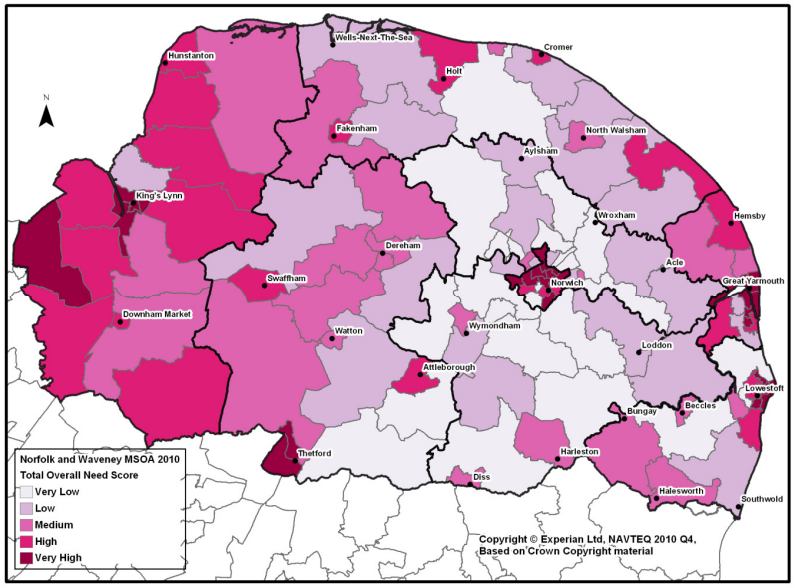
3.1 We have used a multiple health outcome score to identify where the 'overall health need' is amongst our towns in Norfolk. The 10 suggested communities were selected using this health deprivation score and taking into account population, demographic type (Ageing Well priority) and geographical spread.

3.2 The indicators we have used are all those from the Director of Public Health report and additional indicators at Middle Layer Super Output Area (MSOA) level. The indicators were grouped into the following categories

- Demography and Deprivation
- Children and Young People
- Working Age
- Older People
- Emergency Care
- Mortality and Inequality
- Total

3.3 The MSOA values for the different indicators (% rates Counts etc.) have been standardised to z scores (standard scores). At the moment all the public health indicators have equal weight. However, this could be changed in the future (to reflect different health outcomes). The weighted scores have then added together to arrive at the overall score for the MSOA. We have also taken into account where the past pilots for Ageing Well and Healthy Communities have taken place.

3.4 Error! Reference source not found., below, shows the MSOAs with the highest overall need.



3.5 The 10 communities we have identified are:

Phase 1:	Fakenham	Cromer	Diss	Wymondham
Phase 2:	North Walsham	Hunstanton	Downham Market	
	Kings Lynn (ward)	Great Yarmouth (ward)	Hemsby	

Please note that Ageing Well will only take place during Phase 1.

4. Turning the evidence into a programme of work

4.1 The areas, as detailed in section 3 above, have been identified on a data/desk-top approach and has not – to date – taken into account any existing programmes or initiatives already taking place within the local communities, or the capacity of the local area to respond to the programme. This work will be undertaken in the next phase, and forms part of the asset based development and mapping work.

4.2 It is a priority of the programme to identify existing arrangements and priorities at a local level and to make sure that the programme works in synergy with these. Since the work began on this programme there has been considerable progress on local partnerships - particularly between CCGs and district councils which will prove to be very important partners and influencers for this programme. Discussions have taken place with CCG engagement colleagues in North Norfolk and South Norfolk to discuss the CLHI programme and how it fits into Local Authority and CCG priorities.

4.3 Work will continue with the NCC Community Engagement steering group, Local District Councils and other organisations e.g. Norfolk Rural Community Council and CCG's to map out existing projects that may be taking place within the identified communities, and where applicable how we can work with these.

4.4 The next steps for the programme would be to formalise discussions and plans with local partnerships and organisations and agree a delivery and action plan with them as to when and how to take forward the Community led health improvement programme in that area.

5. Governance and reporting

5.1 To date, a small working group of Director of Public Health (Chair), Assistant Director of Public Health (Strategy, Performance and Resource), Director of Children's Services, Director of Community Services, Head of Planning, Performance and Partnerships, Assistant Director of Community Services (Prevention) has been helping to shape and steer the thinking

5.2 Given the importance of local leadership and involvement in the programme, views are sought on whether it would now be more appropriate for a working group of district health leads with CCG engagement officers, and with public health officers to steer the process. This approach has worked effectively for two years in the work around the Winter Warm and Well initiative.

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5.3 The timescales that we are working to are:

Phase 1	First 4 Communities (Ageing Well and Healthy Communities) April 2013 – April 2014.
Phase 2	Remaining 6 Communities (Healthy Communities project only) September 2013 – July 2014.
Phase 3	Evaluation and reporting. July 2014 – September 2014.

5.4 The next report to the Health and Wellbeing Board will be in October 2013 and consist of an update on progress to date, details of the programme infrastructure including membership of the steering group and localised reference groups.

6. Action:

The Health & Wellbeing Board is asked to:

- Comment on the approach and the 10 communities identified from the health evidence base
- Work with appropriate local partnerships to identify how and when to take forward either healthy town or ageing well initiative in that area
- Replace the steering group with a locality implementation group, to co-ordinate the roll-out of the programme

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communication for all

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

Report to Norfolk Health and Wellbeing Board
17 April 2013
Item No 8

Voluntary Sector Engagement Project - Update Report, March 2012- March 2013

Report by the Head of Operations, Voluntary Norfolk

Summary
This report outlines the work of the Voluntary Sector Engagement Project in securing the active engagement of the voluntary sector in the emerging health and social care landscape and the work of the Health and Wellbeing Board. It outlines the focus and key activities over the last 12 months.

Action
The Board is asked to:

- Consider the contribution being made by the Voluntary Sector Engagement Project to the emerging health and social care agenda and the work of the Health & Wellbeing Board, and offer any comments on the focus of that work for the year ahead
- Set up a small Steering Group to provide the strategic lead and oversee the project for the coming year, and appoint Debbie Bartlett, Head of Planning Performance & Partnerships, as the Lead Officer for that sub-group

1. Background

1.1 At its meeting in April 2012, the Shadow Health & Wellbeing Board (H&WB) considered a report by the Chief Executive of Voluntary Norfolk about the Voluntary Sector Engagement Project (VSEP) which had been set up under previous county strategic partnership arrangements to support the engagement and involvement of the voluntary and community sector (VCS) in the changing landscape of health, wellbeing and clinical commissioning.

1.2 The Board noted that during 2011-12 the project had been funded via the Norfolk County Strategic Partnership, through the use of 2nd Homes monies, and managed by Voluntary Norfolk. From 2012-13 the responsibility for funding this work had passed to the County Council with the disbandment of the previous NCSP structures. Current funding for this Project is outlined on the agenda at item 9.

1.3 The Board endorsed the contribution being made by the Voluntary Sector Engagement project to the emerging health and social care agenda, and the work of the Shadow Board.

2. Focus

2.1 The project focuses on ensuring there are effective mechanisms and routes so that the specialisms and expertise of voluntary organisations working in health and social care can feed into, and help shape, the priorities and plans of public bodies such as the Health and Wellbeing Board, Norfolk Public Health and the five Clinical Commissioning Groups.

2.2 The project focuses its activity under the following objectives:

- **Information and communication** to ensure the VCS is up-to-date on developments and opportunities relating to health and wellbeing and to act as a channel for communication to the VCS from public sector partners

- **Capacity building** to enable the VCS to engage in a sustainable way to the health and wellbeing agenda

- **Strategic voice & advocacy** to facilitate opportunities for dialogue and representation between the VCS and relevant public sector partners

3. Outline of Key Activities over the last 12 months

3.1 Health & Wellbeing Board

a) Ensuring the **3 Voluntary Sector Representatives** are well briefed and supporting them to carry out their role
b) Attending HWB Meetings and summarising main points of relevance and interest for the VCS. (Subsequently circulated to c. 100 senior VCS chief executives and Managers.)
c) Establishing & updating Voluntary Norfolk's **webpage on the HWB** http://www.voluntarynorfolk.org.uk/nhawb.
d) Profiling the engagement of the VCS in Norfolk's HWB in a Regional Voices case study. (Regional Voices is a national VCS network operating as part of the Department of Health's Strategic Partners Programme.)
e) Leading/contributing to data for the **Joint Strategic Needs Analysis**

- In partnership with the Norfolk Insight Team, and the Mental Health Provider Forum, survey and published report on **mental health** services delivered by the VCS & identification of common issues impacting on service users.
- In partnership with the Norfolk Drug & Alcohol Partnership (N-DAP), survey of VCS organisations (especially those 'not on the radar' of N-DAP) delivering services that support **substance misusers** and/or their families. (Survey closed 1st March.)
- In partnership with the Norfolk Community Advice Network Strategic Partnership and Public Health, we are currently developing a piece of work/event to assess the knock-on consequences of **welfare reform** on Norfolk's Health & Wellbeing Priorities. The focus will be especially where impact is likely to increase the pressure on health and social care services - such as by low-income working families.

3.2 Adult Social Care

a) Over the year the project has continued its involvement in the **Universal Services Project** – including advising on the Living Well in the Community Fund criteria and grants procedure. We continue to attend the **Locality Provider Forums** (run by the Integrated Health & Social Care Commissioning Teams) and in December participated in a review of their operation.

b) In October we delivered a successful event about the implications of the '**Caring for our Future'** proposals on meeting the long-term care needs of older people and their carers. Key speakers included Harold Bodmer, Phil Wells (Age UK Norwich) and John Newstead (Crossroads Care East Anglia). Feedback from the event contributed to consultation being undertaken by the National Association for Voluntary and Community Action (NAVCA) who, like Regional Voices, are

part of the Department of Health's Strategic Partners programme. We were one of only 5 areas in the country who held a consultation event.

c) We are currently working with the Adult Social Care Prevention Lead and the PCT's Knowledge Manager on systematically incorporating health and wellbeing services delivered by the voluntary sector onto their **directories of services**.

3.2 Clinical Commissioning Groups

a) Regular communication with CCG colleagues – particularly the Engagement Officers

b) A framework for the development of 'structural relationships' with a pilot CCG is currently being scoped

c) Ensuring the VCS are informed and up-to-date on CCG developments, including consultation opportunities and CCG briefing events

d) Delivery of joint District Council/CCG events for the VCS. Currently working with NN CCG & NN District Council. (Scope for more events in pipe-line.)

3.3 Mental Health Trust

We have worked with the Mental Health Trust to deliver voluntary and community sector events with providers of mental health/ wellbeing services. The Trust is keen to forge closer links with the sector. The first event, in Norwich in February, was attended by 100 or so people, and dates for events in Great Yarmouth & West Norfolk are approaching. An Action Plan, based on the outcomes from the events, will shape how that relationship is taken forward.

3.4 Information, Communication & Support

The VSEP reaches a wide variety of voluntary and community organisations of all sizes that offer essential health and wellbeing community services contributing to the prevention agenda, providing knowledge for statutory bodies on their activities and enabling their engagement with and influence on key topics. Activities include:

a) VSEP e-bulletins - primarily intended for chief executives and senior managers in the voluntary and community sector, copies are often circulated to relevant public sector colleagues across the County Council (Adult Social Care, Public Health, Children's Services), District Councils & CCGs. (Feedback from both sectors suggests recipients find them extremely useful.)

b) In June we ran two very successful sessions focused on increasing the sector's capacity and confidence around procurement processes - led by the Head of Procurement for Norfolk County Council, whose input and response to questions was much appreciated; and consortia development – led by NCVO who drew on examples of practice elsewhere in the country.

c) Smaller, niche providers (whose resources tend to limit capacity to engage strategically), are supported in a number of additional ways, including one-to-one advice on service profiling for health/wellbeing commissioners and opportunities to be involved in direct dialogue with senior public sector officers through participation in health/social care events.

3.5 Voluntary Sector Networks & Forums

The Project is engaged with a number of forums which provide a vital link into collective voices and expertise. As well as key for updating members, they are also routes for engaging with public partners on service specific and cross-cutting health and wellbeing issues. The forums the VSEP engages with include:

a) Mental Health Providers Forum
b) Carers Agency Partnership
c) Norfolk Community Advice Network Strategic Partnership
d) Voluntary Sector Forum for Children & Families
e) Older People's Strategic Partnership

There is also the overarching Joint Statutory Voluntary Sector Forum which brings together the Forum Chairs with senior officers e.g. Director of Community Services & Director of Children's Services. (This is the Forum that elects the 3 VCS representatives to the HWB.)

3.6 More information

- More information is available on-line at: http://www.voluntarynorfolk.org.uk/voluntary-sector-engagement-project

- Also, attached for information is a case study on the Norfolk Health & Wellbeing Board's engagement with the sector prepared by Regional Voices for Better Health, which champions the work of voluntary and community organisations to improve health, well-being and care across England (Appendix A).

4. Action

4.1 The Board is asked to:

- Consider the contribution being made by the Voluntary Sector Engagement Project to the emerging health and social care agenda and the work of the Health & Wellbeing Board, and offer any comments on the focus of that work for the year ahead
- Set up a small Steering Group to provide the strategic lead and oversee the project for the coming year and appoint Debbie Bartlett, Head of Planning Performance & Partnerships, as the Lead Officer for that sub-group

Contacts

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Norfolk Health and Wellbeing Board Engagement with the Voluntary Sector

What is the structure of the Norfolk health and wellbeing board?

Norfolk is a two-tier area. There are 26 members on the board including Norfolk's five clinical commissioning groups (CCGs) and seven district councils. (One CCG runs into Suffolk.) In preparation for transition to become fully established, board membership was recently reviewed, but is likely to remain the same as this size leads to richness of discussion[1].

How is the voluntary sector involved in the health and wellbeing board?

The local authority asked the two VCS Norfolk local support organisations (Voluntary Norfolk and West Norfolk Voluntary and Community Action) how best to bring in engagement from the VCS. Three seats were available and following consultation with other sector leaders it was agreed the places be nominated from the Joint Health and Social Care Voluntary Sector Forum (a forum made up of chairs from a range of voluntary sector networks). A 'role description' sets out that representatives attend on behalf of, and are accountable to, this Forum. Representatives also feed back to their own networks. Their voice at the board is one of the voluntary sector as a whole and of service area specialisms (not one from their particular organisation)[2]. The three places are in addition to the statutory seat for Healthwatch.

How are the representatives supported?

The representatives are supported by the Manager of the Voluntary Sector Engagement Project which is funded through Norfolk County Council[3]. This post supports engagement of the voluntary sector in the health and wellbeing landscape. This funding is important not only because it provides resources (such as policy briefings) but because it sends a signal about the importance of involving the voluntary and community sector. The County Council has a good track record having previously supported VCS engagement in the Local Area Agreement.

The value of voluntary sector voice to the health and wellbeing board:

Debbie Bartlett at Norfolk County Council says: "The voluntary sector reaches into all parts of Norfolk, we get grassroots information from them and can harness their energy and networks for health improvement. It has a unique perspective, very often more citizen focused than the local authority. A thriving voluntary sector makes for stronger communities, where people support each other. Norfolk has a good track record of partnership working with the VCS. It is a challenge for public sector bodies to work with the breadth and diversity of the sector- and it has taken a few years to find a way to do that that doesn't bombard all organisations- rather to go through recognised and known networks. We fund Voluntary Norfolk to perform a brokering role, to enable the engagement of smaller organisations as well as the bigger ones. It is their role to keep smaller organisations in touch, interpret things- what it means for them. The approach is broadly well received."

Where is the health and wellbeing board up to?

The board has shortlisted its priorities using a scoring matrix, taking into account whether collective action will help impact on the issues[4]. Through the framework of the Local Area

Agreement the voluntary sector had worked closely with a joint public sector officers group who met regularly to work towards LAA indicators. However, as the health and wellbeing board is an emergent structure, there isn't yet in place an operational network under the strategic board, but it is anticipated this will develop in time, for example through task and finish groups.

Is a seat at the table important?

Public partners often say that most of the work goes on away from the table, and whilst this may be true for the public sector, if the voluntary sector doesn't have a seat at strategic tables, it is much more difficult to influence what goes on away from it. Structural relationships puts the sector in a much stronger position to inform and contribute perspective. It is important for the voluntary sector to be on the Board and to make the agenda work for the vulnerable people it works with.

What are the successes of the voluntary sector representatives to date?

Voluntary Norfolk, and the networks we work with, have found that you need to take a long view to getting things taken up by the health and wellbeing board. For example, recommendations from a piece of research undertaken 12 months ago by Voluntary Norfolk on how to improve outcomes for people with mental health needs was only recently brought to the health and wellbeing board as evidence. (The research was undertaken with JSNA colleagues and published on Norfolk Insight – the 'portal' that hosts Norfolk's JSNA[5].)

It's important to keep knocking on the door and raising important issues. It's an evolving agenda and landscape so it can be difficult to be heard first time.

What is still to do?

We are seeking to develop sector engagement with the CCGs. We are also working with the County Council and the NHS Commissioning Support Unit to profile voluntary sector services in health and social care directories. A survey to raise awareness of organisations delivering substance misuse services has recently been undertaken (with Norfolk Drug & Alcohol Partnership). The voluntary sector representatives have shared research on the impact of welfare reform[6] and are currently organising an event for the health and wellbeing board to raise awareness of the likely consequences for vulnerable people and the knock-on effects on local health and wellbeing outcomes.

Further Information

1. Membership of Norfolk's Shadow Health and Wellbeing Board:
http://www.voluntarynorfolk.org.uk/data/healthwellbeingboard/Membership_Shadow_Board_2012-2013.pdf
2. Role of Voluntary Sector Representatives to the Norfolk (Shadow) Health and Wellbeing Board
http://www.voluntarynorfolk.org.uk/data/healthwellbeingboard/Role_VCS_Reps_to_HWB_-_Aug_2012.pdf
3. Link to the Voluntary Sector Engagement Project:
http://www.voluntarynorfolk.org.uk/voluntary-sector-engagement-project
4. Link to the health and wellbeing board's priorities:
http://www.norfolkambition.gov.uk/view/ncc112242
5. Understanding mental health services & needs in Norfolk:
findings & perspectives from the voluntary sector
http://www.norfolkinsight.org.uk/Custom/Resources/MHServicesNeedsInNorfolk.pdf

6. Welfare Reform – the effects on the people of Norfolk
http://www.norfolkcan.org.uk/media/docs/Welfare_reform_in_Norfolk_-_Full__report_November_2012.pdf

Thanks to Claire Collen at Voluntary Norfolk for supplying the information for this case study. **Voluntary Norfolk** promotes, supports and develops volunteering and the work of voluntary organisations.

And thanks to Debbie Bartlett at Norfolk Local Authority for sharing her thoughts on working with the voluntary sector.

If you require this information in an alternative format or further information email or call:
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14 March 2013

Report to Norfolk Health and Wellbeing Board

17 April 2013
Item No 9

Health & Wellbeing Board – Budget Report

Report by the Head of Planning, Performance and Partnerships

Summary
This report sets out the Health & Wellbeing Board's funding arrangements, outlines expenditure to date and proposals for 2013-14.

Action
The Health & Wellbeing Board is asked to consider the report and endorse the proposals.

1. Background

1.1 The Health & Wellbeing Board does not directly control significant health and health care spending. The £1.4 billion health and social care budget for Norfolk is the responsibility of key organisations on the Board, who in turn commission services to improve health and health care of Norfolk's residents.

1.2 However, in 2012, Norfolk County Council agreed to allocate a proportion of its monies raised through second homes council tax to support health & wellbeing, and the same allocation has been agreed for 13/14.

1.3 This paper reports spending against last year's allocation, and puts forward proposals for this year's funding.

2 Health & Wellbeing allocation 2012-13

2.1 The sum allocated for 2012-13 for the health and wellbeing agenda was £370,820. These funds were allocated as follows:

Community–led Health Improvement Programme	£290,000.00
Voluntary Sector Engagement Project	£70,000.00
H&WB development and contingency	£10,820.00

Community-led Health Improvement Programme

2.2 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, the factors that impacted on their wellbeing, and to take the lead in identifying and implementing solutions.

2.3 The Board agreed that this was an opportunity, in its role as system leader, to embrace the community-led health improvement model behind the two specific approaches Healthy Towns, Ageing Well, and to seek to promote them and accelerate their implementation, where there was a need and appetite from the local community. 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.

2.4 A report on the current focus of this work and key activities over the last 12 months is at item 7 on this agenda.

Voluntary Sector Engagement Project

2.5 At its meeting in April 2012, the Shadow Health & Wellbeing Board (H&WB) considered a report about the Voluntary Sector Engagement Project (VSEP) which had been set to support the engagement and involvement of the voluntary and community sector (VCS) in the changing landscape of health, wellbeing and clinical commissioning. The project was focused on ensuring best use was made of the skills, expertise and capacity of the voluntary and community sector (VCS) by facilitating and supporting positive engagement with the public sector.

2.6 The Shadow H&WB noted that during 2011-12 the project had been funded through the use of 2nd Homes monies and managed by Voluntary Norfolk. The Board endorsed the contribution being made by the Voluntary Sector Engagement Project to the emerging health and social care agenda and the work of the Shadow Board. A report on the current focus of this Project and key activities over the last 12 months is at item 8 on this agenda.

Health & Wellbeing Board development and contingency

2.7 There have been a number of opportunities for development activities during the past year nationally, regionally and locally, including the 'Whole- System Scenario planning session held in February. This event involved the Norfolk H&WB, Healthwatch Norfolk Shadow Board, the voluntary sector, a broad range of statutory and non-statutory providers, Norfolk Health Overview &Scrutiny Committee, etc, working through some simulations of real-life scenarios in the new health and social care system and exploring roles, responsibilities and accountabilities.

2.8 In practice, there was minimal call on this funding as the developmental opportunities outlined above were largely organised and run locally and did not involve outside providers.

3 Funding proposals for 2013-14

3.1 It is proposed that the allocation for 13/14 of **£370k** is used in broadly the similar way as the previous year.

3.2 **Locally-led health improvement** - Healthy towns and ageing well activities are poised to deliver and the funding from last year is fully committed, although as yet unspent. It is proposed that in line with the approach last year, a further sum of **£290,000** is earmarked to locally-led health improvement activity, but that further discussions take place with local partners about the precise use of this. It may that there is capacity for an accelerated roll out of the Healthy Towns and Ageing Well projects; or there might be other locally based health improvement initiatives from CCGs against which this funding could be used as match funding.

3.3 **Voluntary Sector Engagement Project** – renewal of the **£70,000** funding for the VSEP to continue the support in securing the active engagement of the voluntary sector in the work of the Health and Wellbeing Board as it moves from the shadow year to its first year with statutory responsibilities

3.4 **Health and wellbeing board communications, engagement and Board development.** To date the Board has done little in the way of public engagement. In the development of the refreshed Joint Strategic Needs Assessment and Health and Wellbeing Strategy, there will be a need for consultation and involvement. It is proposed to earmark £**10k**. This will leave £10k rolled over from last year to support Board development and contingency.

4. Action

4.1 The Health & Wellbeing Board is asked to consider the report and endorse the proposals.

Officer Contact

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Report to Norfolk Health and Wellbeing Board
17 April 2013
Item No 10

The Francis Inquiry & the new Quality Assurance system - Discussion paper

Report by the Head of Planning, Performance and Partnerships, Norfolk County Council

Summary
The Francis Report indicates that any system must have a 'relentless focus' on patient safety and quality standards. The Health & Wellbeing Board, as a forum which brings together the key commissioners across Norfolk, potentially has an important role in ensuring that local commissioning maintains that focus on quality and safety. This paper looks at the new quality assurance arrangements in the new system and invites discussion on aspects, including the potential role of the Board in quality assurance.

Action
The Health & Wellbeing Board is asked to consider the report and the:

- Discussion points (section 5 below)
- Potential role of the Board in relation to quality assurance

1. Background

1.1 The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis Inquiry) was published on Wednesday 6 February 2013. The report details systematic failings with the number of excess deaths between 2005 and 2008 estimated at 492 people and with numerous examples of poor care. The Inquiry makes some 290 recommendations of which many are detailed proposals for changes to aspects of policy or process. The overall recommendation is that all organisations involved in NHS commissioning, provision and regulation and 'ancillary organisations' should consider the findings and recommendations of the report.

1.2 The full Inquiry Report and Executive Summary are available at the following link - Public Inquiry Final Report and some key recommendations are given in Appendix A.

1.3 The Report indicates that any system must have a 'relentless focus' on patient safety and quality standards. The Health & Wellbeing Board, as a forum which brings together the key commissioners across Norfolk, has an important role in ensuring that local commissioning maintains that focus on quality and safety. The Health & Wellbeing Board is asked to look at the new quality assurance arrangements and the potential role of the Board in quality assurance.

2. The new system – and quality assurance

Structures

2.1 Structures in the NHS have undergone considerable change as a result of the Health and Social Care Act 2012 (H&SC Act) and a summary of these changes is given in Appendix B. This period of change and transition in the health system is also interlinked with change in the social care sector and the relationships and arrangements continue to evolve.

2.2 In January this year, the National Quality Board[1] (NQB) published a report 'Quality in the new health system – Maintaining and improving quality from April 2013' which describes how the system will assure quality in the new architecture. Key extracts of the NQB Report are outlined below; the full report is available at the following link - NQB Report on Quality in the new health system.

Definition of quality

2.3 The NCB single **definition of quality** sets out three dimensions and all three must be present in order to provide a high quality service:

- **Clinical effectiveness** – quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes;
- **Safety** – quality care is care which is delivered so as to avoid all avoidable harm and risks to the individual's safety; and
- **Patient experience** – quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect.

Roles and responsibilities

2.4 The NCB Report emphasises that driving continuous improvement and tackling quality failure is a collective responsibility. The individual roles and responsibilities of the different elements of the new system, in relation to maintaining the 'essential standards of quality and safety', are outlined in Appendix C and Appendix D and a summary of the high level roles and responsibilities is set out in bullet points below:

- **Individual health and care professionals**, their ethos, behaviours and actions, are the first line of defence in maintaining quality
- The **leadership within provider organisations** is ultimately responsible for the quality of care being provided by that organisation
- **Commissioners** are responsible for commissioning services that meet the needs of their local populations. They must assure themselves of the quality of care that they have commissioned
- **Regulators** should perform their statutory functions with the best interests of patients at heart
- **Commissioners, regulators and other national bodies** should share information and intelligence on the quality of services in an open and transparent way, and take coordinated action where appropriate in the event of an actual or potential quality failure.

Information and intelligence – working together

2.5 The distinct roles of organisations in relation to quality result in the various parts of the system holding different information and intelligence on quality within provider organisations and on different groups of health and care professionals. Therefore, the

[1] The (NQB) brings together the leaders of national statutory organisations across the health and care system and its role is to provide leadership and system alignment for quality and to provide a forum for developing collective, cross-system advice to the Department of Health and Ministers on quality.

system cannot operate effectively to improve and maintain quality if different parts of the system work in isolation. The NQB Report sets out that the system must:

- **Proactively work together -** to share information and intelligence about the quality of care in order to spot potential problems early, prevent them having a harmful impact and manage risk; and

- **Reactively work together -** in the event of a potential or actual serious quality failure coming to light, to enable informed judgements about quality and to ensure an aligned response between those with performance management, commissioning and regulatory responsibilities, without undermining or overriding individual accountabilities.

Quality Surveillance Groups (QSGs)

2.6 The new system includes the establishment of a network of new **Quality Surveillance Groups** (QSGs) across the country which will bring together different parts of the health and care economy to routinely and methodically share information and intelligence about quality in order to spot the early signs of problems and to take corrective and supportive action to prevent early problems becoming more serious quality failures. The QSGs will be supported and facilitated by the NHS Commissioning Board and will be operational in each local area and region by 1 April 2013.

2.7 QSGs will operate at both **locally**, on the footprint of the NHS Commissioning Board's 27 Area Teams; and **regionally**, on the footprint of the NHS Commissioning Board's four Regional Teams.

2.8 Members of the local QSGs are determined locally but include as a minimum:
- All local commissioners in the area
- Representatives from the NHS Trust Development Authority (TDA)
- The Local Education and Training Board (NHS LETB)
- Local HealthWatch
- Public Health England Centres
- Monitor
- The Care Quality Commission.

2.9 Each QSG will wish to consider different groups of providers over a range of meetings or discussions and such discussions will be risk and evidence based to help ensure early consideration of priority areas.

2.10 Any statutory organisation – local, regional or national – who has concerns about the quality of care of a provider should alert other QSG members to their concerns by triggering a **Risk Summit.**

3. The position in Norfolk

3.1 The emerging system is new and will continue to evolve over coming years. The NQB intends to oversee the development of how this model will operate in practice, particularly Quality Surveillance Groups and a range of 'How to' guides have been developed to support organisations and individuals in the NHS in maintaining and improving quality. They are available on the National Quality Board's pages of the Department of Health website at the link below - Establishing Quality Surveillance Groups.

3.2 Progress is being made locally, building on existing joint working. During October to December 2012, the QSG operating model was road-tested on behalf of the four regions of the NHS Commissioning Board, by NHS Midlands and East. Roll out across the region was phased and the East Anglia (Local Area Team) Quality Surveillance Group has been set up and held its first meeting in January 2013.

3.2 Membership of the Regional QSG and the East Anglia LAT QSGs to include:

Regional QSG	***East Anglia LAT QSG***
NHSCB Regional director (Chair) Regional Nurse Director Regional Medical Director LAT Directors (from pilot LATs) CQC Monitor NHS TDA HealthWatch HEE GMC NMC (observers – other NHSCB regional directors, DH)	NHSCB LAT director (Chair) LAT Medical Director LAT Nurse Director Leads from each CCG (lead officer to be confirmed) Local Authority leads Local HealthWatch CQC Monitor NHS TDA LETBs (observers – Regional Nurse Director, DH)

3.3 At that initial meeting the core membership of the East Anglia QSG was confirmed with key representatives from across Norfolk, Suffolk and Cambridgeshire as well as national bodies. It was agreed that the QSG's regular meetings would be scheduled to take place in advance of the Regional QSG meetings and terms of reference would be drawn up once the formal mandate had been confirmed.

3.4 Discussion at this first meeting focused on information sharing, the nature and frequency of information and intelligence that would be important, the format of reporting, the interface with other groups/how information might be collected and shared with others, and the development of a surveillance rating system.

4. Potential role for the Health & Wellbeing Board

4.1 The Francis Report indicates that any system must have a 'relentless focus' on patient safety and quality standards. The Health & Wellbeing Board, as a forum which brings together the key commissioners across Norfolk, potentially has an important role in ensuring that local commissioning maintains that focus on quality and safety.

4.2 The NQB use a seven-step quality framework for considering quality and in the 'Leadership for quality' section it states that "Health and Wellbeing Boards will provide local leadership for quality improvement, with local health and care commissioners coming together with the local community to jointly assess needs and determine a joint health and wellbeing strategy to improve outcomes".

4.3 The Norfolk Health & Wellbeing Board has not specifically considered its role in relation to quality assurance in the new system. This discussion paper is intended to start that discussion and for the Board to think about any opportunities their might be to increase our collective positive impact in the drive for continuous improvement in quality, as well as the actions we might need to take individually or collectively to mitigate the risks.

4.4 In terms of development of roles and responsibilities, through the work of its shadow year the Health & Wellbeing Board has been identifying its role in the new health and social care system and developing its ways of working. In July 2012, the Shadow Board agreed an operating framework, based on discussion of a number of Kings Fund scenarios, which sets out what the Board would need to do to achieve a 'systems leadership' approach and the potential challenges it would need to tackle.

4.5 Building on this, under the auspices of the Health & Wellbeing Board we have held a series of themed discussions with a range stakeholders on how the new system would work for us in Norfolk, with the themes including engagement & research, service improvement and complaints & signposting. These discussions fed into a 'Whole System' scenario-planning session held in February 2013, involving the Health & Wellbeing Board, Healthwatch Norfolk Shadow Board, Norfolk Health Overview & Scrutiny Committee, the voluntary sector, a broad range of statutory and non-statutory providers, etc. It was an opportunity for all concerned to work through simulations of real-life scenarios to help illuminate roles, responsibilities and accountabilities, as well as the nature of the linkages/relationships with others and help build a clearer picture of what the H&WB will do (and will not do).

4.6 It is clearly still early days in the new health and social care system, including the new quality assurance system, but it may be timely for the Health & Wellbeing Board to begin a discussion about quality assurance and its potential role, in its capacity as system leader.

5. Discussion

5.1 The Health & Wellbeing Board is asked to consider the following:

- What systems will the H&WB need to rely on to assure itself that the arrangements are/remain satisfactory – and what links will it need with the QSG?
- Is there anything else that the H&WB, collectively or individually, should be doing at this stage?
- What is the role of the H&WB in relation to quality assurance across the health and social care agenda?

6. Action

6.1 The Health & Wellbeing Board is asked to consider the report and the:

- Discussion points (section 5 above)
- Potential role of the Board in relation to quality assurance

Officer Contact

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

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Appendix A

The Mid Staffordshire NHS Foundation Trust Public Inquiry –
(The Francis Inquiry) February 2013

Key Recommendations

- Common values - putting the patient first (NHS Constitution)
- Common Standards - monitor and enforce
- Regulation – simplify, merge CQC & Monitor
- Complaints - source of accountability and improvement
- Commissioners – enhanced quality standards, public involvement
- GPs – monitor patients in spec. services
- Local HealthWatch – secure funding & support
- Health scrutiny – inspect providers, access to complaints
- Systems – collaborative HealthWatch, HWB and Scrutiny
- Patient/public involvement – openess, honesty, transparency, candour
- CQC – constantly review ability to regulate & enforce
- Peer review – learn lessons from others
- Nursing – training, culture, revalidation, professional voice
- NHS Leadership – staff college, ethics, accreditation
- Transparency – make available patient records, performance data, complaints
- Criminal liability – cases of serious harm or death from malpractice

"The first inquiry report stated that it should be patients – not numbers – which counted. That remains the view of this Inquiry." (P.83. Exec Summary)

The new health system

Extract from: 'Quality in the new health system – Maintaining and Improving quality from April 2013' (Report by the National Quality Board, January 2013)

Summary of changes

- **Strategic Health Authorities** and **Primary Care Trusts** have been abolished (end March 2013);

- The **NHS Commissioning Board** has been established and has taken up its full statutory functions, including responsibility for allocating funding to clinical commissioning groups and supporting them to commission high quality services and directly commissioning primary care and certain specialised services (April 2013);

- **Clinical commissioning groups** have been established and authorised, with responsibility for commissioning the majority of local health services for their populations (starting in October 2012 with full authorisation by April 2013);

- **Health and Wellbeing Boards**, based in local authorities, have been established across the country, bringing together NHS commissioners with local government to help join up the commissioning of NHS, public health, social care and other local services (April 2013);

- **Monitor** has become the new sector regulator for all NHS funded care. It will focus on promoting value for money in the provision of services, for example, by regulating prices and taking action against anti-competitive behaviour that harms the interests of patients. As sector regulator, Monitor will issue licences jointly with CQC to providers of NHS funded care (from April 2013);

- All **NHS Trusts** are on their way to becoming Foundation Trusts, free from central direction or control but subject to a new system of economic regulation;

- The **NHS Trust Development Authority** has been established to oversee the performance of NHS trusts and support them to provide sustainable, high quality services as they work to achieve foundation trust status (October 2012);

- **Local government** becomes the local leader for public health, commissioning local public health services and designing cross-sector public health strategies (April 2013);

- **Public Health England** has been established to provide expert advice and specialist services to support partners in improving and protecting the nation's health and reducing inequalities (April 2013);

- **Health Education England** has been established to provide leadership for professional education, training and workforce development, ensuring it has the right

capacity and capability. It will allocate education and training resources and oversee provider-led local allocation of resources (April 2013);

- **HealthWatch** will become the new champion for the patient voice both nationally and locally, with local HealthWatch bodies across the country (April 2013);

- **NICE** has become the **National Institute for Health and Care Excellence**, setting standards across health, public health and social care to help further the integration of services and outcomes (April 2013); and

- A number of **arms length bodies** have been abolished, including the National Patient Safety Agency (NPSA) and the NHS Institute for Innovation and Improvement (the NHS Institute), with their roles and functions transferring elsewhere (April 2013).

Things that will remain the same

These changes mean that the NHS landscape will look very different in terms of the organisations that are operating within it. However, certain elements will not change:

- **Improving quality and healthcare outcomes remains the primary purpose of all NHS funded care** and is the responsibility of everyone working in the NHS. These responsibilities are now reinforced through their definition in statute in the Health and Social Care Act 2012;

- **Healthcare professionals and clinical teams,** their ethos, values and behaviours, will remain the first line of defence in safeguarding quality;

- **The leadership within organisations who provide care** remains ultimately responsible for the quality of care being delivered by their organisation, across all service lines;

- **Commissioners** remain responsible for meeting the needs of their populations through commissioning high quality services;

- **The Care Quality Commission** remains the statutory regulator for the quality of health and social care in England. It will drive improvement in the quality and will be responsible for registering and monitoring services; for making sure people's views and experiences inform its regulatory work; for providing an authoritative voice on the state of care; and for working with strategic partners across the system;

- **The Health Service Ombudsman** will continue to resolve complaints for individuals and feeds information to sector and professional regulators where there are concerns about patient safety;

- **Professional regulators** continue to be responsible for setting the standards of behaviour, competence and education of regulated healthcare professionals, and taking action where those standards are not met; and

- **The Secretary of State** remains ultimately accountable to Parliament for the health service in England.

Appendix C

Duties in relation to quality in the new system

- There is **a duty on the Secretary of State for Health** to exercise his functions in relation to health services with a view to securing continuous improvement in the quality of services and the outcomes that are achieved from the provision of services;

- There is **a duty on the Secretary of State for Health** to take steps to protect the health of the people of England which is exercised through **Public Health England** working with partners in local government and the NHS;

- There is **a duty on the NHS Commissioning Board** to exercise its functions with a view to securing continuous improvement in the quality of services and the outcomes that are achieved from the provision of services and to have regard to the quality standards published by NICE ;

- There is **a duty on clinical commissioning groups** to exercise their functions with a view to securing continuous improvement in the quality of services and the outcomes that are achieved from the provision of services; and

- There are **duties on Monitor** in exercising its functions to protect and promote the interests of people who use healthcare services by promoting services that maintain or improve the quality of care to patients.

There are further duties related to quality:

- **CQC's role** is to drive improvement in the quality of health and social care services through regulating and monitoring services, listening to people and putting them at the centre of its work, providing an authoritative voice on the state of care and working with strategic partners across the system; and

- There are statutory duties on the **professional regulatory bodies**, such as the General Medical Council and the Nursing and Midwifery Council, to ensure that the public are protected from unsafe professional practice.

Appendix D

Outline of roles and responsibilities for Quality
(Extracts from the NQB Report, January 2013)

Providers

This category includes: health and care professionals, clinical leaders, provider leadership (partnerships, boards or their equivalents), Governors (for NHS foundation trusts).

- The early warning system for quality beings within the organisation providing care
- Health and care professionals and clinical leaders, their ethos, values and actions are the first line of defence in maintaining quality
- The leadership at a provider organisation is ultimately responsible for the quality of care that is provided by their organisation
- Provider leadership hold clinical teams and leaders to account for the quality of care they provide

Commissioners

This category includes: Clinical Commissioning Groups, local authority commissioners, NHS Commissioning Board)

- Commissioners are responsible for securing a comprehensive service within available resources, to meet the needs of their local population.
- They must commission 'regulated activities' from providers that are registered with the CQC, and should contract with their providers to deliver continuously improving quality care.
- They must assure themselves of the quality of the services that they have commissioned.
- Where commissioners have significant concerns about the quality of care provided they should inform the CQC

Regulators

a) **Care Quality Commission (CQC)** - the regulator of health and adult social care in England.

It drives improvement in the quality of care by:

- registering and monitoring services;
- listening to people and putting them at the centre of our work;
- reporting authoritatively on the state of care; and
- working with strategic partners across the system

HealthWatch - will be a statutory committee of CQC, established to enable people to help shape and improve health and social care services. It will operate at both a local and national level, championing the views and experiences of patients, their families, carers and the public.

Healthwatch locally will be a valuable source of information and intelligence which they should share as members of Quality Surveillance Groups (QSGs). If they have concerns about any of the providers in their area, QSGs are one of the routes through which they can be raised and shared.

b) Monitor - from April 2013, Monitor is the sector regulator for healthcare in England.

- It will jointly license providers of NHS-funded care with the CQC, and ensure continued access to essential services
- Monitor can vary the terms of licence for different types of providers and can take action where a provider contravenes the terms of its licence
- For NHS foundation trusts, Monitor can take action where there are quality problems as a result of poor governance within the provider
- Monitor will work with the CQC where there are concerns about compliance with the 'essential levels of quality and safety'

c) Professional regulators

Responsible for ensuring that all who practice a health profession are doing so safely. These include Nursing and midwifery Council, Health Professions Council, General Medical Council). They do this by:

- Keeping up to date registers of health professionals in the UK;
- Setting the standards of behaviour and competence that health professionals must meet;
- Approving and quality assuring the education and training of healthcare professionals;
- Dealing with concerns from patients, the public and others about healthcare professionals whose fitness to practise may be impaired because of poor health, misconduct or poor performance; and
- Taking action to restrict or remove a healthcare professional's right to practise if it is necessary to protect patients.

Other National Organisations

a) NHS Trust Development Authority (NHS TDA)

The NHS Trust Development Authority will:

- Be responsible for overseeing the performance of NHS Trusts, including clinical quality, and driving their progress towards NHS foundation trust status
- Have intervention and support mechanisms at its disposal to use if it has concerns about quality in an organisation and can work with commissioners and regulators to address concerns.
- Provide scrutiny and assurance of NHS Trusts in their applications for NHS foundation trust status.

b) National Institute for Health and Care Excellence (NICE)

- NICE is the independent organisation responsible for providing national guidance and standards on the promotion of good health and social care and the prevention and treatment of ill health
- It produces guidance on public health, technologies and on clinical practices. It also produces standards for patient care in the form of Quality Standards
- It provides advice and support on putting NICE guidance and standards into practice through its implementation programme, and it collates and accredits high quality health guidance, research and information through NHS Evidence to help health and social care professionals deliver the best patient care.

c) Public Health England (PHE)

- Public Health England is an Executive Agency of the Department of Health

- It has been established to protect and improve the nation's health and wellbeing, and to reduce inequalities
- It will provide national expertise to support local government and the local NHS across the three domains of public health.

d) Health Education England (HEE)

- Health Education England (HEE) will be responsible for ensuring that the right numbers of health professionals are trained -with the right skills and behaviours -to support delivery of high quality service and health improvement across England
- HEE will authorise and support the development of Local Education and Training Boards (LETBs)
- LETBs will lead workforce planning locally and commission high quality education and training. They will be responsible for securing quality and value from education and training providers locally

e) Health Service Ombudsman

- The Health Service Ombudsman was established by Parliament in 1973 to investigate complaints from individuals that they have been treated unfairly or have received poor service from the NHS in England
- They are independent of Government and of the NHS
- They are not a regulator: by listening to patients and investigating their complaints they help their voices to be heard, and by sharing learning from mistakes they can hold the NHS in England to account for the service it provides and the way in which it handles complaints

f) Department of Health

- The Department of Health is responsible for the effective operation of the health and care system
- It discharges this by designing the system and ensuring that it is fit for purpose, setting strategic objectives, and holding different parts of the system to account, directly or through Parliament, for the effective discharge of their roles.

Appendix E

Summary of Tools and Levers

	Monitoring	Intervening
Provider organisation	Continuous monitoring of quality and performance metrics collected as part of the provision of care	Organisational action to improve quality and performance Action with individuals to improve capacity or capability
Clinical Commissioning Groups	Information gathering and reporting as part of contract management and from wider sources	Contractual levers: ▪ breach of contract ▪ financial penalties ▪ commissioning from another provider Referring primary care providers to the NHSCB
NHS Commissioning Board	National Quality Dashboard and corporate intelligence from local area, regional and national support teams	Contractual levers where it is a direct commissioner: ▪ breach of contract ▪ financial penalties ▪ commissioning from another provider ▪ Referral to the regulators
Care Quality Commission	Quality and Risk Profiles Information from people using services	Inspection; Investigation; Warning notices; Penalty notices; Service/Ward restriction or closure; Criminal proceedings; Special Reviews; Themed Inspection Programmes and Thematic Reviews; publishing Information on good care (what works well) and poor care; reporting on the state of the Care market; influencing the Department of Health on how the sector is regulated
Monitor	Via third party information, e.g., CQC's Quality and Risk Profiles	For licence holders in general, interventions are limited For NHS foundation trusts where governance issues are identified: ▪ Additional conditions ▪ Removal of directors and governors ▪ Appointment of interim directors and governors
Public Health England	Through the work of the Chief Knowledge Officer on the health of the nation and the support to the commissioners of public health services	Expert advice on high quality public health interventions and their adoption and spread. Support for the public health professionals in all part of the NHS and local government.
Professional Regulators	Assessment of individual competence through revalidation/re-registration and investigation of complaints about individuals. Quality assurance of education and training.	Range of powers to restrict or remove a healthcare professional's right to practice. Range of powers to impose conditions or remove recognition from organisations providing education, programmes or posts
NHS Trust Development Authority	Continuous monitoring of performance of NHS Trusts against agreed plans	Support and intervention to NHS trusts to improve performance and secure sustainable futures
Health Service Ombudsman	Provides information to the CQC, Monitor and the professional regulators to assist them in their regulatory role	Resolves individual complaints
Department of Health	Monitoring of performance of the NHS overall against the indicators in the NHS Outcomes Framework. Regular assessment of the performance of arm's-length bodies against their objectives	Holding the NHSCB and other arm's-length bodies to account for their performance. Making changes to how the system operates through legislation or ways or working.

Report to Health and Well Being Board
April 2013
Item No11

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.

The report provides details of the action plan that has been developed and explains the progress that is being made in delivering on the actions that relate specifically to Norfolk.

Action

Members are asked to note the contents of this report.

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 and10 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 The Minister has stated that he anticipates there will be a significant reduction in the number of people living in hospital settings over the next 18 months

1.5 A summary report was provided to the Health and Well Being Board in January to brief board members. This report provides an update on progress that is being made.

2 Progress since January 2013

2.1 The Winterbourne View recommendations and actions are being managed by the Norfolk Mental Health Commissioning Board. On 26th March 2013 an update report was presented to the Mental Health Commissioning Board and a copy of this report is attached for information at Appendix 1.

2.2 A summary of the key local actions and progress against them are given below

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

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

2) By April 2014, each area will have a joint plan to ensure high quality care and support services for all people with learning disabilities or autism and mental health conditions or behaviour described as challenging, in line with best practice.

The plan to monitor the progress against the recommendations which impact upon the Norfolk Health and Social Care economy has been developed and is attached at Appendix 2.

3) By June 2013, all current NHS funded placements will be reviewed, everyone in hospital inappropriately will move to community-based support as quickly as possible, and no later than June 2014.

Hertfordshire Mental Health Partnership Foundation Trust will undertake the required reviews as part of the psychiatry and assessment and treatment services that they provide to Norfolk. The reviews will be undertaken using the national guidance that has been received and will be done in conjunction with social care staff who have care management responsibility for each patient.

The Continuing Health Care Team will also review their funded patients within the required deadline using the new guidance.

At this stage it is difficult to determine if the set deadline to move people to community based support arrangements will be fully achievable by June 2014.This is dependent upon the numbers of people who may move and how quickly the market is able to respond to meet their needs. A number of care providers are already in dialogue with our Joint Commissioner about making plans for the required services to be developed.

2.3 Social Care Placements

Norfolk County Council has 92 people placed out of county in social care funded residential and supported living placements. These people are reviewed annually by their care managers and the same national guidance will be used to to establish if moving back to Norfolk is the best option for them and their families

2.4 The role of Healthwatch

Healthwatch are developing a proposal to use their power of Enter and View to visit NHS and private sector hospitals. The Joint Commissioner will work with Healthwatch and NHS Clinical Commissioning Groups to ensure that future governance arrangements are co-ordinated effectively.

3 Next Steps

3.1 The programme of reviews will be undertaken in accordance with national guidance to establish the numbers of people who will require different services in the community.

3.2 The Joint Commissioner will work with care providers to encourage the development of the required services.

3.3 The Joint Commissioner will work with Healthwatch to link their proposed inspection arrangements with local governance processes that are developed.

3.4 A further update report will be brought to the Health and Well Being Board when the patient reviews are completed

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 and the Association of Directors of Social Services.

5.3 Norfolk also has higher than average number of private hospitals and residential care establishments and is a net importer of people from outside the county. Many London boroughs and other counties place people in Norfolk and the effects on our local health and social care economy are well documented. The movement of these patients into the community could also lead to cost pressures

6 Equality Impact Assessment (EqIA)

6.1 Services for people with a learning disability are individually equality impact assessed. Any service changes that take place resulting from the development of the local action plan will also be EQIA assessed.

7 Section 17 – Crime and Disorder Act

7.1 People with learning disabilities are one of the most vulnerable groups in our society in terms of being potential victims of crime and in a small minority of cases perpetrators of crime.

7.2 The outcome of the local action plan will ensure that this group of vulnerable people are protected and safeguarded.

8 Action

8.1 Members are asked to note the contents of this report

Officer Contact

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

Officer contacts
Clive Rennie Assistant Director Joint Commissioning Tel 01603 257021
Stephen Rogers, Joint Commissioner Learning Disability Services Tel 01603 257071

If you need this Agenda in large print, audio, Braille, alternative format or in a different language please contact **Lesley Spicer, Tel: 01603 638129, Minicom: 01603 223242, and we will do our best to help.**

APPENDIX 1

Norfolk and Waveney

SUBJECT	Winterbourne View DH Report: Recommendation and Action Plan for MHCB and CCGs
SPONSORED BY	Clive Rennie
PRESENTED BY	Derek Holesworth
SUBMITTED TO	*Mental Health Commissioning Board 26th March 2013*
PURPOSE OF PAPER	*Progress against ' Winterbourne View' Action Plan*

EXECUTIVE SUMMARY:

At previous Board meetings it was reported that the report, 'Transforming care: A national response to the Winterbourne View Hospital[1]' outlined over sixty recommendations and actions that were required by the DH to mitigate against the potential of another Winterbourne View scandal taking place. The report referenced the recommendations and actions under five headings:

- The Right Care in the Right Place
- Strengthening Accountability and Corporate Responsibility for Quality of Care
- Tightening the Regulation and Inspection of Providers
- Improving Quality and Safety
- Monitoring and Reporting on Progress

The report recommendations highlighted that there were a number health and social care bodies who would be responsible for the actions which were linked to a timetable when those actions were required to be completed. To help understand and clarify the responsibilities of CCGs and MHCB, the report has been apportioned resulting in a table of sixteen actions with the associated timeframe. (See Appendix i)

The NHS Commissioning Board (NHSCB) made contact on 24th January requesting that PCT / CCG indicate the progress that has been made in the areas of:

- PCT handover to CCGs of patient registers
- Review of people's care
- Progress monitoring of people's care

The result of this process will assure the NCB that those actions that relate to the areas of progress have been completed before 31st March deadline when the PCT ceases to exist.

The PCT Board has been made aware of the requirements of the DH report and is satisfied that the Winterbourne View recommendations and actions are being managed by the MHCB.

[1] https://www.wp.dh.gov.uk/publications/files/2012/12/final-report.pdf

Current Progress against Winterbourne View Action Plan

Of sixteen actions that relate to health and social care, the following relate to those three areas that the NCB require to be reported upon and assured by 31st May

- PCT handover to CCGs of patient registers

  Action 4 - NCB should ensure that all PCT develop a local register of people with challenging behaviour in NHS funded care

  Current Progress: The action above is scheduled to be completed by 31st March. Continuing Health Care BI team have now forwarded all the relevant Patient Lists to each of the CCGS quality leads

- Review of people's care

  Action 5 - Local registers. What handover and legacy arrangements are being put in place for reviewing individual's care and who is each individual's first point of contact?
  Action 8 - CCGs are expected to assure themselves with LA that those people with LD including ASD receive good care and are remaining within their own communities
  Action 10 - Need assurance that providers are held to account for the care they provide
  Action 14 - Are healthcare plans are being reviewed

  Current Progress: The actions above have to be completed by 31st May and currently the information is being collated by the CHC team through the Broadcare data base and will be prepared for the CCG quality leads within the timeframe

  The Continuing Healthcare Practitioners aim to have reviewed all the LD CHC patients by the end of May 2013. During reviews they always have NOK involvement, acknowledging consent and the named care coordinator is identified at this point.

  CHC have also sent a letter to all care providers, requesting that they have an up to date Physical Health Check (PHC) and Personal Care Plan (PCP) for each patient receiving CHC and that all care providers are to forward a copy of the PCP by the end of April so that the target date is achieved

- Progress monitoring of people's care

  Action 11 - The NCB is to produce a joint health and social care self-assessment framework to monitor progress of key health and social care inequalities.
  Action 16 - Monitor any 'whistle blowing' concerns

  Current Progress: CCGs will need to establish protocols that will assure themselves that they have a process where whistle blowers are able to make contact and address potential issues. This should sit with the Quality Leads and will be part of the handover process

Reporting:

The Action Template was completed and forwarded to the NCB as part of the assurance that Norfolk and Waveney PCT has handed over to CCGs a list of patients receiving healthcare and that CCGs are able to assure themselves that patient care is being reviewed and monitored. (See Appendix ii) This information was sent to NHS CB before the 22nd February as requested

Other actions that are required to be completed will be addressed within the time frame as dictated by the Action Plan

Appendices

Appendix i

Recommendations and action from Winte

Appendix ii

Copy of Winterbourne questic

KEY RISKS:
The key risks are:

CCGs do not have the capacity to manage the Patient Register.

Clinical/Patient Safety:

Potential risk of another Winterbourne View Hospital scandal if actions are not completed within the timetabled period

Finance and performance:

None

Impact Assessment (environmental and equalities):

None

Reputation:

Loss of reputation to commission safe and responsible services for vulnerable people

Legal:

Potential litigation against commissioners if actions are not addressed resulting in another Winterbourne View scandal

Workforce Impact (if appropriate)

None

REFERENCE TO RELEVANT BOARD ASSURANCE FRAMEWORK, BOLD AND AMBITIOUS/OPERATIONAL/ORGANISATIONAL DEVELOPMENT PLANS AND NHS CONSTITUTION:
Operating Framework 2012 / 13

RESOURCE REQUIRED (if appropriate):
None

REPORT DISCUSSED WITH (please specify if been to ET/Clinical Cabinet/Delivery Unit/Management Committee):

RECOMMENDATION:

That the Board is assured that the process to manage the recommendation and actions is in place

Recommendations and Actions arising from Department of Health Review Final report - Transforming Care: A National Response to Winterbourne View Hospital (Health and Care Commissioners)

Recommendation	Current situation	Actions required	Lead	Time line	RAG
The Right Care in the Right Place **National leadership supporting local change** To provide leadership and support to the transformation of services locally, the LGA and the NHSCB will develop an improvement programme led by a senior sector manager. **ACTION 1**	We await more information about the Joint Improvement Programme.	The Local Government Association (LGA) and NHS Commissioning Board will establish a joint improvement programme to provide leadership and support to the transformation of services locally. They will involve key partners including DH, Association of Directors for Adult Social Services (ADASS), Association of Directors of Children's Services (ADCS) and CQC in this work, as well as people with challenging behaviour and their families. The programme will be operating within three months and Board and leadership arrangements will be in place by the end of December 2012. DH will provide funding to support this work.	LGA / NHSCB and DH, ADASS, ADCS and CQC	By end December 2012	
The Right Care in the Right Place **National leadership supporting local change**	Joint Health and Social Care Framework consultation document received with consultation deadline of 31st January. Local workshops were arranged to provide a Norfolk collated response by the deadline. There are local concerns over the level of resources that may be required to complete the new monitoring	The NHSCB will work with ADASS to develop practical resources for commissioners of services for people with learning disabilities, including: • model service specifications; • new NHS contract schedules for specialist learning disability services; • models for rewarding best practice through the NHS; commissioning for Quality and	NHSCB	By March 2013	

Recommendations and Actions arising from Department of Health Review Final report - Transforming Care: A National Response to Winterbourne View Hospital (Health and Care Commissioners)

Recommendation	Current situation	Actions required	Lead	Time line	RAG
ACTION 2	arrangements, a proposal will be developed when the new model framework is finalised New services specs and best practice initiatives are to be welcomed and can be incorporated into our NHS and Local Authority contracting arrangements	Innovation (CQUIN) framework; and a joint health and social care self-assessment framework to support local agencies to measure and benchmark progress.			
The Right Care in the Right Place **National leadership supporting local change** Social care and health commissioners will be accountable to local populations and will be expected to demonstrate that they have involved users of care and their families in planning and commissioning appropriate local services to meet the needs of people with challenging behaviour. **ACTION 3**	NCC lead commissioning arrangements for LD in Norfolk can ensure that a consistent approach is taken to these changes The lead commissioner already has well established Locality Groups of stakeholders who can be engaged in this area of development	The NHSCB and ADASS will develop service specifications to support CCGs in commissioning specialist services for children, young people and adults with challenging behaviour built around the model of care in Annex A of the DH report	NHSCB and ADASS	By March 2013	
The Right Care in the Right Place **Review all current placements and support everyone inappropriately in hospital to move to community based support** **Agreeing who should be reviewed and who is responsible for them**	Improved definitions of challenging behaviour will enable improvements to data analysis and collection. Information already available for the register of patients. Collation in the required format is underway. Care Management	The NHSCB will ensure that all Primary Care Trust develop local registers of all people with challenging behaviour in NHS-funded care.	NHSCB	By April 2013	

Recommendations and Actions arising from Department of Health Review Final report - Transforming Care: A National Response to Winterbourne View Hospital (Health and Care Commissioners)

Recommendation	Current situation	Actions required	Lead	Time line	RAG
ACTION 4	reviews take place annually and renewed guidance will be issued to drive movement to community based support where this is possible.				
The Right Care in the Right Place **Review all current placements and support everyone inappropriately in hospital to move to community based support** **Agreeing who should be reviewed and who is responsible for them** Commissioners need to make sure they know who is in hospital and who is responsible for them. **ACTION 5**	Lead Commissioning arrangements and CSU can co-ordinate this work and provide a consistent approach across Norfolk. Local Registers have been forwarded to Quality Leads within each CCG Full audit available and care managers allocated to each patient.	The NHSCB will make clear to CCGs in their handover and legacy arrangements what is expected of them in maintaining local registers, and reviewing individual's care with the Local Authority, including identifying who should be the first point of contact for each individual.	NHSCB / CCGs	From April 2013	
No recommendations associated **ACTION 6**		The NHSCB will hold CCGs to account for their progress in transforming the way they commission services for people with learning disabilities/autism and challenging behaviours.	NHSCB / CCGs	From April 2013	
The Right Care in the Right Place		The strong presumption will be in	NHSCB /	From April	

Recommendations and Actions arising from Department of Health Review Final report - Transforming Care: A National Response to Winterbourne View Hospital (Health and Care Commissioners)

Recommendation	Current situation	Actions required	Lead	Time line	RAG
Locally agreed plans to ensure high quality care and support services which accord with the model of good care **Commissioning the right model of care and challenging poor practice** There should be a clear presumption that budgets should be pooled and that health and wellbeing boards should promote collaborative working and the use of pooled budgets. **ACTION 7**	Joint Commissioning already in place in Norfolk.	favour of pooled budget arrangements with local commissioners offering justification where this is not done. The NHSCB, ADASS and ADCS will promote and facilitate joint commissioning arrangements. Should exhibit support of Health and Well being Board	ADASS / ADCS	2013	
The Government's Mandate to the NHS Commissioning Board **ACTION 8**	Norfolk already has a good record of not placing adults with a learning disability out of county. Improvements in young people`s transition services and preventing out of county placements of children in residential colleges is already a local priority	The NHSCB will ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism receive safe, appropriate and high quality care. The presumption should always be for services to be local and that people remain in their communities.	NHSCB / CCGs	From April 2013	
The Right Care in the Right Place	Quality Assurance staffing	Health and care commissioners	Health and Care	From April	

Recommendations and Actions arising from Department of Health Review Final report - Transforming Care: A National Response to Winterbourne View Hospital (Health and Care Commissioners)

Recommendation	Current situation	Actions required	Lead	Time line	RAG
Review all current placements and support everyone inappropriately in hospital to move to community based support **ACTION 9**	available in local authority to help monitor social care placements. Care managers have responsibility for monitoring quality of all health and social care packages. Herts MH Foundation Trust will provide a review in accordance with national guidance of all Norfolk patients in private hospital care and will link with local care management to help facilitate any moves to the community Those people funded by CHC may require additional care management support.	should use contracts to hold providers to account for the quality and safety of the services they provide.	Commissioners	2013	
Strengthening Accountability and Corporate Responsibility for Quality of Care **Quality of care** Sanctions to hold Boards to account when the quality of care is unacceptable	The primary responsibility for the quality of care rests with the providers of that care. Owners, Boards of Directors and Senior managers of organisations which provide care must take responsibility for ensuring the quality and safety of their services.	Directors, management and leaders of organisations providing NHS or local authority funded services to ensure that systems and processes are in place to provide assurance that essential requirements are being met and that they have governance systems in place to ensure they deliver high quality and appropriate care.	NHS or local authority commissioned service providers	From April 2013	

Recommendations and Actions arising from Department of Health Review Final report - Transforming Care: A National Response to Winterbourne View Hospital (Health and Care Commissioners)

Recommendation	Current situation	Actions required	Lead	Time line	RAG
ACTION 10					
Monitoring and Reporting on Progress: **Developing better information systems** The Department of Health intends to establish key performance indicators (on, for example, numbers of people in hospital, length of stay, incidents of restraint, and number of safeguarding alerts) which will enable the Learning Disability Programme Board and local services to monitor progress. **ACTION 11**		The Department of Health, the Health and Social Care Information Centre and the NHSCB will develop measures and key performance indicators to support commissioners in monitoring their progress.	DH / Health and Social Care Information Centre / NHSCB	From April 2013	
The Government's Mandate to the NHS Commissioning Board **ACTION 12**	Consultation document already received…and Norfolk response submitted by the deadline 31st January	The NHSCB and ADASS will implement a joint health and social care self-assessment framework to monitor progress of key health and social care inequalities from April 2013. The results of progress from local areas will be published.	NHSCB / ADASS	From April 2013	
The Right Care in the Right Place **Locally agreed plans to ensure high quality care and support services which accord with the model of good care**	Norfolk already has a Joint Commissioning Strategy for Adults with a learning disability. The focus upon people with challenging behaviour can be	CCGs and local authorities will set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area.	CCGs	By April 2014	

Recommendations and Actions arising from Department of Health Review Final report - Transforming Care: A National Response to Winterbourne View Hospital (Health and Care Commissioners)

Recommendation	Current situation	Actions required	Lead	Time line	RAG
Prioritising children and young people's services For children and young people with special educational needs or disabilities the Mandate to the NHS Commissioning Board sets out the expectation that children will have access to the services identified in their agreed care plan and that parents of children who could benefit will have the option of a personal budget based on a single assessment across health, social care and education. This means: • integrated planning around the needs of individual children; and identifying best outcomes and measuring progress. **The Right Care in the Right Place** **Locally agreed plans to ensure high quality care and support services which accord with the model of good care** **Commissioning the right model of care and challenging poor practice** We expect commissioners to work together to drive the move from hospital care to good quality local, community-based services, and account for how they do this. This involves: • better joint working between health and care;	strengthened and can be informed by the work that is underway on the Norfolk JSNA.	This could potentially be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) processes.			

Recommendations and Actions arising from Department of Health Review Final report - Transforming Care: A National Response to Winterbourne View Hospital (Health and Care Commissioners)

Recommendation	Current situation	Actions required	Lead	Time line	RAG
using the evidence on good practice. **The Right Care in the Right Place** **Review all current placements and support everyone inappropriately in hospital to move to community based support** **Reviewing care and agreeing personal care plans** Personal care plans should be enacted swiftly and safely. In many instances this will require the development of more personalised services in different settings so that individuals can be better supported at home or in the community. Although doing this can take time, the Department of Health expects it to be carried out with pace and a sense of urgency – whilst always putting the interest of the individual first. **ACTION 13**					
Strengthening Accountability and Corporate Responsibility for Quality of Care **Quality of care**	All people already have a care plan, these are reviewed annually.	Health and care commissioners, working with service providers, people who use services and families, will review the care of all people in learning disability or autism inpatient beds and agree a personal care plan for each individual based around their and their families' needs and agreed outcomes.	Health and Care Commissioners	By June 2013	

Recommendations and Actions arising from Department of Health Review Final report - Transforming Care: A National Response to Winterbourne View Hospital (Health and Care Commissioners)

Recommendation	Current situation	Actions required	Lead	Time line	RAG
ACTION 14					
The Right Care in the Right Place **Locally agreed plans to ensure high quality care and support services which accord with the model of good care** **Prioritising children and young people's services** For children and young people with special educational needs or disabilities the Mandate to the NHS Commissioning Board sets out the expectation that children will have access to the services identified in their agreed care plan and that parents of children who could benefit will have the option of a personal budget based on a single assessment across health, social care and education. This means: • integrated planning around the needs of individual children; and identifying best outcomes and measuring progress. **The Right Care in the Right Place** **Locally agreed plans to ensure high quality care and support services which accord with the model of good care**	Care managers have responsibility for monitoring quality of all health and social care packages. Those people funded by CHC may require additional care management support **Transitional arrangements can often take 12 months. The target date of April 2014 my prove to be ambitious** Funding will need to follow the patient to ensure that the health and social care economy is not destabilised and that the funding is available to commission the new services that will need to be developed.	Health and care commissioners should put plans into action as soon as possible and all individuals should be receiving personalised care and support in appropriate community settings no later than 1 June 2014.	Health and Care Commissioners	No later than 1 June 2014	

Recommendations and Actions arising from Department of Health Review Final report - Transforming Care: A National Response to Winterbourne View Hospital (Health and Care Commissioners)

Recommendation	Current situation	Actions required	Lead	Time line	RAG
Commissioning the right model of care and challenging poor practice We expect commissioners to work together to drive the move from hospital care to good quality local, community-based services, and account for how they do this. This involves: • better joint working between health and care; • using the evidence on good practice. **ACTION 15**					
The Right Care in the Right Place **Locally agreed plans to ensure high quality care and support services which accord with the model of good care** **Evidence on best practice** Commissioning needs to draw on the evidence of what is best practice in the care of people with challenging behaviour. **ACTION 16**	CQC has strengthened its arrangements for responding to concerns that are raised with it by whistle-blowers. Whistleblowing concerns are now monitored to ensure they are followed up and thoroughly investigated until completion and the information provided is included in regional risk registers, which list providers where 'major concerns' have been identified.		Commissioners	Review date	

Recommendations and Actions arising from Department of Health Review Final report - Transforming Care: A National Response to Winterbourne View Hospital (Health and Care Commissioners)

Recommendation	Current situation	Actions required	Lead	Time line	RAG

Appendix 1

- Share the information, data and details they have about prospective providers with the relevant CCGs and local authorities through their existing arrangements, who will, in turn, take account of the information and data shared by CQC when making decisions to commission care from the proposed service provider

- take steps now to strengthen the way we use existing powers to hold organisations to account for failures to provide quality care and report on changes to be made from Spring 2013;

- assess whether providers are delivering care consistent with the statement of purpose made at the time of registration, particularly in relation to length of stay and to whether treatment is being offered. Where it is not, CQC will take the necessary action (including, if necessary, enforcement action) to ensure that a provider addresses discrepancies either through changes to its services or changes to its statement of purpose;
- take tough enforcement action including prosecutions, restricting the provision of services, or closing providers down, where providers consistently fail to have a registered manager in place;

- take enforcement action against providers that do not operate effective recruitment procedures to ensure that their staff are suitably skilled, of good character and legally entitled to do the work in question. Operating effective recruitment procedures is a legal requirement and providers must be able to demonstrate to CQC that they have adequate procedures in place. Evidence of effective recruitment can include a provider showing it has requested criminal records checks for eligible employees (including any staff who regularly provide care or treatment) alongside checking references and qualifications. Where a provider has not requested criminal records checks on eligible employees, it will have to assure CQC that its recruitment procedures are still effective and that it can be evidenced that it is reasonable for the check not to have been made. Providers also commit an offence if they knowingly engage a person who is barred in activities such as providing healthcare or personal care. From 2014 the government will commence an explicit duty to check that a person is not barred before engaging them in these activities;

- continue to run the stakeholder group that helped to shape the inspection of 150 learning disability services. It will continue to meet twice yearly and will be chaired by the CQC Chief Executive. CQC will review the role and function of the group as part of that work programme to make sure it continues to provide advice and critique on CQC's inspection and monitoring of providers;

Recommendations and Actions arising from Department of Health Review Final report - Transforming Care: A National Response to Winterbourne View Hospital (Health and Care Commissioners)

Recommendation	Current situation	Actions required	Lead	Time line	RAG

- continue to make unannounced inspections of providers of learning disability and mental health services employing people who use services and families as vital members of the team;

- take a differentiated approach to inspections between different sectors of care provision to ensure the inspections are appropriate to the vulnerability and risk for the different care user groups (subject to the outcome of consultation on its new strategy);
- review, as part of its new strategy, the delivery of its responsibilities under s120 of the Mental Health Act 1983 for the general protection of patients detained under the Act which include wide powers to review the way in which the Act's functions and safeguards are working and investigating complaints by any person detained under the Act.

Appendix 2

Progress Report Points (Health and Care responsibilities)

A progress report was requested by 28th February on the following areas by NHSCB

A - PCT handover to CCGs of patient registers
B - Review of people's care
C - Progress monitoring

The current position regarding each of the actions above and how they relate to the progress report

Action 1 - The joint improvement plan between the LGA and NHSCB has been established. (**Check to see whether this is happening**)

Action 2 - The NHSCB is to develop resources for commissioners of services of people with LD where models for best practice rewarded through CQuIN. (**Has this been established and has a joint health and social frame work been developed**)

Action 3 - Service specifications to be developed by NHSCB and ADASS to support CCGs in commissioning specialist services (**Check progress**)

Action 4 - NHSCB should ensure that all PCT develop a local register of people with challenging behaviour in NHS funded care (**This relates to Progress point A – *discuss with CHC***)

Recommendations and Actions arising from Department of Health Review Final report - Transforming Care: A National Response to Winterbourne View Hospital (Health and Care Commissioners)

Recommendation	Current situation	Actions required	Lead	Time line	RAG

Action 5 - Local registers. What handover and legacy arrangements are being put in place for reviewing individual's care and who is each individual's first point of contact? **(This relates to Progress point B**)

Action 6 - CCGs are being held to account for the progress against the recommendations of the Winterbourne View recommendations (**This relates to Progress point C**)

Action 7 - Pooled budgets. Joint commissioning already takes place

Action 8 - CCGs are expected to assure themselves with LA that those with LD including ASD receive good care and are remaining within their own communities (**This relates to Progress point B**)

Action 9 - Are contracts being used robustly to hold providers to account for the quality and safety of services they provide (***Discuss with CHC***)

Action 10 - Need assurance that providers are held to account for the care they provide (**This relates to Progress point B)**

Action 11 - The NHSCB is to produce a joint health and social care self-assessment framework to monitor progress of key health and social care inequalities. (**This is linked to Progress point C**)

Action12 - A consultation document is to be published by NHSCB reporting the monitoring of local area progress (**This relates to the Progress report requested**)

Action 13 - The CCGs are to develop a joint strategic plan involving arrange of services possibly through the Health and Wellbeing Boards

Action 14 - Currently healthcare planes are being reviewed (**Confirmation from CHC and NCC LD required**)

Action 15 - Personalisation care. Plans need to be developed for patients to be in appropriate community settings

Action 16 - Monitor any 'whistle blowing' concerns (**This relates to Progress point C**)

Draft Report to Norfolk Shadow Health and Wellbeing Board

17th April 2013

Item No 12

Funding transfers from the NHS for Adult Social Care

Report by the Director of Community Services

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SUMMARY

In previous years, the Department of Health has given Primary Care Trusts funding for social care that was required to be transferred to the Local Authority responsible for social services (i.e. Norfolk County Council). It stipulated that it should be spent on agreed social care priorities with health care benefits. This year, the transfer of funding from the NHS to local authorities is the responsibility of the NHS England (formerly the NHS Commissioning Board) but the plans should be agreed locally with the Clinical Commissioning Groups and Area Team of NHS England.

The amount to be transferred from the NHS England to Norfolk County Council for 2013/14 is £14.956m. This will be transferred through a formal "Section 256 agreement" (of the 2006 NHS Act). The overarching proposals for the use of this funding were agreed by the Norfolk Health and Wellbeing Board in January 2013 with the agreement that the complete proposals would return to the Health and Wellbeing Board in April 2013.

There is an additional transfer to the Local Authority requiring a Section 256 agreement, as detailed in *Everyone Counts: Planning for Patients 2013/14* in which it states that CCGs "will assume responsibility [from the PCTs] for the management and administration of the £300 million a year reablement provision". CCGs are expected to spend a prescribed amount, jointly agreed with the Local Authorities. The proportion for Norfolk is around £4.6m and £1.3m of this is requested to be transferred to Norfolk County Council as the NHS element of the Norfolk First Support re-ablement service.

This paper shows how the funds will be used to address key shared priorities aligned to the NHS Outcomes Framework and to the respective local authority strategic plans: to strengthen care at home, to prevent unnecessary admissions, to promote discharge and to enable integrated care.

Although these proposals will need to be approved finally by the Health and Wellbeing Board on behalf of NHS England, it is the NHS England's intent that the CCGs are in broad agreement with the intended outcomes. The draft paper has been received by the Community Commissioning Board (CCB) and by each CCG through their CCB representative(s).

Action Required

1. Agree to the plan for spend of the funding to transfer from NHS England to Norfolk County Council;
2. Note the requirement for CCGs to agree with the local authority the development and funding of a re-ablement service and the contribution to be transferred to Norfolk County Council;
3. Note and agree the overarching activity indicators as listed in the appendices.

1. Introduction

1.1. The 'Social Care' funding stream requires the NHS England to transfer funding for social care to the Local Authority, i.e. Norfolk County Council. NHS England expects CCGs to be in broad agreement with the proposed use of the funding.

1.2. Transfer of re-ablement funding requires agreement between local CCGs and the local authority (Appendix 1 summarises the values).

1.3. The principles of the spend of the allocation and the broad areas of spend were agreed by the Health and Wellbeing Board at its January meeting. This paper provides the required additional detail on the nature of the spend, outcomes and expected benefits.

2. NHS Funding for Social Care

2.1. It is worth noting that his year, the Government has stipulated only that the money must be used to support adult social care services in each local authority area. It has taken a more flexible view to allow local areas to determine their priorities, and has been explicit about allowing the funds to be used to support existing services that might otherwise not be available because of budget pressures.

2.2. With that in mind, it is suggested that the allocation of these funds should continue to be targeted to address those key shared priorities identified in 2011/12 and 2012/13:

- Mitigate the impact of the Comprehensive Spending Review on social care budgets to secure services which impact for health services;
- Reduce avoidable admissions and promote effective discharge;
- Increase capacity to meet increasing demand.

2.3. Activities to deliver this included using the funding to:

- contribute to the social care demographic pressure;
- reduce savings required on equipment and specialist sensory support services;
- reduce savings on Mental Health to allow for a phased redesign of the services;
- maintain eligibility criteria for social care services at critical and substantial;
- reduce the three year saving on early intervention and prevention by £5m;
- and reduce the proposed savings in quality assurance.

2.4. *Everyone Counts: Planning for Patients 2013/14*, published by the National Commissioning Board, highlighted the need for CCGs and local authorities to continue joined-up planning through Health and Well-Being Boards, and commission a more integrated delivery approach from providers. In particular, joint work by health and social care services can contribute significantly to the following priorities of NHS England:

- Improving care and health services seven days a week (including assessment and rapid care response);

- Support for re-ablement;
- Enhancing the quality of life for people with long-term conditions (including personal health and care budgets);
- Dementia services;
- Helping people recover from episodes of illness (including keeping people out of hospital, post discharge support and preventing inappropriate admission);
- Improving mental health recovery rates.

2.5. Proposals for the use of this funding are detailed in Appendix 2.

2.6. In addition to maintaining the existing spend from the previous NHS transfers, it is proposed that the additional funding in 2013/14 is used for the following broad purposes:

- To contribute to maintaining patient flow through the acute care sector to the community by increasing the availability of domiciliary and residential care packages;
- To contribute to improving hospital discharge arrangements by ensuring seven day per week availability of social care assessment capacity;
- To phase in the mental health savings required in the NCCBig Conversation;
- To invest in a data management system to allow commissioners to analyse activity and cost across health and social care to improve integration and a whole system approach to the local health economy.

2.7. As can be seen, a primary use of these funds is to maintain existing levels of social care services that have a direct impact on the NHS. In the face of significant real-terms cash reductions to the local authorities this funding is intended to preserve levels of social care support. Without this support NHS commissioners would face enormous pressures in terms of increased emergency admissions, slower or delayed discharges and increases in emergency services callouts.

3. **Funding for Re-ablement**

3.1. Paragraph 3.33 of *Everyone Counts* states that "Clinical commissioning groups will assume responsibility for the management and administration of the £300 million a year reablement provision. Clinical commissioning groups will work with local authorities to agree allocation of the monies to benefit health outcomes in their local population. They will account to their Health and Wellbeing Board and the Area Team on how health and care have benefited from the allocation."

3.2. The specific PCT allocations for this are contained within the recurrent baseline. The total local funding allocation is :

- NHS Norfolk: £4.038m
- NHS Great Yarmouth and Waveney: £1.35m (of which £630k is for Great Yarmouth).

3.3. Plans for spending this allocation should be jointly agreed between the CCGs and the local authority and plans presented previously, as endorsed by the

Executive Team of NHS Norfolk and Waveney and Norfolk County Council's Cabinet, were drawn up collaboratively with stakeholders from all agencies.

3.4. This funding is specifically intended to develop current re-ablement capacity in councils, community health services and the independent and voluntary sectors with a specific objective of ensuring rapid recovery from an acute episode and reducing people's dependency on social care services following discharge. It can be used on both health and social care services.

3.5. The allocation for Norfolk and Great Yarmouth re-ablement will contribute to the Norfolk First Support re-ablement service, allowing the health benefits of this service to continue. Norfolk County Council has invested an additional £409k to ensure the service is free at the point of delivery and to remove eligibility restrictions to enable the service to be open to all who may need it across the county.

3.6. Although current unit costs for Norfolk First Support (cost of service per person 'treated') favourably compared with those of other re-ablement services nationally, a comprehensive review and restructure using LEAN methodology has enabled the service to improve upon this. By combining elements from the main re-ablement streams (Norfolk First Support, Swifts and NightOwls) and by reviewing the patterns of use of the service throughout the day, night and week, and using more sophisticated scheduling systems and coordination, the service has forecast savings of £1m from April 8th (the date of implementation), with a sustained 30% increase in patient throughput.

3.7. This has resulted in the required amount to transfer from the NHS reducing from £2.3m (in 2011/12) to £1.3m (a breakdown of this is shown in Appendix 3),with an increased potential for savings for the NHS in three distinct areas:

- Hospital admission and re-admission (i.e., NHS savings);
- Reduced community health activity (community nursing, GP, out-of-hours, emergency services etc., i.e., NHS savings);
- Long-term care (i.e., social care savings).

3.8 Further, a successful pilot run in South Norfolk CCG to speed up discharge directly to reablement services from the acute hospitals is being rolled out across the county and is showing average savings of 3 acute bed days per discharge.

4. Equality Impact Assessment (EqIA)

4.1 There are no new Equality Impact Assessments required as a result of issues in this report.

5. Section 17 – Crime and Disorder Act

5.1 The recommendations in this paper concern the provision of care and support services to vulnerable adults.

6. Environmental Impact

6.1 There are no environmental implications from issues arising in this report.

7. Conclusions

7.1. Recognising the overlap in objectives for re-ablement, some of the planned uses of the "NHS Funding for Social Care" allocation and the NHS and Social Care Outcomes Frameworks, this plan aims to provide a more comprehensive picture for the whole of Norfolk.

7.2. The theme is to use the funds available to promote further effective integration of community health and social care in a way that focuses on the key challenges for the NHS of preventing hospital admissions (and re-admissions) and facilitating hospital discharge, and for the local authority of preventing substantial long-term social care packages and care home placements that allows social care to maintain and improve what is done for individuals at a time of severe financial pressures.

7.3. Any transfer of funding from the NHS to the local authorities in respect of all of the three sources of funding will be through Section 256 agreements, which indicate the planned use of the funding and the health benefit to be achieved through this, as outlined in the plan here. Section 256 agreements will be drawn up for the 2013/14 period with Norfolk County Council (Great Yarmouth will need to be done separately from the rest of Norfolk).

8. Actions required

8.1 The Board is asked to:

3. Agree to the plan for spend of the funding to transfer from NHS England to Norfolk County Council;

4. Note the requirement for CCGs to agree with the local authority the development and funding of a re-ablement service and the contribution to be transferred to Norfolk County Council;

5. Note and agree the overarching activity indicators as listed in the appendices.

Officer Contact

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IN TRAN communication for all

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Appendix 1

Summary of proposed funding to be applied through Section 256 agreements with NCC for 2013/14.

Year	Funding type	Funding Organisation(s)	"Norfolk" (£'000)	Great Yarmouth (£'000)	Total for Norfolk County Council (£'000)
2013/14	**"NHS Funding for Social Care"**	NHS E	-	-	£14,956.185
2013/14	**Re-ablement funds**	CCGs	£1,124.5	£175.5	£1,300
	Total all funds		£1,124.5	£175.5	£16,256.185

Appendix 2

Proposed use for the NHS Funding for Social Care – NB Indicative figures subject to final approval; final framework outcome measures to be added

NHS Outcome Framework Domain	Proposal	£'000s	Health Benefit	Former outcome measure/performance indicators (2011/12) (see Appendix 4)	Current Adult Social Care Outcomes Framework Indicators (2013/14)	NHS Outcomes Framework corresponding (2013/14)
Enhancing Quality of Life for People with Long-Term conditions	Contribution to social care demographic pressure.	£2,565	Ensure continued level of service for people with dementia, carers and people with complex disability. This will help ensure an adequate supply of care and avoid an increase in delayed discharges.	NI 141, 142, 131, 125, HQU 16, HR 506, C 72	1A; 1D; 4A	2, 2.4, 2.6.ii.
	Reduce savings on equipment and on specialist sensory support services	£887	This will avoid disruption to hospital discharge as a result of the availability of equipment.	NI 141, 142, 131, 135		
	Reduce savings on Mental Health.	£900	This funding prevents local authority reductions in expenditure that could impact of NHS services, and allows for a phased redesign of services.	NI C 73, 72, NI 141, 142		2.6.ii
	Maintain eligibility criteria for social care services at "Critical" and "Substantial".	£1,400	By continuing to meet "substantial" needs this will prevent crisis situations, which often result in an NHS intervention and hospital admission.	NI 141, 142, 131, 125, HQU 16, HR 506		
	Maintain capacity for assessments and case management.	£1,141	Ensuring sufficient social work assessment capacity to deal with increased numbers of social care cases.			

NHS Outcome Framework Domain	Proposal	£'000s	Health Benefit	Former outcome measure/performance indicators (2011/12) (see Appendix 4)	Current Adult Social Care Outcomes Framework Indicators (2013/14)	NHS Outcomes Framework corresponding (2013/14)
Helping People to recover from episodes of ill health or following injury	Reduce the three year saving on early intervention and prevention.	£5,495	Investment in prevention has a clear health benefit. This funding allows for the maintenance of a range of community prevention and support services and to allow for a service redesign to take place over time.	NI 141, 131, 125, 142, C 73, HR 506		3; 3.6.i
Ensure people have a positive experience of care	Reduce proposed savings in quality assurance	£100	Develop a Norfolk wide Care Charter for health and social care services.	NI 139, SQU 28, NI 141		4.9
Treating and caring for people in a safe environment and protecting them from avoidable harm.				NI 141, 142		
Additional enhancements for 2013/14	Invest in a data management system to allow commissioners to analyse activity and cost across health and social care.	£250	Aim to improve integration and contribute to a whole-system approach to the local health economy by providing commissioners with integrated intelligence.	New activity		
	Contribute to improving hospital discharge	£1,500	Improved out-of-hours discharge pathway for weekends and public holidays, reducing or preventing delays.	New activity		

NHS Outcome Framework Domain	Proposal	£'000s	Health Benefit	Former outcome measure/performance indicators (2011/12) (see Appendix 4)	Current Adult Social Care Outcomes Framework Indicators (2013/14)	NHS Outcomes Framework corresponding (2013/14)
	arrangements by ensuring seven day per week availability of social care assessment capacity.					
	Contribute to maintaining patient flow through the acute care sector to the community by increasing the availability of domiciliary and residential care packages.	£2,000	Reduction of potential blockages in discharge destinations (at home or in residential care) will contribute to speed of discharge to appropriate environment, benefitting both the patient and the speed of discharge.	New activity		
TOTAL		£14,956				

Appendix 3

Proposed use of the Re-ablement funding for Social Care (2013/14)

Objective: Investment (reduced) in Norfolk First Support home care re-ablement service, Swift and Night Owls services to maintain existing re-ablement support.

Main performance measures:

- NHS Outcomes Framework indicators: 3.6.i, 3b, 3.3, 3.4,3.5
- Adult Social Care Outcomes Framework indicators: 2A, 2B, Placeholder 2E

Suggested funding breakdown between CCGs (by population from baseline funding). NB bulk of re-ablement money is, by default, spent with NHS services.

CCG Area	West Norfolk CCG	North Norfolk CCG	Health East	Norwich CCG	Southern CCG	Totals
Population	163,000	167,000	Not applicable	205,000	220,000	755,000
Funding	**£242,770**	**£248,730**	**£175,500**	**£305,330**	**£327,670**	**£1,300,000**

Alternatively, funding could be allocated according to current referral rates, which would give a split of:

	West	**North**	**East**	**Norwich**	**Southern**	**Totals**
Referrals average quarter	220	190	185	250	245	1,090
% of total	20.2%	17.4%	17.0%	22.9%	22.5%	100.0%
Share of £1.3m	**£262,385**	**£226,606**	**£220,642**	**£298,165**	**£292,202**	**£1,300,000**

Appendix 4

Details of Monitoring Arrangements to Measure Impact

	Former MEASURE	DEFINITION	Aim	Adult Social Care Responsibility	TARGET	Basis of Target	NHS Outcomes Framework equivalent (2013/14) (To Finalise)	Social Care Framework equivalent (2013/14) (To finalise)
NI125	Rehabilitation and Intermediate care users 3 months after discharge	Achieving independence through rehabilitation/ intermediate care	Improve current performance	Contributory	80%	2011/12 target	3.6.i	
NI131	Delayed transfer of care from hospital	Delayed transfer of care from hospital (per 100,000 population aged 18+)	Maintain current performance	Primary for social care DToCs	8	2010/11 target	2.3	
N1 139	PROMS Support and choice for independent living	People over 65 years who say that they have received the information, assistance and support needed to exercise choice and control to live independently	Maintain current performance	Contributory	TBC – annual survey			
SQU28	People with long term conditions feeling independent and in control of their conditions	% of people with LTC who said they had had enough support from local services.	Current performance not clear	Contributory	50%	Proposed Operating Plan target	2	

	Former MEASURE	**DEFINITION**	**Aim**	**Adult Social Care Responsibility**	**TARGET**	**Basis of Target**	**NHS Outcomes Framework equivalent (2013/14) (To Finalise)**	**Social Care Framework equivalent (2013/14) (To finalise)**
NI 141	Percentage of vulnerable people achieving independent living	Number of vulnerable people living independently	Maintain current performance	Primary	70%	2010/11 target	3.6.i; 4.9	
NI 142	Percentage of vulnerable people who are supported to maintain independent living	Number of vulnerable people who are supported to maintain independent living	Maintain current performance	Primary	97%	2010/11 target		
HQU16	Emergency readmissions	Emergency admissions within 30 days	Current performance not clear	Contributory	TBC			
C72	Permanent admissions to residential/nursing care 65+		Improve current performance	Primary	65	2011/12 target		
C 73	Permanent admissions to residential/nursing care 18-64		Improve current performance	Primary	1.8	2011/12 target		
NI 135	Carers supported following an assessment or review		Improve current performance	Primary	43%	2011/12 target	2.4	
HR 506	Emergency admission rate			Contributory	Tbc once baseline agreed	2011/12 target		