5. PUBLIC QUESTIONS TO HEALTH AND WELLBEING BOARD: WEDNESDAY 31 OCTOBER 2018

5.1 Question from Mrs S Vaughan

The consultation that closed on 26th October about the proposed ICP contract says that “An Integated Care Provider will not be right for every area”, page 16, easy read version. Assuming that this is accurate, what features of Norfolk and Waveney footprint make NHSE think we will be suitable and what factors would make an ICP the wrong way to go?

Response from Chairman of Health and Wellbeing Board

NHS England have said they don’t think that Integrated Care Provider (ICP) contracts will be right for every area. They explain that they’ve created the ICP contract in response to “the demand in some areas for a single contract through which general practice, wider NHS and in some cases, some local authority services can be commissioned from a ‘lead’ provider organisation, responsible for delivering integration of services”. ICPs are not a new type of legal entity, but rather provider organisations which have been awarded ICP contracts.

It will be up to us, as a partnership of local health and care organisations, to assess whether this is a contract which we might want to use in Norfolk and Waveney. We will be able to decide this once NHS England has published the final version of the contract, taking into account all the feedback it received during the consultation.

At the moment the Norfolk and Waveney Sustainability and Transformation Partnership (STP) is working towards becoming an Integrated Care System (ICS), because we believe that this will accelerate the improvement in our health and care system. Becoming an ICS would mean formalising how we work together and building on what we are already doing, but it does not require us to commission using an ICP contract.

Supplementary question from Mrs S Vaughan

Item 5 of the Update on the Norfolk and Waveney Sustainability and Transformation Partnership (October2016) also refers to "engagement with the public, staff, voluntary and community sector and other stakeholders in the development of our integrated care system". How is this being done?

Response from Chairman of Health and Wellbeing Board

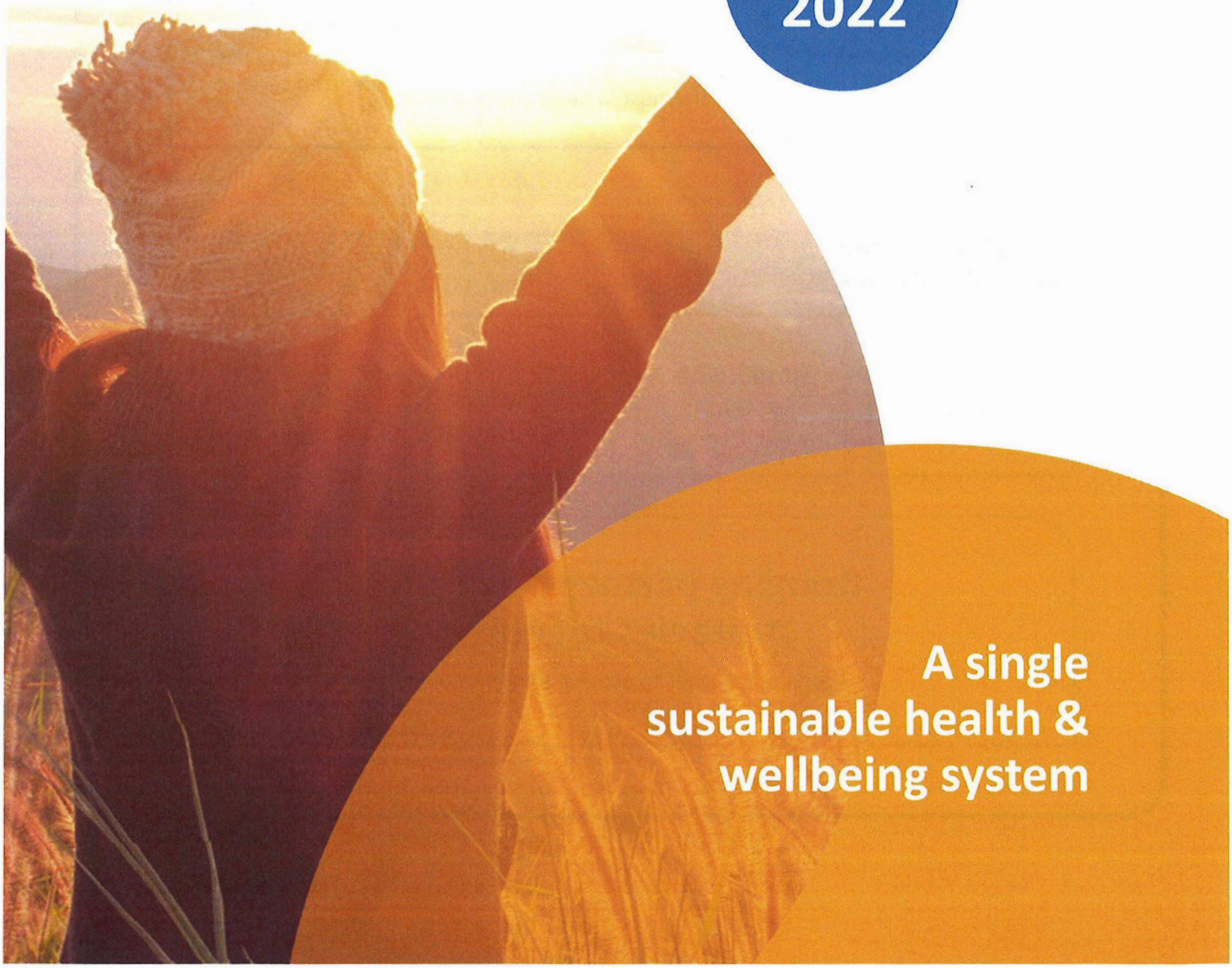
We are organising a programme of engagement for the autumn and winter to develop our integrated care system. This started off with an event in mid-October for non-executive directors of provider boards, lay members and GP leads from CCG governing bodies and councillors. We’re now having discussions with CCG governing bodies, provider boards, the Norfolk Health and Wellbeing Board and the Sector Leadership Group for the voluntary, community and social enterprise sector (VCSE). The purpose of our engagement is to make sure we have a shared understanding of what an integrated care system is, and is not, and to talk about what becoming an ICS could mean for Norfolk and Waveney. We are continuing to develop our engagement plans, which will include further VCSE and stakeholder events, attending existing forums of local groups and opportunities for the public to have their say too, details of which will be publicised shortly.

Appendix B

Health and Wellbeing Board
Norfolk & Waveney

Joint Health & Wellbeing Strategy

2018 – 2022



Our Strategic Framework

Health and Wellbeing Board
Norfolk & Waveney

Our Vision

A Single Sustainable System

Working together we will use our resources in the most effective way to prioritise prevention and support to the most vulnerable

Our Priorities

Prioritising Prevention
Supporting people to be healthy, independent and resilient

Tackling Inequalities in Communities
Providing most support for those who are most in need

Integrating Ways of Working
Collaborating in the delivery of people centred care

Our Values

- Collectively Accountable
- Simplifying Systems
- Promoting Engagement & Involvement
- Based on Evidence of Needs

Bringing partners' existing strategies together

Working together to achieve joint outcomes

Welcome

We are delighted to introduce our **Joint Health and Wellbeing Strategy 2018-22: A single sustainable health and social care system** for the people and communities in Norfolk and Waveney.

This Strategy is **different** - it's about **how we all work together** as system leaders to drive forward improvement in the health and wellbeing of people and communities, given the unprecedented challenges facing our health, care and wellbeing system.

Health and care services across the country are under **considerable financial strain** - and Norfolk and Waveney is no exception. There is a significantly large total annual budget for health and social care services in Norfolk and Waveney, but with growing demand our budget spend continues to increase leading to over-spend which needs to be addressed.

At the same time, our **population continues to grow**, and the pattern of family life has changed. **People are living longer** and have access to many more medical specialists than in the past. **Families are under increasing pressure**, and society's concern for children's and adults' safety has placed additional responsibilities for ensuring their protection.

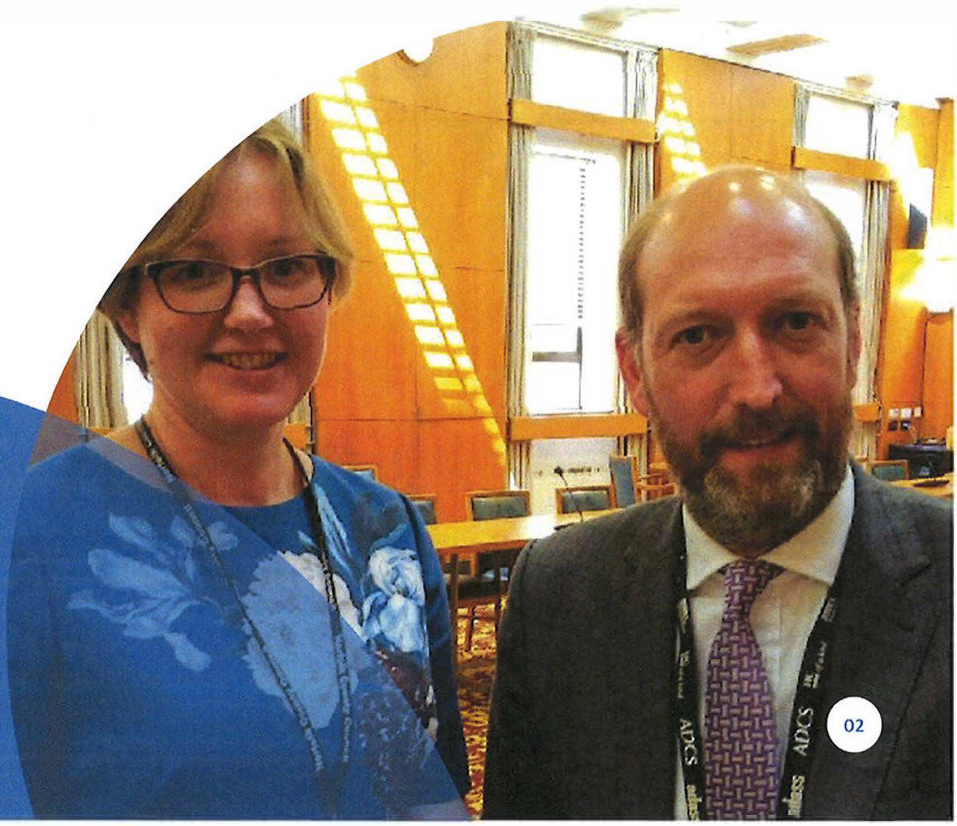
The health and social care system is working together under the **Norfolk and Waveney Sustainability & Transformation Partnership** and underpins support for the move towards an **integrated care system** from the Health & Wellbeing Board for Norfolk and Waveney.

This Strategy builds on that **collaborative mandate - our top priority is a sustainable system** and we are evolving our longer-term priorities from our previous Joint Health & Wellbeing Strategy to help us face the challenges of the future. **Prevention and early intervention is critical** to the long term sustainability of our health and wellbeing system. Stopping ill health and care needs happening in the first place and targeting high risk groups, as well as preventing things from getting worse through systematic planning and proactive management. Through our Strategy, we are focusing the whole system on **prioritising prevention, tackling health inequalities in our communities and integrating our ways of working** in delivering people centred care.

Dr Louise Smith
Director of Public Health

Cllr Bill Borrett
Chairman of the Health and Wellbeing Board

Through our Strategy, we are making a difference – creating a single sustainable health and wellbeing system for Norfolk and Waveney.



Our Values

Our values describe our shared commitment to working together to make improvements and address the challenges:

Values	By this we mean:
Collectively Accountable	As system leaders, taking collective responsibility for the whole system rather than as individual organisations.
Simplifying Systems	Reducing duplication and inefficiency with fewer organisations - a commitment to joint commissioning and simpler contracting and payment mechanisms.
Promoting Engagement and Involvement	Listening to the public and being transparent about our strategies across all organisations.
Based on Evidence of Needs	Using data, including the Joint Strategic Needs Assessment (JSNA), to target our work where it can make the most difference- making evidence-based decisions to improve health and wellbeing outcomes.
Bringing partners' existing strategies together	Under the umbrella of the Health and Wellbeing Board for Norfolk and Waveney- identifying the added value that collaboration brings and working together to achieve joint outcomes.

Our Priorities

Our vision of a single sustainable system requires us to work together, implementing what the evidence is telling us about health and wellbeing in Norfolk and Waveney, on these key priorities:

Priorities	By this we mean:
1 A Single Sustainable System	Health and Wellbeing Board partners taking joint strategic oversight of the health, wellbeing and care system – leading the change and creating the conditions for integration and a single sustainable system.
2 Prioritising Prevention	A shared commitment to supporting people to be healthy, independent and resilient throughout life. Offering our help early to prevent and reduce demand for specialist services.
3 Tackling Inequalities in Communities	Providing support for those who are most vulnerable in localities using resources and assets to address wider factors that impact on health and wellbeing.
4 Integrating Ways of Working	Collaborating in the delivery of people centred care to make sure services are joined up, consistent and makes sense to those who use them.

1 A Single Sustainable System

Working together we will use our resources in the most effective way to prioritise prevention and support to the most vulnerable.

Our Population

Norfolk and Waveney's population of 1.01 million is forecast to increase by over 10% by 2037, about 120,000 people.

The main population growth will be people aged 65+ years. Life expectancy is 80 years for men and 84 years for women.

Currently 90% of retirement age people are economically inactive. By 2037 this is forecast to be 1 in 3 of the population.

Our System

Our health and wellbeing system is complex.

Future Activity

Planning future services is challenging with increasing demand and needs alongside reducing or level budgets.

What has happened between 2011 and 2016

Median age for emergency admissions has increased from 62 to 64

- Births from 10,600 to 10,200 per year
- 20% A&E attendances from about 204,000 to 245,000
- A&E ambulance arrival from 63,000 to 82,000
- 12% Emergency admissions from 90,000 to 101,000
- 12% Average ordinary admission from about 34,800 to 30,500
- 26% Day case admissions from 125,400 to 158,600
- 10% 10,300 to 11,400 in 2016

What is likely to happen between 2016 and 2022

- Births remained about the same 10,200 per year
- 27% A&E attendances from about 245,000 to 313,000
- 28% A&E ambulance arrival from 82,000 to 105,000
- 24% Emergency admissions from 101,000 to 125,000
- 15% Average ordinary admission from about 30,500 to 26,000
- 41% Day case admissions from 158,600 to 224,100
- Deaths will remain about the same 11,500 per year

1 A Single Sustainable System - Actions

What's important strategically?

Norfolk and Waveney has an annual budget in excess of £1.5bn for health and social care services. However as a system we are seeing increasing demand resulting in budget pressures.

Needs are becoming increasingly complex and so our service improvements must be more co-ordinated and effective for the service user and their carer.

Services are improved where there is a coordinated, effective and seamless response.

Key Challenges

- Addressing needs with all partners managing on reducing or level budgets.
- Working as a single system in the delivery of people centred care, across a complex organisational and service delivery landscape.
- Driving the cultural change necessary to deliver a single sustainable health and wellbeing system.

Key Measures

Each HWB organisation can clearly report to the HWB how they are:

1. Contributing to financial sustainability and an integrated system.
2. Reviewing the impact of strategy and outcomes.
3. Using the evidence intelligently – including evidence from service users- in our discussions and our planning.
4. Working in partnership with others to support delivery of partners' transformation plans.

Priority actions

We will work together to lead change for an integrated financially sustainable system by:

- Sharing our thinking, planning, opportunities and challenges – informing new ways of working and transformation.
- Engage with and listen to service users, residents and communities to inform our understanding and planning.
- Undertake needs assessments, including the JSNA, to help us keep our Strategy on track and understand its impact.
- Use partners' existing plans- building on the priorities partners are already working hard to address, identifying the added value that collaboration through the HWB's Strategy can bring.
- Develop mechanisms such as risk stratification tools and the sharing of information to target care where it is needed most.

1 A Single Sustainable System - Case Study

Healthwatch Norfolk (HWN)

The development of the Pharmaceutical Needs Assessment (PNA) is a good illustration of collaborative working in Norfolk.

The Health and Wellbeing Board is responsible for publishing and updating the PNA which sets out the current pharmaceutical services available in Norfolk, identifies any gaps in services, and makes recommendations on future development.

Healthwatch Norfolk (HWN) were selected to coordinate and produce the PNA through a steering group of partners. A HWN survey to support the assessment resulted in over 2700 responses.

Alex Stewart, Chief Executive of Healthwatch Norfolk, said:

"This has been the liveliest and most interactive Needs Assessment that HWN have been involved in to date and we have had pleasure in helping to ensure that the voice of the public and patients are represented in this process. A feeling of trust and sound working relationships built over time between several group members has enhanced the sense of achievement. Other additional benefits to this collaborative partnership approach has brought a cultural sensitivity to the PNA. Recommendations around translation services in pharmacies have identified possible cost savings with avoidance of potential adverse events."

2 Prioritising Prevention

Supporting people to be healthy, independent and resilient.

Children & Young People

About 283,300 under 25 year olds live in Norfolk and Waveney- this number is forecast to rise slightly.

The health and wellbeing of children is consistent with the England average, as are recorded levels of child development.

1 in 4 children are overweight by age 4 – 5.

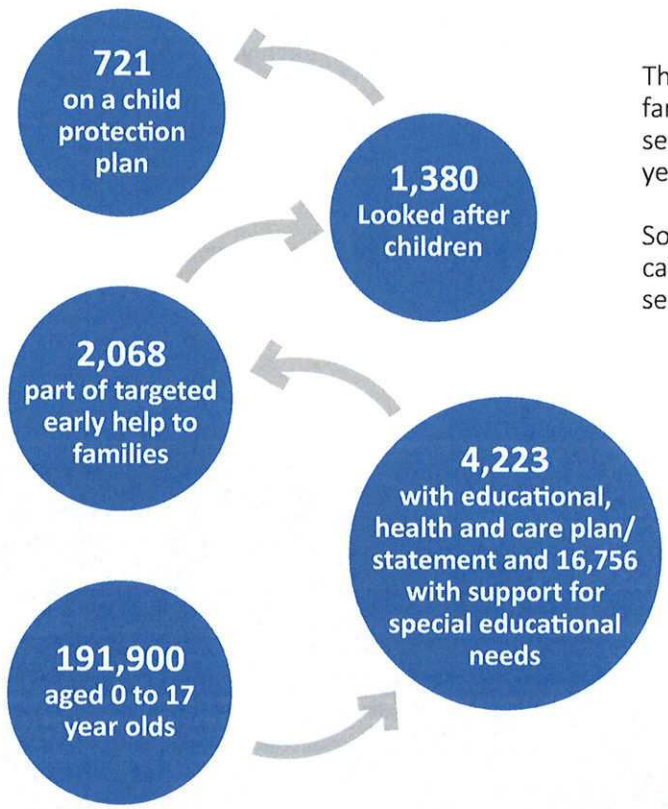
There are fewer teenage pregnancies but we remain above the England average in Great Yarmouth and Norwich.

1 in 7 women are smokers at the time of having a baby.

Levels of anxiety in young people are rising as are hospital admissions for self-harm.

1 in 7 children live in relative poverty.

2015		Change	2025
54,200	0-4	↑ 1%	54,700
74,400	5-11	↑ 6%	78,700
73,400	12-18	↑ 12%	82,500
81,300	19-25	↓ 10%	73,500



The vast majority of children and families are supported by universal services such as health visiting, early years provision, schools and colleges.

Some children access additional social care and educational support and services based on their needs.

2 Prioritising Prevention

Unhealthy lifestyles impact on our health outcomes and need for health services.

Healthy lifestyles and health services

We are seeing demands on our hospital based services with:

- 10,900 smoking attributable hospital admissions in 2016/17.
- 8,911 hospital admissions where obesity was the main or secondary diagnosis.
- 6,020 hospital admissions for alcohol related conditions.
- 3,852 emergency hospital admissions due to falls in people aged 65 and over.

Inequalities in healthy lifestyles

If the most deprived areas had the same rates as other areas then each year we would see:

- 400 more children at a healthy weight.
- 1,000 fewer emergency admissions for older people.
- 60 fewer deaths due to preventable causes.

2 Prioritising Prevention - Actions

What's important strategically?

There is strong evidence that interventions focussed on prevention are both effective and more affordable than just focussing on providing reactive emergency treatment and care. To build a financially sustainable system means we must promote healthy living, seek to minimise the impact of illness through early intervention, and support recovery, enablement and independence.

Priority areas for prevention are:

- Creating healthy environments for children and young people to thrive in resilient, safe families.
- Delivering appropriate early help services before crises occur.
- Helping people to look after themselves and make healthier lifestyle changes.

Key Challenges

- Identifying and protecting investment in prevention within budgets.
- Identifying needs early and providing early access to support.
- Embedding prevention across all of our strategies and policies.
- Raising awareness of the impact of lifestyle on health, for example with diabetes.

Key Measures

Each HWB organisation can clearly report to the HWB how they are:

1. Implementing an integrated strategy and a single system approach for children and young people where need is understood and priority actions shared.
2. Prioritising prevention both at a policy level and in decision-making.
3. Promoting the health and wellbeing of their workforce.

Priority actions

We will work together to lead change for an integrated financially sustainable system by:

- Developing, in partnership, a systematic approach for children and young people's support and provision.
- Embedding prevention across all organisational strategies and policies.
- Providing joint accountability so that as a system we are preventing, reducing and delaying needs and associated costs.
- Promoting and supporting healthy lifestyles with our residents, service users and staff.

2 Prioritising Prevention - Case Study

Early Help and Family Focus

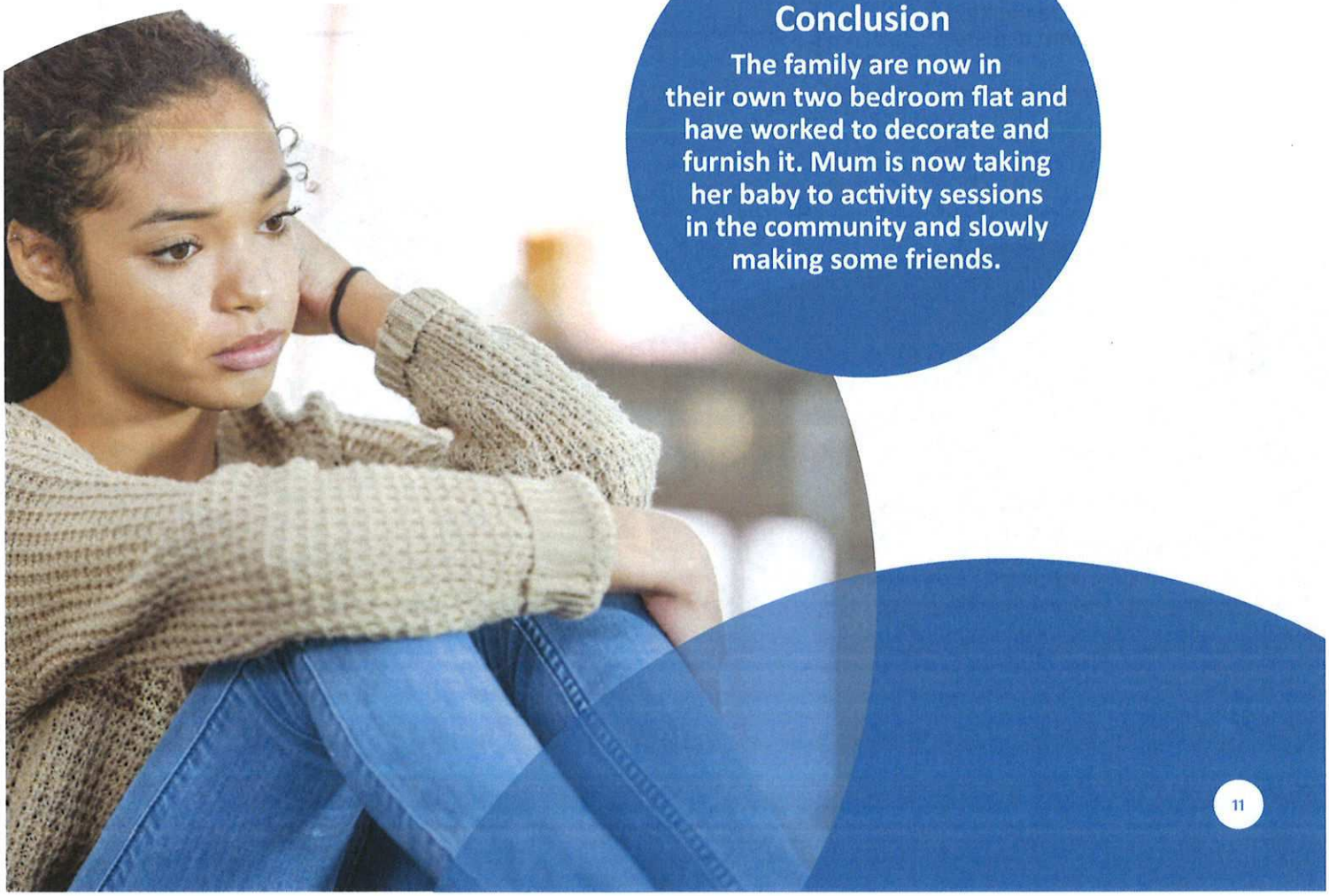
Early Help and Family Focus Broadland received a request for support for a young couple who had just had a baby and were homeless with no extended family support. The early help practitioner arranged a joint visit with the health visitor and talked with them about their worries and what was working well for them. (This is the Signs of Safety approach). The 'team around' the family then worked with the young parents to produce a plan which resulted in the following support:

Who did what

The young parents met with the debt advisor from Broadland District Council who helped them understand how to plan a budget and manage their finances. A benefits advisor made sure they were claiming the correct benefits.

The Early Help practitioner supported the young parents to talk with each other and to understand both their own and each other's emotions - encouraging them to argue less.

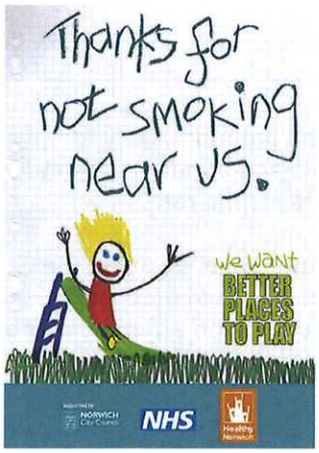
The Early Help practitioner worked with the health visitor to explain to the young parents how babies develop and what they need at the different stages of development.



Conclusion

The family are now in their own two bedroom flat and have worked to decorate and furnish it. Mum is now taking her baby to activity sessions in the community and slowly making some friends.

2 Prioritising Prevention - Case Study



A Smoke Free Norfolk

Healthy Norwich is an example of an approach to improving health and wellbeing in the greater Norwich area by working together to make a healthier community.

Smoke Free Park signage has been placed in play areas to ask adults not to smoke nearby. This voluntary code will directly **help prevent children and young people taking up smoking** and potentially help smokers to **seek support to quit**.

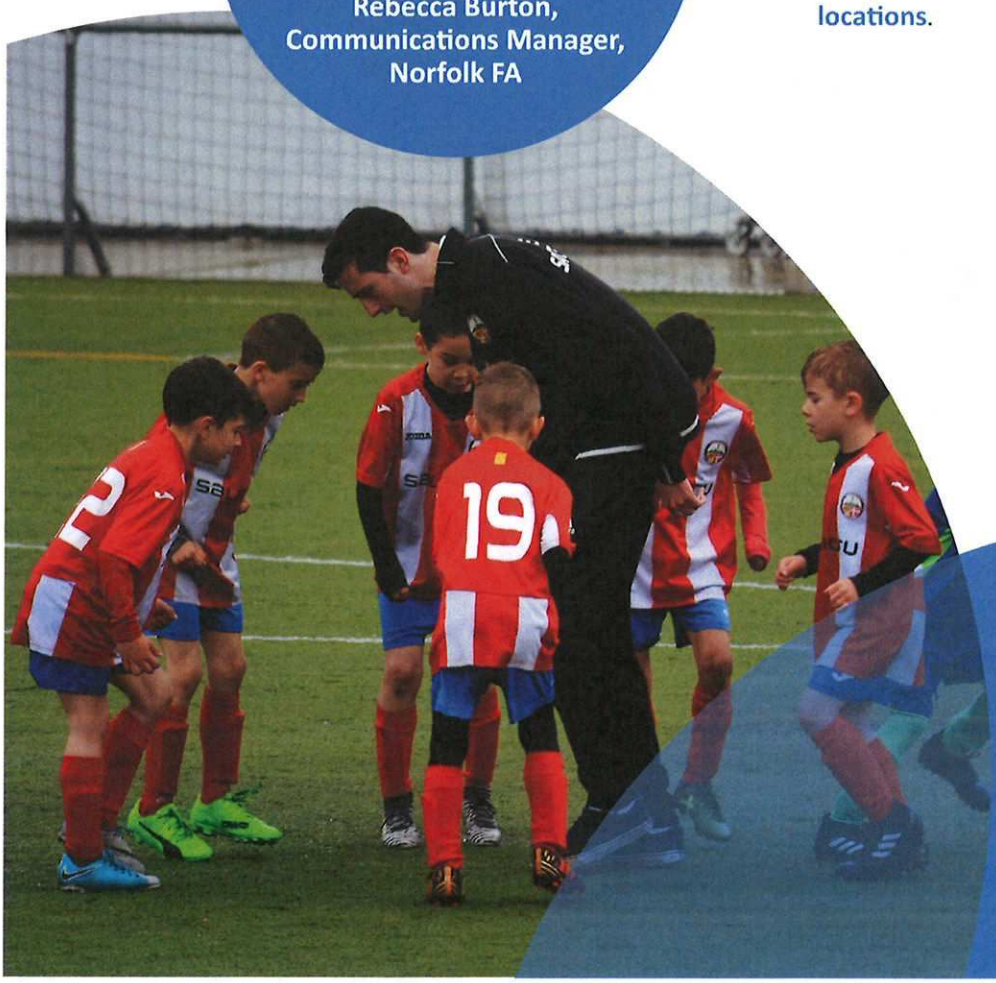
Smoke-free sport, including **#Smokefree Sidelines**, is backed by Norfolk Football Association (FA) where local youth football clubs are championing the message that smoking has no place in youth sport.

"#Smokefreesidelines uses non-judgemental messaging and will encourage people to think twice before exposing young people to smoking. This will make the idea of smoking less normalised."

Rebecca Burton, Communications Manager, Norfolk FA

As well as discouraging smoking, **Smoke Free Sport** brings about additional benefits including:

- **Protecting the environment** and saving money by reducing tobacco-related litter.
- Offering further protection from the **harmful effects of second-hand smoke**.
- Providing the opportunity for public acceptance of voluntary **smoke-free locations**.



3 Tackling Inequalities in Communities

Providing most support for those who are most in need.

Deprivation

Norfolk has average levels of deprivation but an estimated 68,700 people live in the most deprived areas of England.

Norfolk and Waveney has a diverse population and deprivation can be experienced in both urban and rural settings.

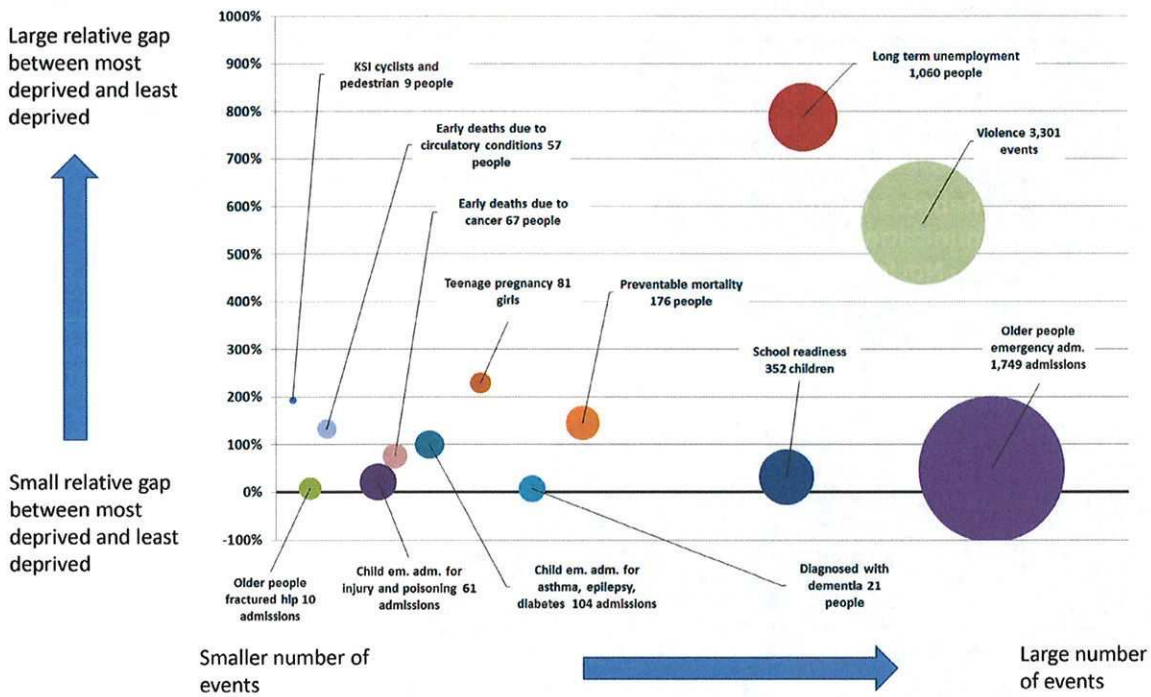
People living in deprivation are more likely to experience violence, crime and accidents despite Norfolk having a low overall crime rate.

Four districts in Norfolk and Waveney are in the lowest quintile in England for social mobility - driven by lower levels of education attainment and skill level.

Inequalities and life expectancy

The difference in life expectancy gap between those living in the most deprived and the least deprived areas is about 7 years for men and 4.5 years for women.

People living in our 20% most deprived areas are more likely to smoke, have an unhealthy diet and be less active.



Preventable illness, violence, drug overdose, suicide and accidents outcomes do correlate with deprivation. For example, if the most deprived experienced the same rates as the least deprived there will be 3,301 fewer violent events per year.

3 Tackling Inequalities in Communities - Actions

What's important strategically?

Those living in our most deprived communities experience more difficulties and poorer health outcomes. We recognise that together, we need to deliver effective interventions, to break the cycle, mobilise communities and ensure the most vulnerable children and adults are protected.

To be effective in delivering good population outcomes we need to most help those in most need and intervene by working together at county, local and community levels to tackle issues reflecting whole system priorities as well as specific concerns at the right scale.

Reducing inequalities in health and wellbeing will involve addressing wider issues that affect health, including housing, employment and crime, with community based approaches driven by councils, the voluntary sector, police, public sector employers and businesses.

Key Challenges

- Identifying and ensuring access to services for those most vulnerable.
- Promoting healthy relationships in families and communities.
- Helping people out of poverty, particularly hidden rural poverty.

Key Measures

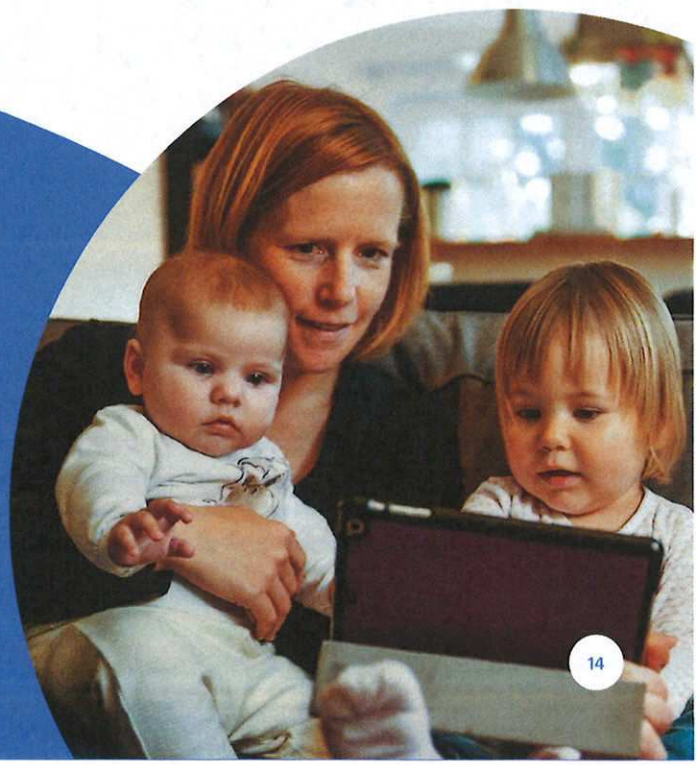
Each HWB organisation can clearly report to the HWB how they are:

1. Promoting alignment and consistency in local delivery partnerships to plan for, and with, their local community.
2. Reducing the impact of crime, injuries and accidents in our most deprived areas.
3. Using source data available (including from the JSNA) to inform strategic plans.

Priority actions

We will commit to working together to build on the strengths in local communities, rural and urban, by:

- Improving locality working and sharing best practice.
- Providing and using the evidence to address needs and inequalities.
- Addressing the impact of crime, violence and injuries.
- Joining up development planning by working with those with planning responsibilities.



3 Tackling Inequalities in Communities - Case Study

Great Yarmouth - Neighbourhoods that work

Neighbourhoods that Work (NTW) is a partnership initiative led by Great Yarmouth Borough Council together with seven partner organisations. NTW aims to connect local communities to the benefits of economic growth by:

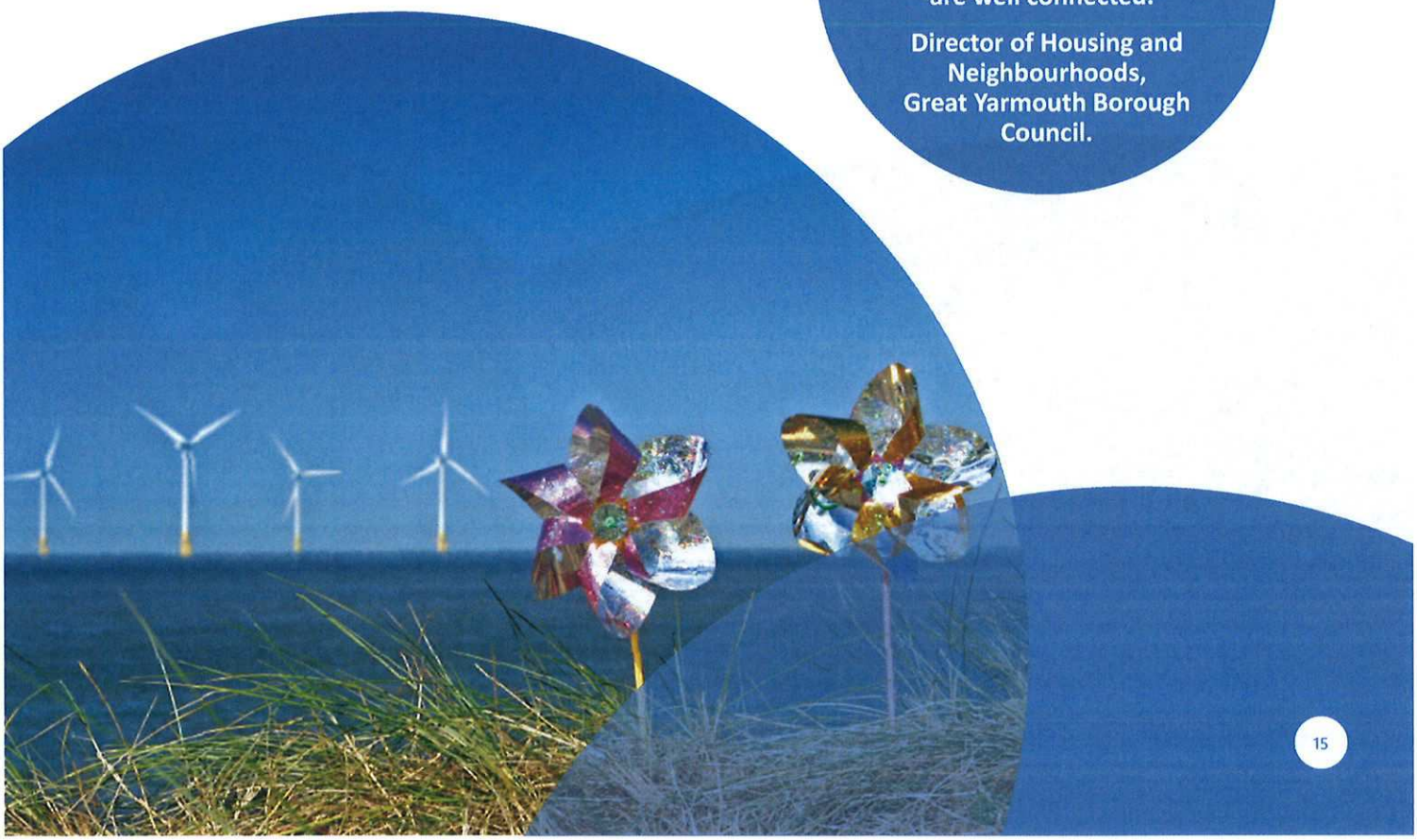
- **Increasing community resilience.**
- **Improving the responsiveness of voluntary sector support services.**
- **Increasing the participation of communities in driving forward sustainable economic development.**

The vision is to work with local residents to build stronger communities- focussing on people, neighbourhoods, and the things that matter most. Community Development approaches are used to work with local people in the places they live to identify and act upon things that matter most to communities.

The project builds upon 10+ years of work in Great Yarmouth building on existing and award winning community development infrastructure - incorporating engaged local residents, neighbourhood boards and a variety of diverse community and voluntary based organisations.

"Our starting point is that communities are full of people who can provide the connections that make their neighbourhood stronger. People thrive in communities that are well connected."

Director of Housing and Neighbourhoods, Great Yarmouth Borough Council.



3 Tackling Inequalities in Communities - Case Study

Arts and Culture for health and wellbeing

Collaboration between Norfolk's arts, culture, health and social care sectors is well established with some major successes in attracting investment to deliver effective joint programmes.

Norfolk County Council's award-winning **Culture & Heritage, Communities, Information and Learning Services** including museums, libraries, archives, arts, community learning and sports play a key role in supporting local health and wellbeing priorities through the provision of: collaborative programmes; volunteering; learning and skills development; provision of welcoming and enriching spaces and professional development for arts, health and social care professionals.

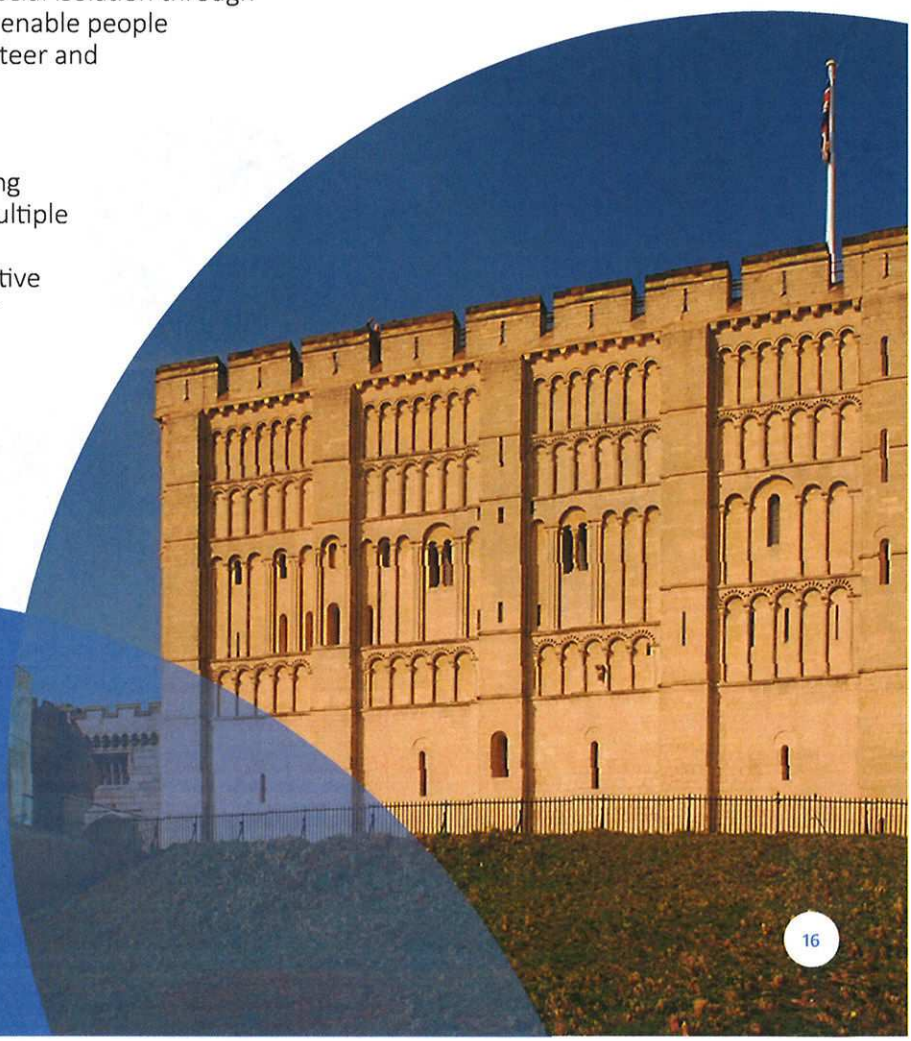
"There is growing evidence that engagement in activities like dance, music, drama, painting and reading help ease our minds and heal our bodies. It is most encouraging to see just how much potential and ambition there is for joined-up action on this vital work in Norfolk."

Sir Nicholas Serota, Chair, Arts Council England.

With ten outstanding museums, **Norfolk Museums Service** is strongly embedded in our local communities, providing excellent and ongoing support for health and wellbeing priorities through its extensive public programmes and targeted projects.

With 47 community libraries, **Norfolk Library and Information Service** has a strong focus on reducing social isolation through providing safe and welcoming venues to enable people to engage with others, participate, volunteer and develop new creative skills.

Norfolk Arts Service leads the strategic development of arts, health and wellbeing collaboration in Norfolk. It works with multiple local and national partners to influence policy, identify and broker new collaborative opportunities and secure investment for new initiatives.



4 Integrating Ways of Working

Collaborating in the delivery of people centred care.

Living Independently in Later Life

Whilst life expectancy has risen only half of our retirement years are spent in full health. We will see the largest increases in the number of people over 65 years old.

There are 14,000 people living with dementia now- this is forecast to almost double to 25,000 by 2037 and most of these new cases will be in people aged over 85.

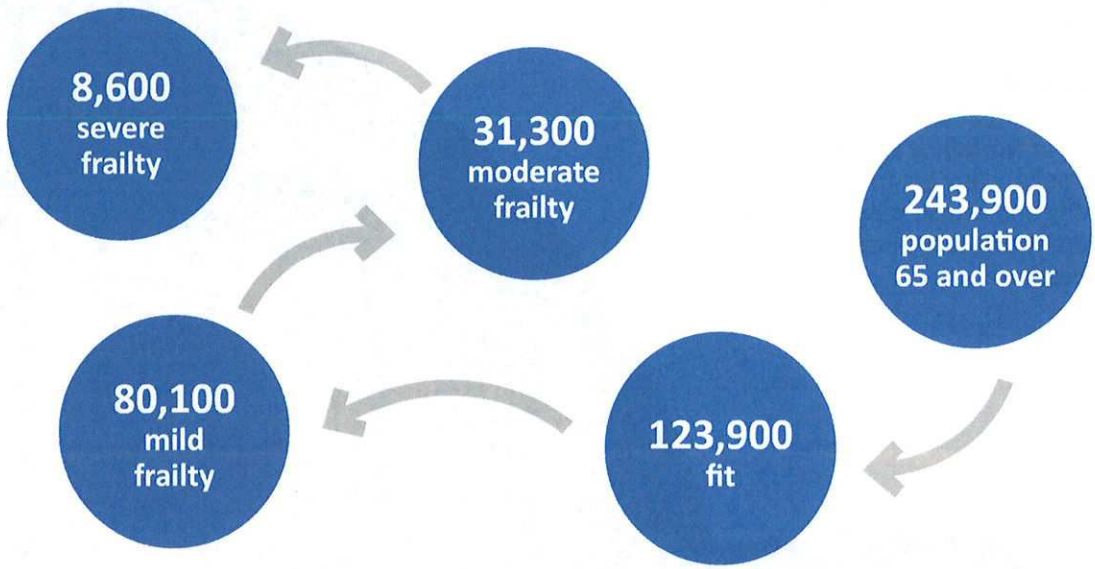
An estimated 23,200 people provide 50+ hours of unpaid care a week.

Mental health and wellbeing

About 1 in 7 people in Norfolk and Waveney experience a common mental health disorder with long term mental ill health being higher than the average for England.

- 8% of adults were recorded as having depression.
- 1,712 emergency hospital admissions were for intentional self harm in 2016/17.
- About 110 people die each year from suicide.

The number of ill health conditions an individual has contributes to the complexity of how to manage, and increases the cost of health and social care.



4 Integrating Ways of Working - Actions

What's important strategically?

We are seeing increasing demand with an ageing population. It is only by working together, in an integrated way, that we can meet the needs of people with more complex health and care challenges, managing with reducing or level budgets.

We want vulnerable people of all ages to live as long as possible in their own homes and to be independent, resilient and well- having access to early help and person centred care when needed. Long term mental ill health is associated with significantly poorer physical health and shorter life expectancy.

Working together with and within communities is important to promote good mental health support and wellbeing. It is also important to recognise the contribution of carers and the support they need.

Key Challenges

- We are seeing increasing demand with an ageing population.
- Disease patterns are changing: multiple morbidity, frailty in extreme old age, and dementia are becoming more common.
- Ensuring parity of approach between physical and mental health.

Key Measures

Each HWB organisation can clearly report to the HWB how they are:

1. Prioritising promoting independence and healthy later life both at a policy level and in decision-making.
2. Contributing to the Sustainability & Transformation Partnership's Strategy.

Priority actions

We will ensure integrated ways of working by:

- Collaborating in the delivery of people centred care to make sure services are joined up, consistent and makes sense to those who use them.
- Working together to promote the important role of carers and the support they may also require.
- Embedding integrated approaches in policy, strategy and commissioning plans.

4 Integrating Ways of Working - Case Study

History of dementia partnerships in Norfolk

Dementia as a priority for Norfolk has been championed by a series of partnership groups over the years: The Norfolk Older People's Strategic Partnership, the Dementia Strategy Implementation Board, the Norfolk and Waveney Dementia Partnership and more recently the Dementia Academy.

Areas of focus continue to include:

- Early diagnosis and a gap free pathway for people with dementia and their carers.
- Improving advice and Information.
- Launch of **www.dementiafriendlyNorfolk.com**.
- Support for employers with a resource pack – addressing an ageing workforce, early onset dementia and more of us becoming carers.
- Medication advice – a leaflet detailing medication effects.
- Life stories as a resource to support stages of dementia.
- Prevention – research and evidence-based approaches to prevent and delay the onset of dementia.
- Involvement as a 'critical friend' in the dementia subgroup of the Norfolk and Waveney Sustainability & Transformation Partnership's Mental Health work stream.

4 Integrating Ways of Working - Case Study

Promoting independence in older age

Physical activity has been introduced into Norwich care settings by **Active Norfolk** through the Mobile Me scheme.

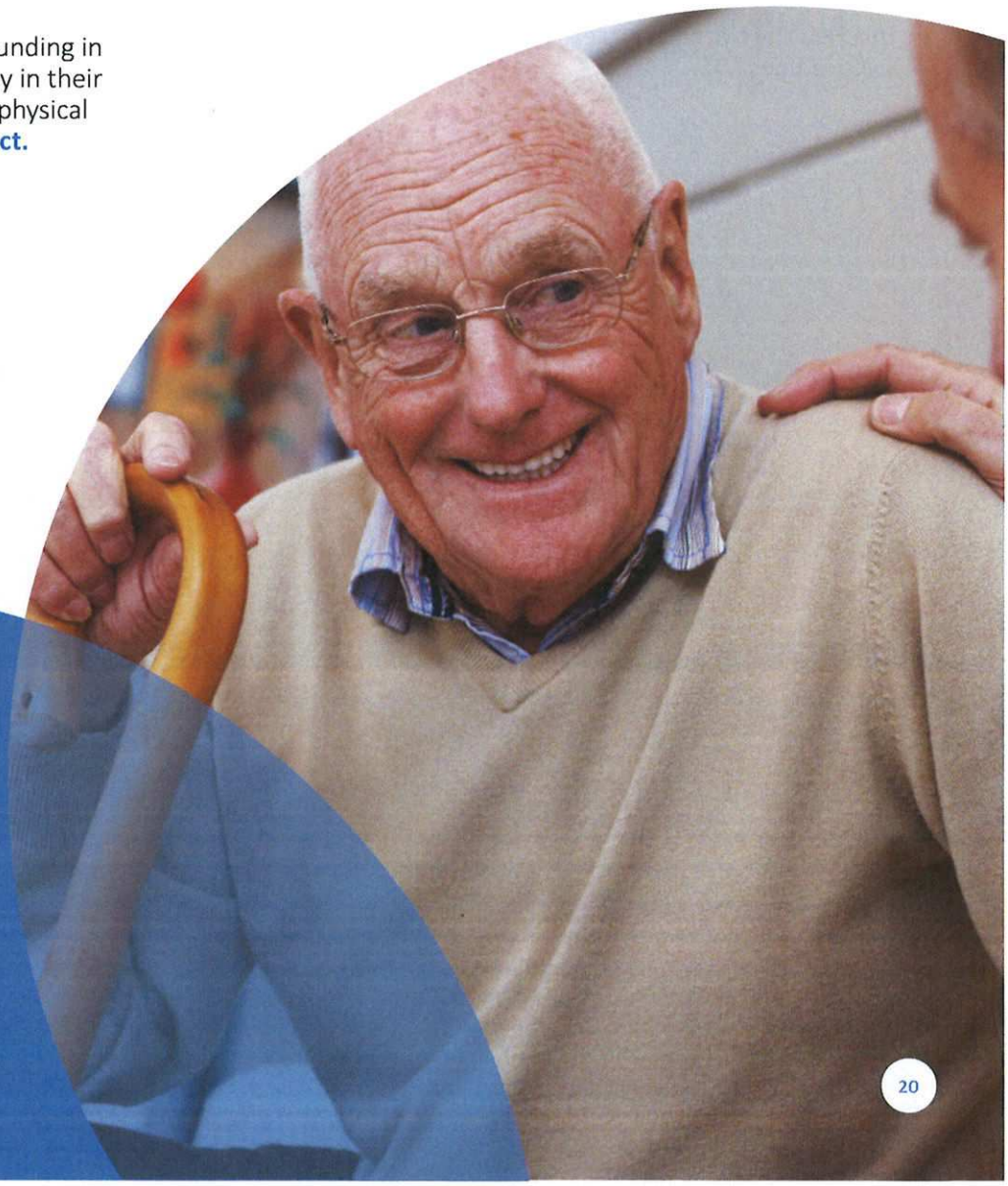
Jack, in his 90s, lives in an area where there is little interest in socialising as a community. He was inactive and rarely left his flat. Through Mobile Me Jack is now playing a sport he enjoyed in his youth.

"I feel better in myself as I can play table tennis again. I'm surprised I still have the touch"

Norse Care employs a physical activity coordinator for their housing schemes.

"We have seen an increase in physical abilities, improvements in confidence and general wellbeing. There are also new social groups forming"

Cotman Housing has secured funding in order to embed physical activity in their homes. Age UK has integrated physical activity into the **Agewise project.**



4 Integrating Ways of Working - Case Study

Improving mental health and wellbeing

Norwich Theatre Royal's **Creative Matters** includes performances and workshops to think about important societal and personal issues. This included sessions on men's mental health, stigma, and male suicide- sessions on dementia and homelessness are planned for 2018/9.

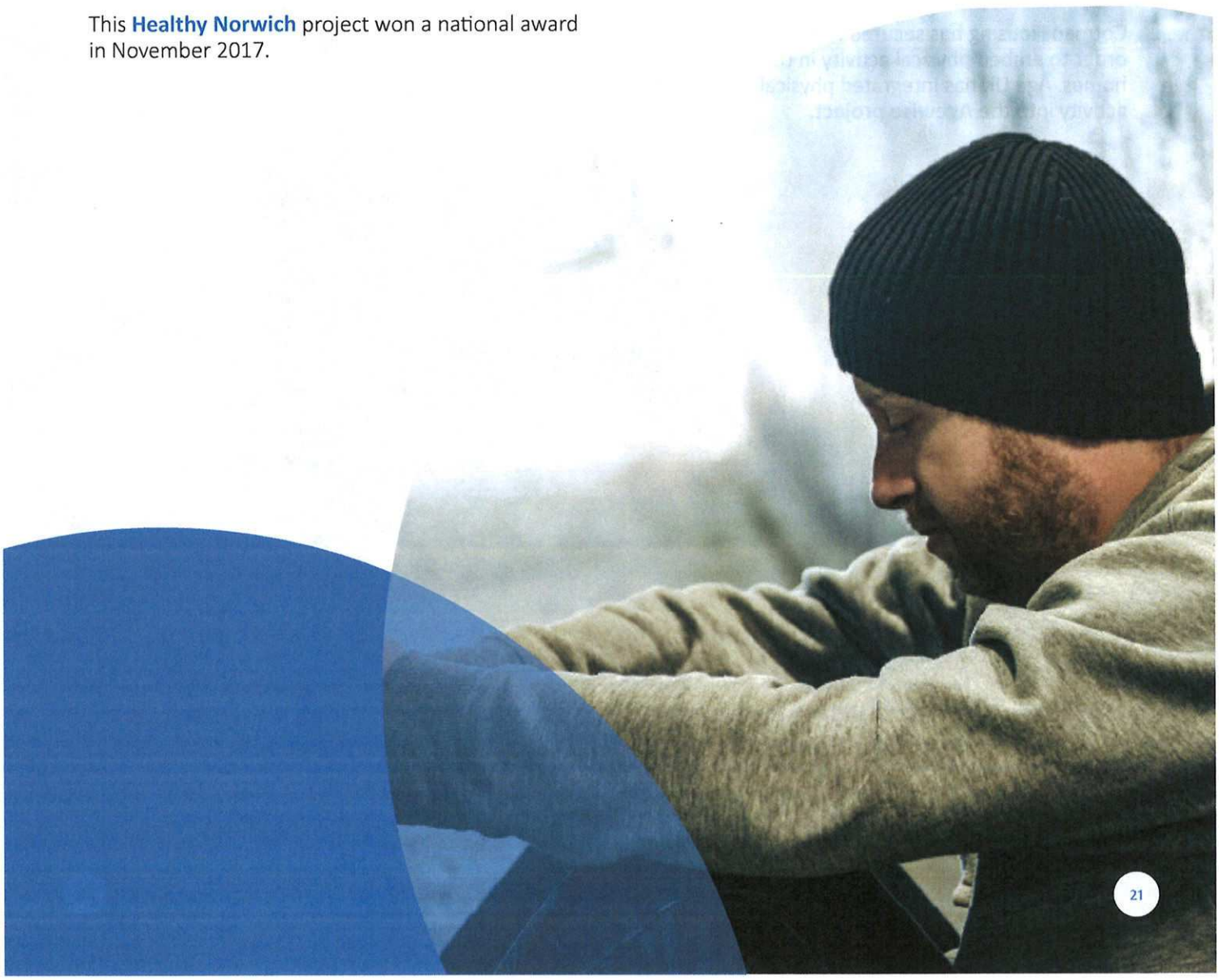
MensNet in Norfolk brings together organisations with a strategic interest in mental health. All to Play For is aimed at men struggling with mental health issues. John, 24, participates weekly:

"It has been very beneficial for me dealing with my mental health, boosting my confidence,and helping improve my people skills".

The **12th Man** project identified barber shops as positive spaces where discussions could happen.

Barbers are trained in Mental Health First Aid and subtle prompts are used to encourage these discussions.

This **Healthy Norwich** project won a national award in November 2017.



Implementing our Strategy

Working together to achieve joint outcomes

We commit to:

- **Identifying the actions** that each Health and Wellbeing Board partner will take in delivering our strategy, either through partners' existing plans or new initiatives.
- **Developing an implementation plan** so we can focus on the important things we have agreed to do together.
- **Holding ourselves to account** and be an accountable public forum for the delivery of our priorities.
- **Monitoring our progress**- reviewing data and information which impact on our agreed outcome measures.
- Carrying out in-depth reviews to **understand the impact** we are making.
- Reporting on our progress to the Health and Wellbeing Board – **challenging ourselves** on areas where improvements are needed and supporting action to **bring about change**.
- **Keeping our Strategy live** – reflecting the changes as we work together towards an integrated system.

Partner organisations involved in the Health and Wellbeing Board – Norfolk and Waveney

Health and Wellbeing Board
Norfolk & Waveney

- Healthwatch Norfolk
- Broadland District Council
- NHS Great Yarmouth and Waveney CCG
- Voluntary Community and Social Enterprise Sector representatives
- Police and Crime Commissioner's Office
- Norfolk and Suffolk NHS Foundation Trust
- Breckland Council
- NHS North Norfolk CCG
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- East Coast Community Healthcare Community Interest Company
- Great Yarmouth Borough Council
- Norfolk Independent Care
- Borough Council of King's Lynn and West Norfolk
- Norwich City Council
- NHS West Norfolk CCG
- North Norfolk District Council
- Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust
- South Norfolk Council
- Waveney District Council
- Norfolk and Waveney Sustainability Transformation Partnership
- Norfolk County Council
- NHS Norwich CCG
- Norfolk Constabulary
- NHS South Norfolk CCG
- James Paget University Hospitals NHS Foundation Trust
- Norfolk Community Health & Care NHS Trust

Appendix C

HELP US HELP YOU
STAY WELL THIS WINTER

in good health

NHS 70 YEARS OF THE NHS 1948 - 2018

Winter 2018/19 - investing to improve services

Winter always brings additional pressures on health and social care services. It always has. It is the same across the country and Norfolk and Waveney is no different.

This year we expect pressures over the winter to be just as great as ever. So we have planned well ahead with more services, more capacity and more support for local people and patients.

This year we're asking everyone: 'Help Us Help You'

- Use local pharmacies where appropriate and walk-in or minor injury units if it's more serious and urgent
- Seek advice for serious health problems early, to stop them getting worse
- Be a good friend or neighbour if they need a little more support

What's different this year?

More beds, more services

Extra £3 million NHS money

Extra £4.1 million (Norfolk) and £3.2 million (Suffolk) for social care, to speed discharge from hospitals

Learning from last winter and changing the approach for 2018-19

See centre and back pages

How some staff got to work last winter

Why winter is a challenge

- Demand is rising
- We have more older and frail people
- Winter makes breathing illnesses worse
- Flu and norovirus always strike

Our people: Our biggest and best asset

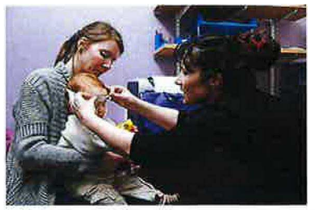
Make no mistake, staff and volunteers working across health and social care in Norfolk and Waveney are our best asset.

Over winter, many agree to work longer, harder and take on more shifts. Day after day they provide dedicated and compassionate care and support for people in our communities, going the 'extra mile' when they can.

We thank them and ask everyone to appreciate their hard work too. Here are some facts about demand in our area:

- More ambulances arriving per day at the Norfolk and Norwich University Hospital than any other hospital in East Anglia - and significant increases in people attending A&E departments across our area.
- As many as 40,000 calls to 111 a month
- More than 1,800 weekend and evening GP appointments per week

These are just some of the additional services or capacity we are introducing to reduce pressures on urgent and emergency services, and look after people



West Norfolk area plans include:

- Enhanced and enlarged discharge lounge at the Queen Elizabeth Hospital to help people return home sooner
- Six more community beds, more provision around end of life care.
- Nurse-led clinic to support homeless people, reducing their reliance on hospitals.
- Continued funding for SOS bus.
- Increase in Mental Health Liaison cover in hospital.
- Increase weekend Discharge Planning Team to help patients get back home as soon as appropriate.
- More use of on-call consultants to avoid admissions
- Greater use of day surgery
- Surgical Emergency Ambulatory Care launched

Across all of Norfolk and Waveney

- Flu vaccinations
- Provision to manage outbreaks of flu within care homes
- Six more ambulance rapid response vehicles staffed with paramedics who can treat people at the scene and save them a trip to hospital
- Ambulance service will hire in more ambulances if it needs to
- Ambulance Patient Safety Intervention Teams as required, to ensure patients awaiting handover to hospital are well looked after and assesse.
- 1800 weekend and evening GP/nurse appointments per week
- More people safely assisted and managed in their first call to 111 (more call handlers and more clinicians in the Clinical Assessment Service)
- More therapy resource in hospitals and community teams to help people get home sooner and live as independently as possible at home
- Social care Trusted Assessor Facilitators are working with residential homes to help people return to their home from hospital
- Local authorities are training some of their staff and volunteers to support older people and carers in the community.

Great Yarmouth and Waveney area plans include:

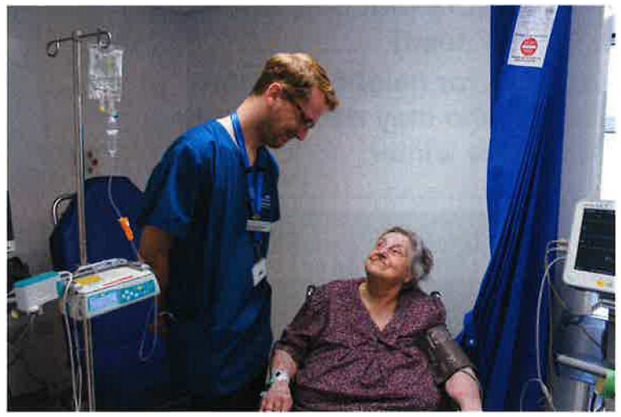
- Enhanced ambulatory care unit at the James Paget University Hospital (pictured below), providing prompt assessment and treatment to help reduce patients' time in hospital and prevent admissions. The new facility is more than double the size of the old unit, with capacity to see many more patients.
- Early Intervention (falls) Vehicle - ambulance and community staff respond to people who have fallen to prevent hospital admission
- Ensuring enough therapists to undertake discharge assessments at JPUH.
- More re-ablement and specialist beds in the community
- More home-based re-ablement to help people remain safely at home

Central Norfolk area plans include:

The Norfolk and Norwich University Hospital's 8-point plan includes:

- 57 additional beds
- New discharge suite (artist's impression right) for up to 28 people to improve the patient's experience and improve patient flow through the hospital
- 8 more rapid assessment spaces for the Emergency Department to assist with ambulance handover and early patient assessment
- Older People's Emergency Department opening hours to be extended
- NNUH at Home - care at home for up to 30 patients at a time, who are medically well enough to leave hospital.
- Additional Physiotherapy and Occupational Therapy Resource

- Hospital Ambulance Liaison Officers help speed up handovers in the NNUH Emergency Department, releasing crews as soon as possible
- More appointments at the Rouen Road Walk in Centre
- GP surgeries providing welfare checks to 'high risk' patients to help them remain safe and well at home
- 'Admission avoidance' teams will extend working to 7 days a week, (ie the Norwich Escalation Avoidance Team and the Supported Care Services in North/South Norfolk). They arrange multi-agency packages of health and care support, for people at home.
- Up to ten more 're-ablement' beds in the community
- Mental Health night hub in Norwich - enhanced crisis response
- Care homes: Support and training on falls management and new ways of hydrating residents to keep residents out of hospital; more short-term mental health beds to help avoid hospital admission and help people return home
- Early Intervention (falls) vehicle



Boost for social care

In October, the Health and Social Care Secretary Matt Hancock pledged an extra £4.1 million for Norfolk and £3.2 million for Suffolk. This will go to our local social care teams, to help them do even more to support local people get home and stay well at home.

Mr Hancock said: "This additional funding is intended to enable further reductions in the number of patients that are medically ready to leave hospital but are delayed because they are waiting for adult social care services."

Our strategy for winter

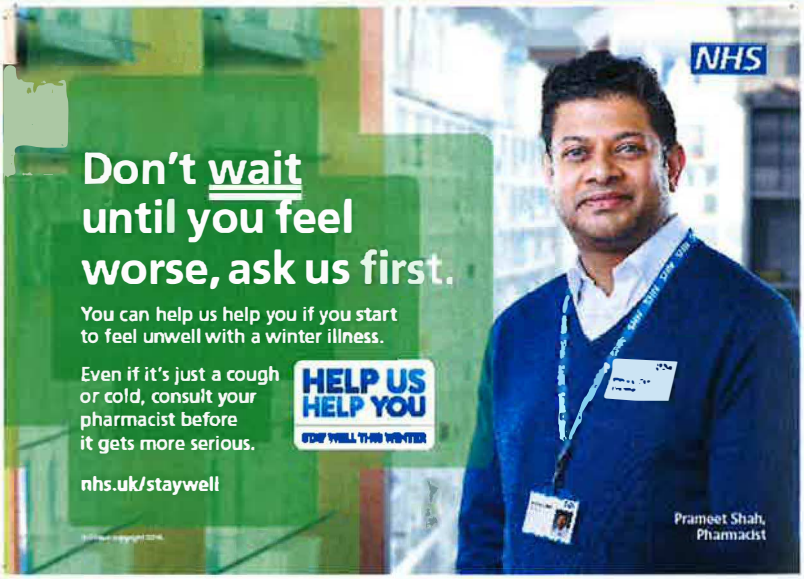
We have been drawing up our winter plans since last winter. All of the initiatives listed in the centre pages - and many more - have been put in place to:

- Provide the people of Norfolk and Waveney with health and care services when needed, closer to home where possible because the best bed is your own bed
- Reduce pressures on our ambulance and hospitals

HELP US HELP YOU
STAY WELL THIS WINTER

Help yourself to stay well this winter

- **Make sure you get your flu jab**
- **Keep your home at 18°C (65°F) or higher if you can**
- **Make sure you order repeat prescriptions in time, so you don't run out (but only order what you need)**
- **Look out for neighbours and friends who may need extra help during the winter.**



Be a germbuster: don't spread diseases

Norovirus (sickness and diarrhoea)

You can catch it by close contact with someone with norovirus, touching surfaces or objects that have been touched by someone with norovirus, eating food that has been prepared or handled by someone with norovirus

- **Wash your hands frequently**
- **Wash surfaces and towels**
- **Do not come back to school, work public spaces or use public transport for 48 hours after the last symptom**

Flu

Flu is spread by germs from coughs and sneezes, which can live on hands and surfaces for 24 hours. You are more likely to give it to others in the first 5 days.

- **Wash your hands often, with warm water and soap**
- **Use tissues to trap germs when you cough or sneeze**
- **Put used tissues in a waste bin as quickly as possible**

Homes and Health

Report of the Health and Wellbeing Board District Councils' Group

Jamie Sutterby
Director of Communities & Wellbeing
South Norfolk Council

Core Services


Homelessness


Planning


Building control


Environmental Services


Housing


Community Protection


Leisure


Food Safety & Licensing


Community Engagement


Elections


Refuse Collection


Economic Development

Keeping residents healthy

Sport and leisure – Broadly Active, leisure centres, community sports, Fit 4 Life

Supporting local and national events – Tour de Norfolk

Energy advice – Warm Homes Fund

Supporting our older population

Maintaining independence - Handyperson schemes

Keeping active – Reducing loneliness, Fit 4 Life, Silver Social

Dementia Friendly Neighbourhoods

Supporting hospital discharge

LILY (living Independently in Later Years)

Encouraging the best start in life

Early Help hubs

Kids Clubs

Hardship funding, Debt advice, FIRST officers

HONOR programme

Jobs Clubs and apprenticeships

Warm and healthy homes: to work in partnership and build on existing initiatives such as promoting winter wellness, providing energy and money saving advice and installing central heating systems to fuel poor households

Programme Summary

Category 1 - Urban

- Private Sector 150 Gas boilers
- Social Housing 15 gas boilers
- Project Support/EPCs

Category 2 - Rural

- Private Sector 250 Oil/LPG boilers
- Social Housing 118 Air source heat pumps
- Project Support/EPCs

Category 3 – Energy Efficiency and Health

- Emergency funds
- Training/evaluation
- Direct 1:1 support
- Marketing, admin and programme management
- Health and Housing data mapping

Discharge Hubs

Local Councils

Direct marketing

Agencies and self referrals

Triage
Age, benefits, health, income, tenure, excess cold, heating system and fuel type,

Further advice

1:1 Support

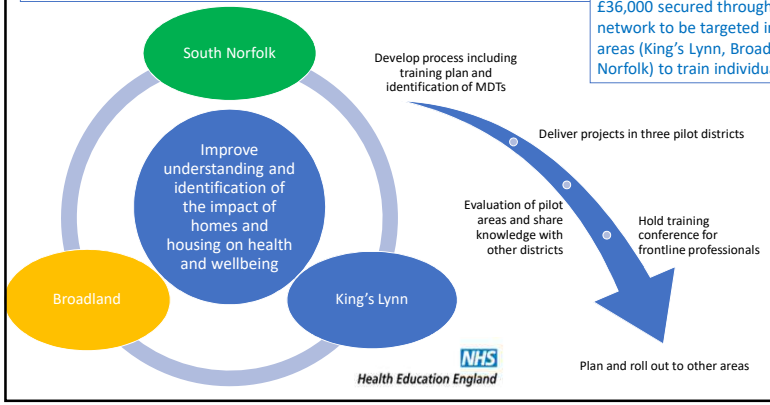
Emergency Funds

Insulation/ FTCH

Referral → Assessment → Delivery

Integration with MDTs: Integration with Multi-Disciplinary Team activities in localities to identify need and any value added district offer

£36,000 secured through Health Education network to be targeted in three district areas (King's Lynn, Broadland and South Norfolk) to train individual health



Discharge from hospital: Coordinate and share learning on working with the three acute hospitals to help find a sustainable model and consider extending the district offer to acute patient flow to include discharge from mental health and community hospitals

Queen Elizabeth Hospital Trust KL&WN Council are funding a 12-month pilot using the District Direct model as a proof of concept

Community hospitals

Norfolk & Norwich University Hospital – 3 District Direct officers based within the integrated discharge until July 2019. Funding through 4 District Councils, ASC & 3 CCGs

James Paget Hospital – Healthy homes assistance undertaking works within a patient's property to facilitate safe discharge.

Hellesdon hospital

Aims:

- Alleviate winter pressures
- Reduction in delayed discharge
- Fewer re-admissions
- Delayed need for formal health and social care packages

HWB is asked to agree:

1. To focus on Homes and Health as a priority for HWB member organisations. While there is a breadth of ongoing activity in this area, in order to focus our collective efforts and to see system wide improvements, it is further proposed that the HWB agrees:

- To build on existing initiatives on **warm homes** such as sourcing cheaper energy, securing debt and money advice, and working in partnership to maximise the efficacy of the recently won £3M capital investment programme
- **Integration with Multi-Disciplinary Team activities** in localities to identify need
- **Discharge from hospital** – coordinate and share learning on working within the three acute hospitals and consider extending initiatives to include discharge from mental health and community hospitals

2. Support cross partner activity, coordinated by staff from the organisations above, to explore ways in which (a) short term improvements can be made to support work on winter pressures for this year and (b) longer term system changes to support working with residents and their homes to improve health and wellbeing.