# Norfolk Health & Wellbeing Board

Date: **Wednesday 15 July 2015**

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

Venue: **Edwards Room, County Hall**

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

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

**For further details and general enquiries about this Agenda please contact the Committee Administrator:**

Nicola LeDain on 01603 223053
or email committees@norfolk.gov.uk

**Business items**

| | | | |
|---|---|---|---|
| **1** | **Apologies** | Clerk | |
| **2** | **Election of Chair** | Clerk | |
| **3** | **Election of Vice Chairs** | Chair | |
| **4** | **Members to Declare any Interests** | Chair | |
| **5** | **Minutes** | Chair | Page 3 |
| **6** | **DPH Annual Report - presentation** | Lucy Macleod | |
| **7** | **Joint Health and Wellbeing Strategy 2014-17 Annual Report 2014/15** | Lucy Macleod | Page 8 |
| **8** | **Joint Strategic Needs assessment (JSNA) Annual Summary Report 2014/15** | Lucy Macleod | Page 36 |
| **9** | **Locally-led health improvement** | District/City/Borough Council leads | Page 40 |
| | **Break – at the Chairman's discretion** | | |
| **10** | **Re-Imagining Norfolk** | Dr Wendy Thomson | Page 64 |
| **11** | **Integration and the Norfolk Better Care Fund Plan** | Harold Bodmer/CCGs representatives x 5 | Page 70 |
| **12** | **Children's Services Improvement & Performance** | Sheila Lock/Don Evans | Page 87 |
| **13** | **Healthwatch Norfolk verbal update** | William Armstrong | |
| **14** | **NHS Five Year Forward View: New Models of Care** | NHS England East Sub-Region Team | Page 97 |
| **15** | **Road Casualty Reduction Partnership** Appointment of a H&WB member to this partnership – further details available on the website: http://www.think.norfolk.gov.uk/about-us | Chair | |
| **16** | **Norfolk Health & Overview Scrutiny Committee minutes of the meeting held on 26 February, 16 April and 28 May 2015** | Chair | Page 102 |

Norfolk County Council

**Health and Wellbeing Board**
**Minutes of the meeting held on Wednesday 29 April 2015 at 9.30am**
**in Edwards Room, County Hall, Norwich**

**Present:**
Mr D Roper, Norfolk County Council – Chairman

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|---|---|
| William Armstrong | Healthwatch Norfolk |
| Harold Bodmer | Executive Director of Adult Social Services, NCC |
| C/Supt Nick Davison | Norfolk Constabulary |
| Dr Anoop Dhesi | North Norfolk Clinical Commissioning Group |
| Richard Draper | Voluntary Sector Representative |
| Ann Donkin | South Norfolk Clinical Commissioning Group |
| Dr Chris Francis | Norwich Clinical Commissioning Group |
| Joyce Hopwood | Voluntary Sector Representative |
| Cllr James Joyce | Chair, Children's Services Committee, NCC |
| Sheila Lock | Interim Executive Director, Children's Services, NCC |
| Dr Ian Mack | West Norfolk Clinical Commissioning Group |
| Lucy Macleod | Interim Director of Public Health |
| Cllr Lisa Neil | South Norfolk Council |
| Cllr Elizabeth Nockolds | Borough Council of King's Lynn and West Norfolk |
| Dr John Stammers | Great Yarmouth & Waveney Clinical Commissioning Group |
| Dr Wendy Thomson | Managing Director, Norfolk County Council |
| Cllr Sue Whitaker | Chair, Adult Social Care Committee, NCC |

Also present: Debbie Bartlett,

**1 Apologies**

1.1 Apologies were received and accepted from Brenda Arthur, Norwich City Council, Pip Coker, Voluntary Sector representative, Cllr James Joyce, Norfolk County Council, Cllr Andrew Proctor, Broadland District Council, Cllr Lynda Turner, Breckland District Council, Ruth Derrett, Locality Director East Sub-Region Team, NHS England.

**2 To agree the minutes**

2.1 The minutes of the Health and Wellbeing Board (HWB) held on the 4th February 2015 were agreed as a correct record, subject to one addition to paragraph 3.1 (declarations of interest. The minutes were signed by the Chair.

**3 Declarations of Interests.**

3.1 A blanket declaration was declared in respect of the period of Purdah for the forthcoming Parliamentary and District Election.

**4 To receive any items of urgent business**

4.1 There were no items of urgent business.

**5 Clinical Commissioning Groups' plans 2015/16**

5.1 The Board received presentations from each of the CCG's on their commissioning plans. It provided an opportunity for the Health and Wellbeing Board to consider key elements of Norfolk's CCG's plans for the period 2015-2016 and the extent to which they take proper account, and are contributing towards, the Joint Health & Wellbeing Strategy.

5.2 In relation to Child and Adolescent Mental Health, there was a suggestion that together more could be done in terms of early help to prevent escalation to tiers 3 and 4.

5.3 There followed a discussion around outcomes-based commissioning approach as a potential area for collaboration and engaging the community in the outcomes sought. Members discussed their role in taking a more strategic view and building on what we already have in place to help achieve this. It was recognised that there was an opportunity to engage the community in the outcomes we are seeking and the voluntary sector welcomed involvement in this and, for example, would be willing to help with engagement. The Board also noted the challenges, for example the practicalities in terms of alignment of commissioning cycles, and the need for the Board to be ready and equipped to influence commissioning cycles at the appropriate stages going forward.

5.4 The Board heard that work had been done in the work on early help to better understand what is being spent across the system for children and young people. This work had enabled dialogue across the system to link partners' spend on the various different pathways to delivering outcomes for children and young people. The mapping of those pathways and, in particular, the role of schools would be helpful for the Board to understand. The Board also noted that Public Health had carried out some population segmentation work for West Norfolk which might usefully be replicated in other parts of the county.

5.5 The Board **RESOLVED** to;

- Note each Clinical Commissioning Group plan.

**6. Norfolk Better Care Fund – Delivering the Plan**

6.1 The Board received the report which made proposals for future monitoring and reporting of the BCF to provide assurance and to support the Board in leading the transformation of health and social care services needed to deliver the BCF plan. It also provided the H&WB with information about NHS England's recent detailed 'Guidance for the Operationalisation of the BCF in 2015/16' together with proposals for meeting these requirement.

6.2 It was suggested that the Board's focus should be on the impact of integration in Norfolk, including the BCF and, for example, it should consider its level of ambition around the pooling of budgets going forward. There were models elsewhere involving the pooling of much bigger budgets and it would be useful to have a discussion around this and how it could be a further tool of achieving the best value.

6.3 The Board **RESOLVED** to;

- Note the national guidance
- Agree arrangements going forward, including the setting up of a sub group for the purposes of meeting the specific requirements for quarterly reporting to NHS England**.**

## 7. Annual Report of the Independent Chair of Norfolk Safeguarding Children Board 2013-14

7.1 The Board received the Annual Report from the Norfolk Safeguarding Children Board which provided details of activities for the year 2013-14 and was presented the Health and Wellbeing Board as part of the accountability of the NCSB in discharging its responsibilities to co-ordinate safeguarding work and to ensure the effectiveness of partnership arrangements.

7.2 The NSCB Chair highlighted key areas of work including, for example, the Advisory Groups which had been set up in March 2014 to improve communications in three sectors – health, education and district councils and which were proving a real opportunity with partners in those sectors getting together to do joint work. The Board heard that work was being carried out in partnership with Healthwatch in order to engage more young people on their views.

7.3 The NSCB Chair confirmed that this report served as a first step in what would be a regular dialogue with the Board. The NSCB Annual Report for the year 2014-15 was underway and the Chair planned to bring it, and related information, to a future Board meeting. It was suggested that the Board might consider reporting around children's safeguarding alongside adults safeguarding to bring the discussion together.

7.4 The Board **RESOLVED** to;

- Note the report and note that it had been reported to the Children's Services Committee, Norfolk County Council's Managing Director, the Police and Crime Commissioner and to partner agencies.

## 8a. Children's Services Performance Monitoring Report

8.1 The report provided an update on Children's Services operational performance, including Support for School Improvement and Social Care and Safeguarding.

8.2 The Board heard from the Assistant Director that he was reviewing performance reporting, both within the County Council and to partnerships, and this would move away from descriptive reporting and further towards outcomes and impact.

8.3 Members discussed issues such as the further development of early help in localities as well as social care caseloads and work both to reduce the numbers of Looked After Children and to improve the quality of reviews. Areas highlighted included support for school improvement, where there was joined up work across the districts, and social care information about the numbers of contacts where multi-agency work was taking place to better understand the variations in the data. The Board heard that although the caseload figures were increased, it was being addressed. Caseloads figures were in line or better than other parts of the Country and within the new structure there was increased short term capacity and a workforce development plan was in place.
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8.4 In terms of future reporting, Don Evans confirmed that he was looking at the way in which improvement and performance was reported to partners and welcomed feedback. Sheila Lock explained that they were planning to move away from the descriptive reporting around performance indicators and more towards reporting outcomes and impacts.

8.5 The Board **RESOLVED** to;

- Note the report

**8b. LAC Health Report**

8.1 The Board received the report which updated members on the performance concerns around Health Assessments for Looked After Children which had been requested at the last H&WB meeting. The report provided an overview of performance on the provision of Health Assessments for Looked After Children (LAC).

8.2 There followed some discussion about the complexity of the landscape and the Board noted the need for all partners to work together to find solutions to the issues raised. Assurance was sought that problems were taken forward in a timely manner to identify any gaps.

8.3 It was recognised that help was needed from all partners in ensuring that the right assessment was carried out at the right place in the journey of the child and all partners had a corporate parenting responsibility to ensure this happened.

8.4 It was agreed that a meeting would be set up between Children's Services, a CCG representative and a representative of NHS England East Sub Region Team to take this forward.

8.5 The Board **RESOLVED** to;

- Acknowledge the poor historical performance and significant decline in year to date performance in this key area and offer a way forward.

**9. Voluntary Sector Engagement Project Final Report**

9.1 The Board received the final report from the Voluntary Sector Engagement Project (VSEP) whose funding from Health and Wellbeing Board ended on 31st March 2015. The report highlighted some of the main achievements of the Project's work in bringing the active engagement of the voluntary sector into the Health and Wellbeing Board and the wider health and wellbeing agenda. It also identified gaps which had been left behind as a result of the Project's closure and concluded with some recommendations.

9.2 The Board **RESOLVED** to;

- Note the content of the report and the achievements of the VSEP.

**10. Healthy Communities – Evaluation Report**

10.1 The report updated the Board on the progress and final evaluation of the Healthy Communities Project, summarised key activity since the last report and made recommendations on further development.

10.2 The Board heard there had been courses arranged to help groups apply for their own funding. However it was also important to develop community power and resilience.

10.3 Members discussed the project's overall legacy and ways of keeping a focus on asset based work including, for example, looking at possible ways to mainstream this kind of work**.**

10.4 The Board **RESOLVED** to;

- Note the report and the closing of the Healthy Communities Project.

## 11. CCG's draft Annual Reports

11.1 The annexed report (11) was received by the Board. The report provided relevant extracts of the Clinical Commissioning Group (CCGs) draft Annual Reports 2014/15 in line with NHS England's Guidance. It brought together the reviews prepared by each of the CCGs of the extent to which the CCG had contributed to the delivery of the joint health and wellbeing strategy.

11.2 The Board **AGREED**;

- That the draft extracts were acceptable

## 12. NHS England's 5 year Forward View

12.1 The Board received a briefing report from the Locality Director, East Anglia Sub Region Team, on NHS England's 5 Year Forward View (FYFV). The Board heard that, following the recent restructure, a representative from NHS England was not available to attend the meeting for the discussion of the report.

12.2 Members discussed the pressing need for transformation as envisaged in the FYFV and about the Board's role, as system leader, in driving this – and at a pace, given the shortfall in funding for health and social care.

12.2 It was suggested that it would be productive for the Board to have this discussion post general election and that, although clearly valuable to have NHS England's input, it was for the H&WB to drive locally.

## 13. Healthwatch Norfolk minutes of the meetings held on 19 January 2015

13.1 The Board received and **NOTED** the minutes of the meetings of Healthwatch Norfolk which took place on 19th January 2015.

## 14. Norfolk Health and Overview Scrutiny Committee minutes of meetings held 15 January 2015

14.1 The Board received and **NOTED** the minutes of the meetings of the Norfolk Health and Overview Scrutiny Committee meetings which took place on 27 November 2014 and 15 January 2015.

The next meeting would take place on **Wednesday 15 July 2015** at 9.30am. The venue would be confirmed.

The meeting closed at 1.30pm

Chairman

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

## Cover Sheet

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

The Health and Social Care Act 2012 sets out a number of legal responsibilities for the Health and Wellbeing Board, including a duty to prepare a Joint Health and Wellbeing Strategy, which the Board signed off in July 2014

The Board has oversight of the implementation of the strategy. Board Champions are leading and directing action plans.

This Annual Report advises the Board of progress to date.

## Key questions for discussion

What are your views on:

- Progress made to date?
- Can more be done between partner organisations to achieve the strategic goals of prevention, reduced inequalities and integration
- Future plans for 2015/16?

## Actions/Decisions needed

The Board needs to:

- Consider the report and give views on delivery of the Strategy to date and any changes of emphasis or reporting required in the coming year.

**Report to Norfolk Health and Wellbeing Board**
**15 July 2015**
**Item 7**

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

Report of the Interim Director of Public Health


**Summary**

This report provides information on the H&WB's Joint Health & Wellbeing Strategy including its achievements to date.

**Action**
The Health and Wellbeing Board is asked to:

Consider the report and give views on delivery of the Strategy to date and any changes of emphasis or reporting required in the coming year.


## 1. Background

1.1 The Norfolk Joint Health and Wellbeing Strategy 2014-2017 was agreed by the Health and Wellbeing Board in July 2014. The goals of the strategy are to increase the emphasis on prevention, reduce inequalities in outcomes and improve integration. These are tested through the three strategic priority areas; improving the social and emotional wellbeing of pre-school children, preventing obesity and making Norfolk a better place for people with dementia and their carers.

1.2 In identifying and agreeing its priorities, the Board took account of data from the JSNA http://www.norfolkinsight.org.uk/jsna and the key messages of the Director of Public Health's Annual Report 2013.

1.3 By focusing on a small number of priorities, the Board's aim was to make a significant impact in the priority areas within the life of the Strategy and t for partner organisations to align their own planning and spend to the joint priorities to drive sustainable change.

1.4 This Annual Review highlights the key achievements in the first year and outlines how the remainder of the Strategy will continue to be implemented.

## 2. National and local drivers supporting the Strategy's goals

**Focus on Prevention**

2.1 The NHS Five Year Forward View – Time to Deliver (June 2015) emphasises the imprtance of prevention in health and wellbeing service planning with the establishment of a National Prevention Board chaired by Public Health England (PHE). Dr Duncan Selbie the Chairman of PHE visited Norfolk in May 2015 and

commended the Norfolk Health and Wellbeing Board's priorities and the work underway. The introduction of a national diabetes prevention programme has now begun and obesity prevention interventions at scale are to be rolled out in pilot areas with details of the national roll out plans expected in Autumn 2015. Norfolk has applied for pilot status and is under consideration for the regional grant for implementation.

2.2 The Local Government Information Unit released a policy briefing in May 2015, outlining the Commons Health Select Committee's recommendations to the new government in how to tackle obesity and the importance of prevention on individual wellbeing, economic prosperity and reducing the burden on local services.

2.3 The Prime Minister's challenge on dementia 2020 and the 'Dementia Friends' campaign are national programmes.

**Reducing inequalities**

2.4 'Fair Society, Healthy Lives' (The Marmot Review) 2010 continues to be the most important national policy driver on how to tackle inequalities. With spending reviews and cuts to budgets likely to make a bigger impact on those in the more deprived population, it will continue to be a challenge to ensure the inequalities gaps are not widened further.

2.6 The DPH Report for 2013/14 highlighted the disparity in Norfolk beween those living in the areas classified within the most deprived 10% nationally and the remainder of the population. The Board may wish to revisit this work to challenge the Strategy outcomes and the extent to which there has been targeting of inputs, or specific interventions to close the gap.

2.7 The Child Poverty Needs Assessment and the Parent and Infant Mental Health Strategy, together with the early help work in the childrens' partnerships underpin the developing action plans.

**Integration**

2.8 Developing a Health and Social Care Systems Leadership Group (SLT) and aligning it with the Health and Wellbeing Board provides important infrastructure to improve integration across the system.

2.9 West Norfolk (CCG and Borough Council) have been identified as an Integration Pioneer for the Five Year Forward View pilot programme. District, Borough and City Council Health and Wellbeing Plans and CCG Operating Plans are also in place and all serve as local drivers informing the implementation of this strategy.

2.10 The Better Care Fund is a mechanism for improved integrated working across health and social care organisations in Norfolk. However, the Fund is essentially only a tool to support change and the Board may wish to consider broadening the Strategy to include a vision and strategic direction for the better delivery of health and social care outcomes within a climate of reducing funding.

## 3. Key achievements in year 1 of the current strategy

**Partner Engagement**

Board Members will recall that the Strategy was substantially developed using the best national evidence for effective action and the intent was that partners would align their strategic direction accordingly. Inevitably this is working better in some areas than in others, but overall there is still a good sense of partner engagement and in some cases a streamlining and focusing of existing partnerships on delivery.

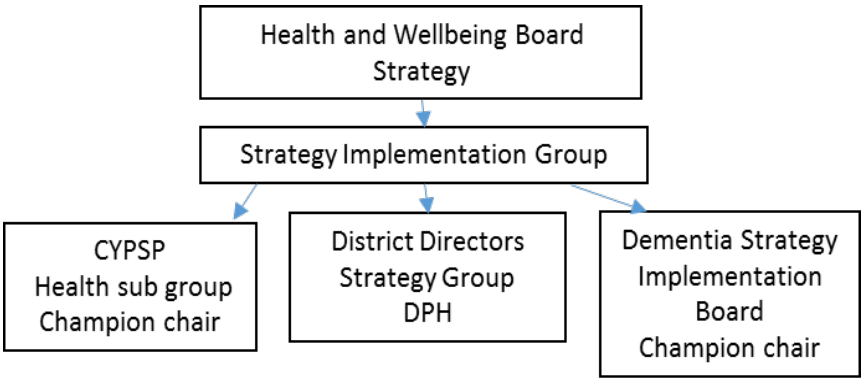
**Processes in place**

3.1 As this was the first year of the Strategy there has inevitably been a certain amount of focus on process and governance. The initial phase of the implementation required extensive mapping and documenting of the existing services across Norfolk which impact upon the strategy priorities. This has been captured using 'plan on a page' documentation.

3.2 A successful action planning workshop was held at the Board meeting in February 2015, facilitated by the Board Priority Champions and Strategy Coordinators, who were appointed in October/ November 2014 . Action plans are now in place for the three priorities (see Appendix 1).

3.3 Monitoring of the Strategy continues through the Strategy Implementation Group and a governance structure has been developed to monitor the delivery of action plans.

Fig 1 Governance Structure of the Strategy




3.4 An executive summary of the strategy has been produced (Appendix 2), the strategy branding is being used and a website is now in place to support communication of achievements across Norfolk www.norfolk.gov.uk/hwbstrategy

**Social and Emotional Wellbeing of pre-school children**

3.5 The key areas of activity in this area were drawn from national evidence including the NICE Guideline and the Marmot Report. The summary action plan (Appendix 3) emphasises the importance of addressing

overarching mental health issues and particularly, 'early attachment' as crucial to the social and emotional wellbeing being of children. A range of activity is in progress and the integration of this workstream into the Children's Strategic Partnership process will ensure that delivery on the Strategy becomes part of the mainstream work in this area.

**A more detailed report of actions towards achieving the strategic goals can be found in Appendix 3**

**Preventing Obesity**

3.6 The evidence base for this action plan was drawn both from the NICE Guideline and the work of the National Obesity Observatory. Preventing obesity (both preventing the development of unhealthy weight and preventing the worsening of obesity and associated conditions) continues to be a challenge, with currently only 33% of adults in Norfolk being of a healthy weight. The summary action plan (See Appendix 3) addresses three of the main ways that obesity can be prevented: promoting behaviour change, creating a healthy built environment and building an integrated approach to tackling issues that hinder maintaining a healthy weigh

**A more detailed report of actions towards achieving the strategic goals can be found in Appendix 3**

**Making Norfolk a better place for people with dementia and their carers**

3.7 The Dementia Strategy Implementation Board continues to drive the progress of the agreed overarching action plan (see Appendix 3) and provides a robust reporting mechanism for dementia developments across the county. A number of different Task and Finish groups have been set up to implement the strategic intentions. There has been a strong focus in year one on the areas of prevention and integration but more attention will be given to addressing inequalities in the next phase.

**A more detailed report of actions towards achieving the strategic goals can be found in Appendix 3**

**Measuring Progress**

3.8 A performance profile (See Appendix 4) has been published to demonstrate the current position of health and wellbeing in Norfolk. This profile will also be available at Electoral Division level on Norfolk Insight and profiles at District and CCG level are being developed.

3.9 A Strategy implementation progress framework (See Appendix 5) has also been produced to indicate which intentions in the strategy are progressing well, which require closer monitoring by the Strategy Coordinators and Champions and those intentions that need action from the Board.

3.10 Some intentions have been programmed to be implemented in years 2 and 3 of the strategy.

## 4. Year 1 Challenges

Inevitably in the first year there has been a focus on developing frameworks processes and mechanisms. This is not to say that delivery is not underway, but in so short a time it would be hard to identify clear changes on the ground. In the

coming year it will be essential to shift the emphasis onto being clear what is being done differently as a result of the strategy and what impact the change is having. In this context it would be helpful to the implementation group for the Board to have a wider look at metrics and in particular to agree indicators of change.

The Strategy implementation group is also concerned to ensure that attention does not drift from the goals of prevention, integration and reducing inequalities to the more tangible thematic strands. In order to prevent this it would perhaps be helpful to try and get some service user measures of whether integration of commissioning activity leads to any change on the ground and to link the Better Care Fund work in more closely to the Strategy.

The scale of the challenge is such that any impact on inequalities could not be attributed directly to the Strategy, however the change in inequalities can be monitored using the methodology presented in last year's DPH Report and this should be included in the monitoring report for the year 2015/16.

Prevention is a difficult concept to measure, but for next year it would be possible to develop a self assessment challenge questionnaire to partners to try to identify to what extent there has been a funding shift to preventative and collaborative activity.

## 5. Implementing the Health and Wellbeing Strategy through to 2017

5.1 The Strategy Implementation Group will continue to review the progress of the strategy on behalf of the Board and quarterly updates will be prepared. Where a strategic intention requires Board involvement to achieve increased focus on prevention, to address identified inequalities or to remove barriers to better integration, a more detailed report will be given.

## 6. Action

5.1 The Health and Wellbeing Board is asked to:

- Consider the report and give views on delivery of the Strategy to date and any changes of emphasis or reporting required in the coming year.

**Officer Contact**

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


| Name | Tel | Email |
|---|---|---|
| Lucy Macleod | 01603 638407 | lucy.Macleod@norfolk.gov.uk |
| Deborah Elliott | 01603 638393 | deborah.elliott@norfolk.gov.uk |

# Norfolk Joint Health & Wellbeing Strategy 2014-17 Summary Action Plan: Promoting the social and emotional wellbeing of preschool children

*Health and Wellbeing Board Champion: Richard Draper richard.draper@benjaminfoundation.co.uk*

*Partners involved or expecting to have a main role in this plan: Norfolk County Council Public Health, Norfolk County Council Children's Services, Domestic Abuse and Sexual Violence Board, District Directors Strategy Group, CCG's,, CAMHS, NSFT, FNP, Cambridge Community NHS Trust and NCC Norfolk Library and Information Service.*

- Improve the promotion of and opportunities for breastfeeding, healthier diets, physical activity and tooth brushing
- Promote programmes which support vulnerable parents.
- Develop arrangements for integrated commissioning of universal and targeted services including GP's, maternity, Health visiting, school nursing and all EY's providers.
- Ensure the social and emotional wellbeing of under 5's is assessed as part of the JSNA
- Support development of parental and child literacy
- Ensure maternal mental health is assessed and issues are identified and addressed at an early stage.
- Promote early intervention and a single programme to address empowerment and self-esteem in relation to domestic abuse
- Improve contact between substance misusing parents and treatment services.
- Promote projects addressing child safety in the home

Action: Links have now been established with the Children's Centre Development officer and work will commence to align work of Children's Centres with the HWBB strategy. This work includes parenting programmes, breastfeeding and dental support, provision of a new universal antenatal programme to be piloted Autumn 2015 and ongoing support for families needing extra support.

Action: A new, robust, outcome-based, integrated 0-19yrs HCP, including Health Visiting, School Nursing, NCMP, Healthy Weight, Hearing and Vision screening, Healthy Schools and Family Nurse Partnership has been commissioned. Following the transition period work can commence to align this work with the HWBB strategy with a priority focus on maternal mental health.

Action: Partnership working with the Norfolk Library and Information Service has resulted in an Early Years Summer Reading Challenge and a championing of the HWBB strategy linking into the development of the child literacy intention. The Early Years logo is being used widely on leaflets, posters and in Your Norfolk.
Action: To include the voice of the service user, a questionnaire has been developed and will be targeting early years settings and libraries across Norfolk. This work has been supported by Healthwatch. Results will be gathered by the end of the summer and used to inform further actions for the strategy.
Action: The implementation of The Nurtured Heart Approach is being considered.

Action: Priority champion to sit on the Children and Young Peoples Strategic Partnership and take the lead in the Health sub group. This group will include many partners and will reinforce the strategy priorities.
Action: Partnership work with NCCSP to align the Domestic Abuse strategy with the HWBB domestic abuse intentions.

**Impacts on Public Health Outcomes**

1.01 Children in poverty
1.02 School readiness
1.11 Domestic abuse
1.16 Utilisation of outdoor space for exercise/health
2.01 Low birth weight of term babies
2.02 Breastfeeding prevalence at 6-8 weeks
2.06 Excess weight in 4-5 year olds
2.07 Hospital admissions caused by unintentional and deliberate injuries in children
2.08 Emotional wellbeing of looked after children
3.03 Vaccination
4.01 Infant mortality
4.02 Tooth decay in children aged 5

The Department of Health
Early Years High Impact Areas 1-6

The National Child Measurement Programme

The Department of Education
Early Years Foundation Stage Profile

## Norfolk Joint Health & Wellbeing Strategy 2014-17 Summary Action Plan: Ref: Promoting the social and emotional wellbeing of preschool children

**Partners and associated operational plans or strategies:**
**Public Health** http://www.norfolkinsight.org.uk/jsna/youngpeople
**Children's Services**
**Norfolk Library and Information Service**
**CAMHS**
**PIMHS**
**FNP**
**HCP provider**
**Home Learning Environment**
**Active Norfolk** http://www.activenorfolk.org/core/core_picker/download.asp?id=5312&filetitle=CYP+Strategy
**West Norfolk CCG** http://www.westnorfolkccg.nhs.uk/sites/default/files/pdf/Final%2015_16%20Operational%20Plan.pdf
**North Norfolk CCG** http://www.northnorfolkccg.nhs.uk/sites/default/files/Strategic_Operational_Financial%20Plan%2014-15%20to%2018-19%20Report.pdf
**Great Yarmouth and Waveney CCG**
http://www.greatyarmouthandwaveneyccg.nhs.uk/_store/documents/nhsgreatyarmouthandwaveneyccgoperationalplanpublicfacingversion_activelinks.pdf
**South Norfolk CCG** http://www.southnorfolkccg.nhs.uk/sites/default/files/pdf/DRAFT%20-%20NHS%20South%20Norfolk%20CCG%20Operational%20Plan%2011th%20July%202014.pdf
**Norwich CCG** http://norwichccg.nhs.uk/publications-policies/doc_download/485-operating-plan-14-16

**Progress Report to Health and Wellbeing Board**
www.norfolk.gov/hwbstrategy
**All committee papers and reports can be found here.**
http://norfolkcc.cmis.uk.com/norfolkcc/Committees/tabid/62/ctl/ViewCMIS_CommitteeDetails/mid/381/id/39/Default.aspx

**Future plans and challenges**
The commissioning regulations of the Healthy Child Programme (HCP) contract and a period of change in Children's Services has meant that elements of the strategy implementation have had to wait. Now that the HCP contract has been awarded, the intended outcomes built into the service specification will strongly support the implementation of the strategy. Increased involvement in the Children and Young People's Strategic Partnership and the health sub-group will better integrate the developing action plans.
Maternal mental health has been identified as a priority within the strategy so work will continue in this area with further investigation in to the possibility of broadening the reach of Circle of Security http://circleofsecurity.net/. The Future in Mind document also highlights the importance of maternal mental health and attachment https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf
Following the completion of the research questionnaire, the voice of the service user can be used to highlight issues experienced at point of delivery and inform future actions. The research report will be included in the JSNA.

## Norfolk Joint Health & Wellbeing Strategy 2014-17 Summary Action Plan: Reducing the Prevalence of Obesity

*Lead Partner name & contact details:* Champion Cllr Yvonne Bendle ybendle@s-norfolk.gov.uk. Coordinator: Public Health Officer lara.williamson@norfolk.gov.uk
*Other partners:* District & Borough Councils, CCG, Active Norfolk, other NCC Departments: Community & Environmental Services; Planning; Road Casualty Reduction Team;

NB Obesity Intentions O2 and O4 are completed.

**O1:** Develop a comprehensive county-wide obesity strategy.

**O3:** Undertake engagement activity to better understand perceptions of obesity in high prevalence areas

**O5:** Ensure elected members& staff working with community advocate action on obesity

**O6:** Work with local businesses & partners to increase access to healthy food

**O7:** Make the most of potential of planning system to create a healthier built environment

**O8:** Work with registered social landlords to Design Council priorities to incr. opportunities to utilise outdoor space

**O9:** Make most of opportunities to engage with community & promote behaviour change.
**O10:** Combat prejudice against obese people in workplace

**Action:** Obesity Strategy drafted in light of HNA findings & recommendations and in context of JHWB Strategy; task & finish group workshops x2 scheduled May & July 2015. Meet District, Borough & City Council Members & Officers + voluntary sector providers of weight management services (WMS) to research current provision/barriers & address gaps. Tailor interventions- Proportionate universalism, families, IHLS.

**Action:** promote HNA/JHWB Strategy & data updates to highlight need to embed this priority in planning services/ more integrated working/ staff training. HONOR Scheme promoted & extended county wide.

**Action** work with partners to promote healthy options: food & active travel; consider regulation of factors that increase obesogenic environment using Health Intelligence data, HNA, PHE, Town & Country Planning Assoc. and Foresight Report recommendations

**Action** raise profile of Design Council action plan with District Councils Housing Leads to ensure social landlords are aware of priorities for change. Identify gaps in current provision & promote JHWB Strategy/HNA recommendations & PHE/NICE guidelines for offering WMS. Promote wkpl health services. Agree & implement a plan for organisations to monitor & identify staff training needs incl equalities, RSPH, MECC, MHFA, and Understanding Eating Disorders.

**Measured using the following success criteria:**
Obesity Strategy circulated & available; increased uptake of current services including Health Trainer, Physical Activity programme & family engagement; Increase provision of WMS & of staff with MECC training; increase number of businesses signed up to HONOR; recommendations for reduced obesogenic environment/increase use of outdoor space integrated in Section 106 planning & Social landlords' planning

**Impacts on Public Health Outcomes**
**1.16i** Utilisation of outdoor space for exercise/health reasons **2.06i** Excess weight in 4-5 year olds; **2.06ii** Excess weight in 10-11 year olds; **2:12** Excess weight in adults; **2.13i** percentage of physically active & inactive adults – active adults; **2.13ii** percentage of active & inactive adults – inactive adults; **4.04ii** Under 75 mortality rate from cardiovascular diseases considered preventable. Also ensure services look at increasing self-confidence, wellbeing, & health-related quality of life.

**Future Intentions for 2015/16 & 2016/17**
- All Obesity Intentions from JHWB active
- Progressing all interventions/actions
- Ongoing updates to partners as new data emerges

## Norfolk Joint Health & Wellbeing Strategy 2014-17 Summary Action Plan: Reducing the Prevalence of Obesity

**Partners and associated action plans: Obesity Strategy Group attendees**
**Active Norfolk** http://www.activenorfolk.org/core/core_picker/download.asp?id=5312&filetitle=CYP+Strategy
**West Norfolk CCG** http://www.westnorfolkccg.nhs.uk/sites/default/files/pdf/Final%2015_16%20Operational%20Plan.pdf
**North Norfolk CCG** http://www.northnorfolkccg.nhs.uk/sites/default/files/Strategic_Operational_Financial%20Plan%2014-15%20to%2018-19%20Report.pdf
**Great Yarmouth and Waveney CCG**
http://www.greatyarmouthandwaveneyccg.nhs.uk/_store/documents/nhsgreatyarmouthandwaveneyccgoperationalplanpublicfacingversion_activelinks.pdf
**South Norfolk CCG** http://www.southnorfolkccg.nhs.uk/sites/default/files/pdf/DRAFT%20-%20NHS%20South%20Norfolk%20CCG%20Operational%20Plan%2011th%20July%202014.pdf
**Norwich CCG** http://norwichccg.nhs.uk/publications-policies/doc_download/485-operating-plan-14-16
**District, Borough & City Action Plans**

**Progress Report to the Health and Wellbeing Board** www.norfolk.gov.uk/hwbstrategy
**All committee papers and reports can be found here.**
http://norfolkcc.cmis.uk.com/norfolkcc/Committees/tabid/62/ctl/ViewCMIS_CommitteeDetails/mid/381/id/39/Default.aspx
**Intentions completed 20%: O2 Appointed an individual to coordinate activity on obesity; O4 agree local obesity branding – logo designed, circulated & agreed.**
**In process: O1 Obesity Strategy workshops underway and drafting of Strategy almost finalised, action planning is focus of second workshop July 2015.**
**O3, O5 communications increasing and promotion of these intentions continues; O7 will also be developed in a TCPA/PHE workshop in July 2015.**

**Supported launch of Tackling Obesity: a Health Needs Assessment for Norfolk January 2015, promotion of executive summary to partners underway.**
**Spine Charts are being prepared to be included in the Annual Report to demonstrate extent of challenge still to address.**

**Future plans and challenges:**

**Summary action plan overleaf.**

**Completion/launch of Healthy Weight Strategy (O1) in October 2015 after two workshops with multiagency partners May/July 2015**
**Continue to work with District Directors Strategy Group – development of action plans**
**Progression of work in partnership with Business in the Community**
**Providing local update on progress in Norfolk to Regional PHE Obesity Network**

## Norfolk Joint Health & Wellbeing Strategy 2014-17 Action Plan: Dementia Strategy Implementation Board

**Lead:** Joyce Hopwood (Chair) and Board Champion Coordinator: Nicola.gregory@norfolk.gov.uk
**Other Board members:** Norfolk County Council (NCC) Director of Adult Social Services (Vice Chair), Norfolk Integrated Health and Social Care Commissioning, Integrated Mental Health and Learning Disabilities Commissioning Manager (NCC and CCGs), 5 Clinical Commissioning Group (CCG) Managers, Consultant in Public Health, Norfolk and Suffolk Dementia Alliance (NSDA), Norfolk Independent Care (NIC), Acute Hospital Consultant, Norfolk Community Health and Care, Norfolk and Suffolk Foundation Trust.

**Objective 1.** Develop action plans for the Health and Wellbeing Dementia Strategy under the 5 main headings (integration, awareness, care pathway, independent living and non-independent living), and update them on a regular basis to reflect the progress delivered towards the strategy and its overarching aims of prevention, reduction of inequalities and improved integration.

**Objective 2.** Use focused time-limited Task and Finish groups to achieve strategy actions.

**Objective 3.** Involve older people and carers, and specifically people with dementia and their carers.

**Objective 4.** Ensure information is disseminated through local networks, and relevant issues regarding dementia services are reported to the Health and Wellbeing Board (HWB) and, where appropriate, to relevant commissioners.

**Objective 5.** Identify how help and support can be identified at an earlier stage before problems become acute for people with dementia and their carers.

**Objective 6.** Make sure the HWB Dementia Strategy priorities, and the 9 national dementia strategy outcomes are reflected in the strategies and action plans of statutory and voluntary agencies.

**Objective 7.** Champion innovative services which meet the needs of people with dementia and their carers.

**Objective 8.** Publicise the work of the Board to the public, especially to older people.

**Action: Dementia Advice & Information Task & Finish group**

A group comprising of NSDA, Norfolk County Council, NorseCare, Alzheimer's Society, Age UK Norfolk, Carers Agency Partnership, Admiral Nurse service, Healthwatch Norfolk and two carers was set up to look at the information and support available for people with dementia and carers, from onset to end of life.

It was highlighted at the second meeting in March that the Admiral Nurse service is currently working with CCGs to develop the advice and information pathway, and focus on evaluation of services to inform future commissioning. To avoid duplication of work it was decided that this Task and Finish group would met again in September/October, when progress regarding the pathway work would be reported back by the Admiral Nurse service. The evaluation of the NNCCG dementia information packs should also have been completed by this time.

Healthwatch Norfolk's report, 'Experiences of accessing information for people with dementia and their carers', has linked in to the work of this Task and Finish group. A specific meeting was held in April to focus on and discuss the findings and recommendations of the report, and look at actions and ways in which they can be taken forward.

**Action: Dementia Friendly Norfolk website**

NSDA are funding the development of a website primarily for people with dementia and carers. This is being produced in co-production with a group of carers, based on the ethos that the website is designed by the people, for the people. Once the content has been finalised in the next month or so the website will be trialled initially with user groups, with the hope that it is launched in the autumn. The website will be partnered with a printed County Council dementia guide being produced.

**Action: Dementia Friendly Employers & Business Task & Finish group**

A Task and Finish group consisting of many of the statutory bodies; Police, Fire and Rescue Service, Prisons, NCC, UEA, NNUH, East of England Ambulance Service NHS Trust and District Councils, was set up to focus on becoming more dementia friendly. Following the first meeting in April the group will now link up with the dementia friendly businesses group in Norwich, developed from a proposal to the Norwich Business Improvement District (BID) and led by the Norwich University of the Arts Business Director. Learning and developments can be shared and duplication of work avoided.

An area of work prioritised by the group is dementia training for all levels of employees/staff, with the aim of setting standards across the board. A half day workshop is being held on 22nd June to focus on this area. Age UK Norfolk are attending to link in with their successful Dementia Friendly Communities work, having already worked with businesses in

**Impacts on Public Health Outcomes**

1.18 Social isolation

2.22 Take up of the NHS Health Check programme by those eligible

4.11 Emergency re-admissions within 30 days of discharge from hospital

4.13 Health related quality of life for older people

4.16 Estimated diagnosis rate for people with dementia

## Norfolk Joint Health & Wellbeing Strategy 2014-17 Action Plan: Dementia Strategy Implementation Board

**Partners and operational plans or strategies**

- Public Health: http://www.norfolkinsight.org.uk/jsna/mentalhealth
- Great Yarmouth and Waveney CCG: http://www.greatyarmouthandwaveneyccg.nhs.uk/_store/documents/nhsgreatyarmouthandwaveneyccgoperationalplanpublicfacingversion_activelinks.pdf
- North Norfolk CCG http://www.northnorfolkccg.nhs.uk/sites/default/files/Strategic_Operational_Financial%20Plan%2014-15%20to%2018-19%20Report.pdf
- Norwich CCG http://norwichccg.nhs.uk/publications-policies/doc_download/485-operating-plan-14-16
- South Norfolk CCG http://www.southnorfolkccg.nhs.uk/sites/default/files/pdf/DRAFT%20-%20NHS%20South%20Norfolk%20CCG%20Operational%20Plan%2011th%20July%202014.pdf
- West Norfolk CCG http://www.westnorfolkccg.nhs.uk/sites/default/files/pdf/Final%2015_16%20Operational%20Plan.pdf
- Healthwatch Norfolk: ..\..\..\1. Key Policy Documents and resources\General\Healthwatch Norfolk Strategy 2015 - 17 Final Version.docx
- Admiral Nurse service
- Alzheimer's Society
- Age UK Norfolk
- Carers Agency Partnership
- District Councils
- East of England Ambulance Service NHS Trust
- Norfolk Fire and Rescue Service
- NorseCare
- Police
- Prisons
- UEA

**Future plans and challenges**

**Cognitive Stimulation Therapy:** CST has been highlighted as an area where great benefits are experienced by not only people with dementia, but also those with memory problems. CST is the only non-drug intervention to be recommended for cognitive symptoms and maintenance of function and is recommended in NICE guidelines 2006. However, gaps in CST provision have been identified across Norfolk. The Dementia Champion and Dementia Priority Coordinator are currently involved in promoting this service and looking at ways in which it can be successfully developed across the county.

**Comorbidities and dementia:** The Dementia Champion and Dementia priority Coordinator are due to meet with the Big C discuss the interrelationship of dementia and cancer, and what can be done to help people with that co-morbidity. This ties in with intention no.10 from the Norfolk Joint Health and Wellbeing Strategy.

**Co-production:** Following on from the dementia work Healthwatch Norfolk have been involved in, there is scope for some of their volunteers with a keen interest in services for people with dementia to get involved with appropriate pieces of work developed from the Dementia Strategy Implementation Board.

2014-17 Summary

# Norfolk Health and Wellbeing Strategy

## About us

### 'Working together for a healthier, happier Norfolk'

Norfolk's Health and Wellbeing Board is a partnership of local organisations – including local councils, clinical commissioning groups (CCGs), GPs, voluntary groups and charities – working together to improve the health of people in Norfolk.

## Our vision

### 'Everyone in Norfolk living healthy, happier lives for longer'

Our strategy aims to reduce inequalities in health and wellbeing across Norfolk while improving outcomes for all. Our priorities are focused on issues where we think the maximum impact can only be achieved by working together – using practical action to bring about sustainable change.


## Our health priorities

The big health issues we are focusing on are based on the findings of the Joint Strategic Needs Assessment (JSNA), which has helped identify three priority areas:

1. Promoting the social and emotional wellbeing of pre-school children
2. Reducing obesity
3. Making Norfolk a better place for people with dementia and their carers

We have also added three cross-cutting goals to this, which are:

- Prevention
- Reducing inequalities
- Integration

A copy of Norfolk's JSNA is available at **www.norfolkinsight.org.uk/jsna**

Vision

Everyone in Norfolk living healthy, happier lives for longer

Priority

Strategic intentions

## Promoting the wellbeing of pre-school children

### Giving every child the best start in life

**C1.** Improve the promotion of and opportunities for breastfeeding, healthier diets, physical activity and tooth brushing in pre-school children.

**C2.** Promote programmes which support parents and particularly fathers in vulnerable groups such as young fathers, war veterans and offenders.

**C3.** Develop arrangements for integrated commissioning of universal and targeted services for under 5s - including GPs, maternity, health visiting, school nursing and early years providers.

**C4.** Ensure the social and emotional wellbeing of under-5s is assessed as part of the JSNA.

**C5.** Support and encourage development of parental and child literacy, including 'Raising Readers'.

### Improving mental health

**C6.** Ensure that maternal mental health is assessed and any issues identified are addressed at an early stage.

### Ending domestic abuse

**C7.** Promote early intervention with potential perpetrators and victims of domestic abuse and co-ordinate identification of abuse and referral training across partner organisations.

**C8.** Develop and pilot a programme which addresses empowerment and self-esteem in relation to domestic abuse, relationships and risk taking behaviour in teenagers.

### Minimising harm caused by substance misuse

**C9.** Improve contact between substance misusing parents and treatment services.

### Keeping children safe in the home

**C10.** Promote projects addressing child safety in the home.

## Reducing obesity

### Build an integrated approach to obesity

**O1.** Develop a comprehensive countywide obesity strategy.

**O2.** Put in place an individual to co-ordinate activity on obesity.

**O3.** Engage with communities to better understand perceptions of obesity in high prevalence areas and what messages and services will be effective.

**O4.** Agree 'obesity branding' such as Change4Life to create a shared vision, speak with 'a common voice' and be clearly identifiable to the community.

**O5.** Ensure elected members and all partners working with local communities are aware of the importance of preventing and managing obesity and that they advocate for action on obesity.

### Create a healthier physical environment

**O6.** Work with local businesses and partners to increase access to healthy food choices.

**O7.** Make the most of the potential for the planning system to create a healthier built environment.

**O8.** Work with registered social landlords to implement the practical action plan led by the Design Council and the National Housing Federation, which sets out ten priorities for change to provide more opportunities for people of all ages to be more active and enjoy the space outside their homes.

### Promote behaviour change

**O9.** Make the most of key opportunities to engage with communities and promote behaviour change.

**O10.** Provide ongoing training and awareness raising to combat prejudice and discrimination against obese people in the workplace.

## People with dementia and their carers

### Build an integrated approach to dementia

**D1.** Ensure that a comprehensive Joint Strategic Needs Assessment (JSNA) informs strategic planning.

**D2.** Ensure that the needs of hard to reach groups are recognised and addressed in all localities, such as people who are socially or geographically isolated, those without an advocate and black, Asian and minority ethnic groups. Work with Norfolk County Council, Norfolk Community Transport and bus companies to ensure access for all.

**D3.** Commissioners and providers including voluntary and independent organisations should develop organisational structures, workplaces, processes and referral pathways that encourage joint working and sharing of expertise so that services are person-centred and duplication reduced.

**D4.** Make sure that new services are robustly evaluated, including measures of user and carer satisfaction, monitoring outcomes throughout not just outputs, and if effective, commission long-term.

### Promote awareness of dementia

**D5.** Improve the awareness and understanding of memory loss through general and targeted information campaigns. Promote preventative measures to improve health and wellbeing, and forward planning including on Attendance Allowance, financial planning, and Lasting Power of Attorney and wills.

**D6.** Promote and support communities, councils, agencies and businesses to be dementia friendly.

**D7.** Ensure the public, independent and voluntary sector workforce, including housing, who support older people and people with dementia are required to have appropriate levels of dementia training.

### Improve the dementia care pathway

**D8.** Include people with dementia and their carers in service planning from the start and through the whole process from strategy development, to implementation, evaluation and shaping the market (co-production).

**D9.** Improve the rate of timely diagnosis of dementia.

**D10.** Ensure continuity of care within and between GP practices, hospitals, community services and home in order to deliver patient-centred care, especially for those with other co-existing health problems.

**D11.** Ensure a range of professional services through **specialist** information, advice and advocacy, specialist practical support, specialist groups and therapies, dementia nurses, adult social care and mental health services is available 24/7 for all people with dementia and their carers, and tailored to their stage of dementia and their age.

**D12.** Ensure all acute hospitals have a dementia strategy, a dementia lead, a holistic view of the person with dementia and other co-existing long term conditions and a co-ordinated approach to treatment by different specialists.

**D13.** Develop and implement across all relevant agencies an individualised and planned approach to end of life care for people with dementia and their carers so that they have an integrated health and social care plan in place to meet their needs and preferences.

### Support independent living in the community

**D14.** Ensure high quality information, advice and advocacy on maintaining **general** wellbeing and independence, including on finances and housing, are provided in different ways (eg print, face-to-face, telephone and web) for older people including those with dementia and their carers.

**D15.** Establish and maintain sustainable, low level, preventative services which help people with dementia and older people remain living independently for longer. These should include Handyperson services, referral agencies, assistive technologies and aids, home safety and security, community alarms, falls prevention and urgent help.

**D16.** Recognise and address loneliness and social isolation in people with dementia using an asset-based approach to help them enjoy the activities of their choice.

### Improved services for those unable to live independently

**D17.** Ensure independent and voluntary home care agencies provide high quality care for their clients who have dementia. This should include a leadership and culture which focuses on treating people with dementia with dignity and respect.

**D18.** Identify, assess and meet the ongoing health and wellbeing needs of carers of people with dementia, and treat them as valued and equal partners. Ensure that they have access to a choice of affordable, flexible breaks and respite including emergency respite, to peer support (including web-based forums), to training on providing personal care and managing dementia-related behaviours, and to therapy and counselling.

**D19.** Ensure commissioners of sheltered housing, housing with care, care homes and nursing homes incorporate best practice design for people with dementia.

**D20**. Ensure residential care and nursing homes provide high quality care for their residents. This should include signposting to an independent advocate, co-ordination across organisations, provision of activities, promotion of dementia friendly design, and a culture and leadership focused on providing high quality care and on treating people with dignity and respect.

Prevention
Reducing inequalities
Integration

## Success measures


**Each child to:**

- ✓ Be a healthy weight
- ✓ Be ready for school
- ✓ Have a mum who's been supported to breastfeed
- ✓ Have parents who've been supported to quit smoking

**Living in homes:**

- ✓ Free of domestic abuse
- ✓ Free of drug and alcohol abuse
- ✓ Where they are safe


**Each person to:**

- ✓ Be a healthy weight
- ✓ Live in a healthy environment
- ✓ Walk and cycle more

**Supported by access to:**

- ✓ Healthy food
- ✓ Open spaces
- ✓ NHS Health Checks
- ✓ Health trainers
- ✓ Healthy options if fast food outlets are planned


**People with dementia:**

- ✓ Are diagnosed early
- ✓ Can enjoy their life
- ✓ Get right advice and information
- ✓ Can make decisions about their future
- ✓ Get the right treatment and support
- ✓ Are treated with dignity and respect
- ✓ Feel part of the community
- ✓ Have carers who are well supported
- ✓ Know their end of life wishes are respected

## What will success look like?

We have identified some outcomes that we want to see improved for each of our three priorities, which are covered in our 'measures of success' (see opposite).

## How will we get there?

Each priority has a named champion (one of our Board partners) who works with a co-ordinator to draw up a clear plan to make it happen. They will also keep us updated on their progress and achievements.

## Who will make it happen?

The Health and Wellbeing Board has overall responsibility for the strategy. We will make sure that actions are being taken, improvements are being made and that partners are working together to improve the health and wellbeing of people in Norfolk. However, to improve health and wellbeing we need it to be everybody's responsibility.

## How will we know if we have made a difference?

We will know a difference has been made if people living, working and registered with a GP in Norfolk can see improvements in their own, families' and friends' health and wellbeing.

We will find this out by:

- Asking local people for their views on whether a difference has been made
- Monitoring the success measures in our plan (see list opposite)

Norfolk **Health** and **Wellbeing** Board

Find out more
**www.norfolk.gov.uk/hwbstrategy**

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# Norfolk Health and Wellbeing Strategy

**Detailed Summary of Action Plan progress**

**Social and Emotional Wellbeing of pre-school children**


The summary action plan (Appendix XXX) emphasises the importance of addressing overarching mental health issues and particularly, 'early attachment' as crucial to the social and emotional wellbeing being of children. Now the Healthy Child Programme Contract has been awarded, monitoring of the required health and wellbeing outcomes can be used to demonstrate progress on the strategy.

Other key actions this year include:

**Prevention**

- NLIS now include British Heart Foundation physical activity leaflets in the bookbags given to all babies and 3-4 year olds.
- The Voluntary and Community sector has circulated a smart survey to map partners working with early years in December 2014.
- The Department of Health 6 High Impact Areas were the subject of an early years conference attended by the coordinator. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/326888/Early_Years_Impact_Overview.pdf ) This has confirmed that the 6 High Impact Areas are all covered by the H&WB strategy intentions. Helpful case studies were gathered as to what is happening nationally to help inform action plans.
- The proposed spring conference was postponed in favour of a service user questionnaire. Developed with the support of Healthwatch, service users have given insight into the availability of services to identify any gaps or barriers to accessing these services.

**Inequalities**

- The Norfolk Library and Information Service (NLIS) has extended a targeted Early Years Summer Reading Challenge pilot into 2015 – 2017. UEA is supporting evaluation design.
- The Home Learning Environment team are working on a definition of "Readiness for School"
- Targeted work by FNP, Early Help, Health Visitors, Home Learning Environment and Children's Centres continues as a priority.

**Integration**

- NCCSP are working to align the domestic abuse strategy with the HWBB strategy.

- Working relationships have been developed between Children's Services, Norfolk County Community Safety Partnership, the Home Learning Environment, Norfolk Library and Information Service, Public Health, the voluntary sector and Healthwatch.
- The Priority champion chairs the Children and Young Peoples Strategic Partnership Health and Wellbeing sub-group. The Priority coordinator now attends the Perinatal and Infant Mental Health Service (PIMHS) steering group and CAMHS Partnership group

**Future actions and general developments**

- A pilot of 'The Nurtured Heart Approach' in early years' settings is being planned
- A partnership group is looking at how to increase access to 'Circle of Security' attachment courses for vulnerable families
- NCC Children's Services continue to work with NSFT through PIMHS and CAMHS.
- Priority Coordinator to complete the Train the Trainer course for the Take 7 Steps Out campaign aimed at reducing harm to children caused by second hand smoke, to be delivered to Children's Centres and other professionals working with children and families.
- Priority Coordinator has been invited to the Children's Centre leads meeting to encourage take up of Joy of Food courses and to promote the Take 7 Steps out campaign.
- NCC Children's Centre development officer is working with centres to align with the strategy intentions.
- Collate information from the service user questionnaire (Autumn 2015) to inform further actions for the strategy.
- Cambridge Community Services NHS trust have been awarded the HCP contract.
- The CYPSP Health sub-group to be used to further inform work on the strategy and enable further alignment with partners.
- NCC Early Years Team have been in discussions regarding workforce development.
- The Family Nurse Partnership have extended its membership to include the priority coordinator on the advisory board.
- Multiagency work will commence with a Toxic Trio workshop in July. Mental health, substance misuse and domestic abuse are all identified in the strategy and any actions agreed can support implementation of the intentions.

**Preventing Obesity**


Tackling obesity continues to be a major health and wellbeing challenge with only 33% of adults being a healthy weight. The summary action plan (See Appendix XXX) adresses three of the main ways that obesity can be prevented: promoting behaviour change, creating a healthy built environment and building an integrated approach.

Other Key actions this year include:

**Prevention**

- Tackling Obesity: A Health Needs Assessment for Norfolk' completed with recommendations for action
- Healthy Child programme contract awarded to Cambridge Community Services NHS Trust.
- Healthy lifestyle services to support long term life style changes and reduce health risks of CVD are being reviewed and future plans are being considered
- Tier 1 universal prevention activity/tier 2 provision by NCC PH and other providers across Norfolk service mapping onto action plans; smart survey questionnaire circulated

- Norwich locality application to become a pilot site for the national diabetes prevention programme.
- NCC Road Casualty Reduction Team promoting active travel– encouraging walk/cycle to school/work schemes
- promotion of HONOR scheme county-wide
- Newly appointed workplace health officer in Reducing Early Mortality Team, NCC PH
- Business in the Community (BITC) to promote workforce health in businesses – links made

**Inequalities**

*The Health Needs Assessment recommendations and plans for Healthy Child Programme also fit into this section*

- Continued promotion/ongoing evaluation of NHS Health Checks, Joy of Food, HONOR, fruit and vegetable van service and other interventions to tackle obesity
- Health & Wellbeing Board grants aimed at tackling obesity priority
- B-eat (Eating Disorders charity), Family Matters and Great Yarmouth Bike Project and Community Engagement Neighbourhood Networks in Norwich.

**Integration**

- Workshops with partners developing the 'Healthy Weight Strategy for Norfolk' with launch planned autumn 2015
- District Directors Strategy Group identifying how district, borough and city councils can work towards an integrated approach to obesity
- EoE Obesity Network and Norfolk Obesity Network attendance and involvement.

*The mapping onto action plans of Tier 1 universal prevention activity/tier 2 provision by NCC PH and other providers across Norfolk service, and the mapping of current Weight Management Services tier 1/2 submission to Public Health England demonstrate integration approach as well as fitting in with Prevention. The same applies to review of the Healthy lifestyle services to support long term life style changes and reduce health risks of CVD.*

- Improving integrated working with Business in the Community (BITC), B-eat (Eating Disorders charity), Family Matters and Great Yarmouth Bike Project and Community Engagement Neighbourhood Networks in Norwich.

**Future actions and general developments**

- Healthy Weight Strategy continued development with workshop on action planning, launch Strategy autumn 2015.
- Town and Country Planning Association workshop in July 2015 promoting Obesity Intentions/Health Needs Assessment recommendations relating to planning:
    - These include: need to promote healthy food and active travel options
    - consideration of regulation of factors increasing obesogenic environments
    - raising profile of Design Council action plan to social landlords to ensure they are aware of priorities for change.
- Maintain/extend successful services such as mobile fruit and veg van, Joy of Food, Health Trainers.
- Continue to implement Strategy with all Districts/Borough and City Councils, and others such as Active Norfolk and BITC
- Making Every Contact Count (MECC) training to be offered to ensure all opportunities are taken in community engagement to promote healthy lifestyle

- NCC PH to agree and implement a plan for organisations to monitor and Identify staff training needs to combat prejudice towards obese people in workplace – training including equalities, RSPH, MECC, Understanding Eating Disorders, Mental Health First Aid.

**Making Norfolk a better place for people with dementia and their carers**

**The Dementia Strategy Implementation Board continues to drive the progress of the agreed overarching action plan (see Appendix XXX) and provides a robust reporting mechanism for dementia developments across the county. A number of different Task and Finish groups have been set up to implement the strategic intentions identified as priority areas. There has been a strong focus in year one on the areas of prevention and integration but more attention will be given to addressing the inequalities in the next phase.**

Other Key actions this year include:

**Prevention**

- **A Dementia Friendly Employers and Businesses Task and Finish group consisting of many of the statutory bodies and representation from the Norwich Business Improvement District (BID) group has been set up to focus on becoming more dementia friendly. A workshop was held in June to focus on producing a standardised framework for staff/employee dementia training, linked in with the successful Age UK Norfolk Dementia Friendly Communities work.**
- A Dementia Friendly Norfolk website, funded by the NSDA has been designed in co-production with carers. The content includes details of dementia friendly services and events across Norfolk. The website will be trialled with user groups such as Healthwatch Norfolk volunteers, before being launched in the autumn.
- In June an Alcohol, Memory Loss and Dementia Learning Day was organised by Public Health, whereby specialist and general information was provided to increase the knowledge and skills of those working in health, social care and the third sector.
- Following on from the success of the Dementia Friendly Day held in Norwich at the start of this year, a similar such event took place at Sheringham in June.
- The University of East Anglia are currently putting together a proposal to make the UEA a dementia friendly community.

**Inequalities**

- **Cognitive Stimulation Therapy (CST) has been highlighted as an area where great benefits are experienced by not only people with dementia, but also those with memory problems.** It is the only non-drug intervention to be recommended for cognitive symptoms and maintenance of function, and is **recommended in NICE guidelines.** However, gaps in CST provision have been identified across Norfolk. The Dementia Champion and Dementia Priority Coordinator are currently involved in promoting this service and looking at ways in which it can be successfully developed across the county.

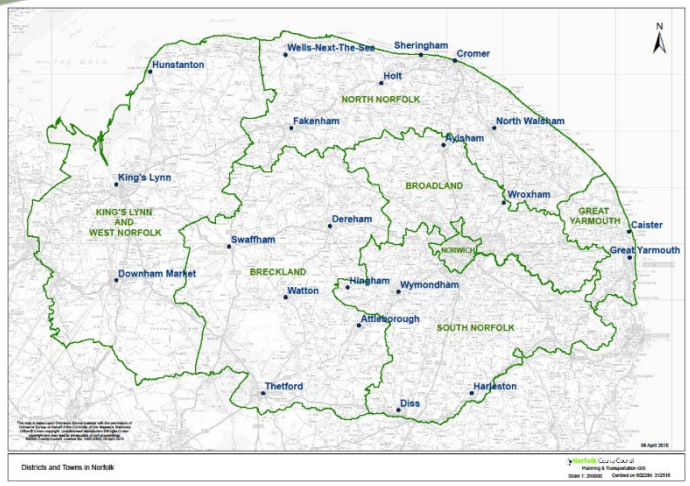
**Integration**

- A Dementia Advice and Information Task and Finish group comprising of a range of organisations including the Norfolk and Suffolk Dementia Alliance (NSDA), Alzheimer's

Society, Age UK Norfolk, Carers Agency Partnership and carers will meet again in the autumn to learn from the work underway by the Admiral Nurse service, working with CCGs to inform future commissioning. Current services are being evaluated and an advice and information pathway will be produced.

- Linked into this group was the development of the dementia information packs produced by North Norfolk CCG. 1000 packs were distributed during Dementia Awareness week, the majority of which will be distributed by NSFT to people on diagnosis across Norfolk.
- The findings and recommendations from the Healthwatch Norfolk report, 'Experiences of accessing information for people with dementia and their carers' published in May, have fed into the work of this Task and Finish group.
- The strength of partnership work across Norfolk is reflected by the recent commendation Public Health received in the MJ Local Government awards for dementia work in 'Public Health Partnerships'.
- Lawson Road Health Centre are planning to put forward a proposal to become a central hub for dementia advice and information for the practices in Norwich, launched as a pilot in 2016.

# Health and Wellbeing Profile June 2015 Norfolk




## Population 870,100

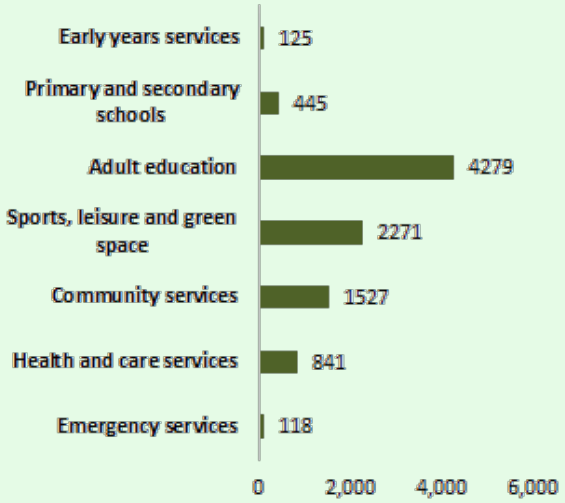
2013 mid-year estimate | Source: Office for National Statistics



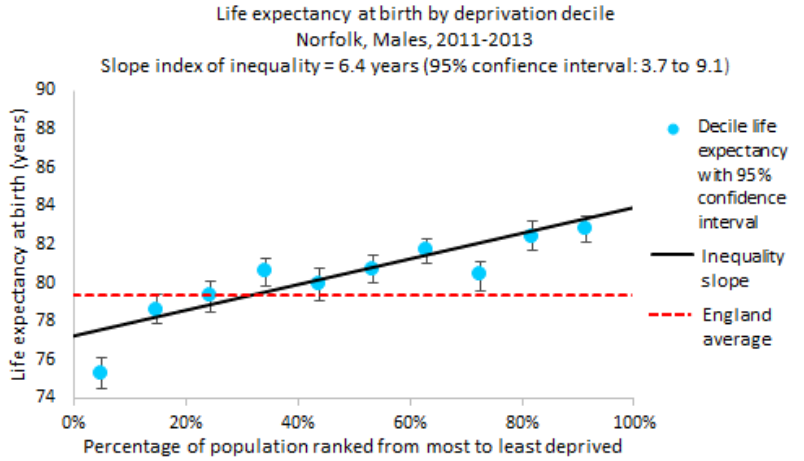
This profile gives a broad picture of the key health and wellbeing issues for Norfolk and shows how it compares with England. These are a snapshot in time of the latest information available and are only a sample. For more information go to the county's Local Information System - Norfolk Insight **www.norfolkinsight.org.uk**.

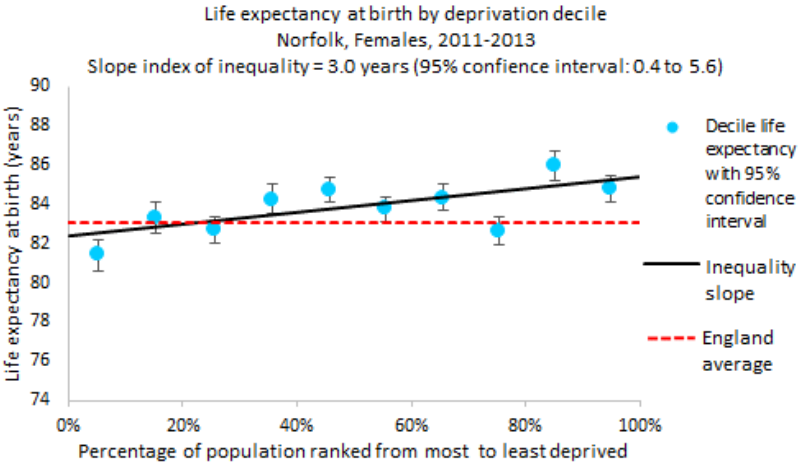
If you have any queries about this profile or its data, please email joshua.robotham@norfolk.gov.uk.

## Community assets supporting Health and Wellbeing




*Source: see indicator notes on page 4*




*Source: see indicator notes on page 4*

## Current Health and Wellbeing priorities


**46%** of children have a good level of development at age five

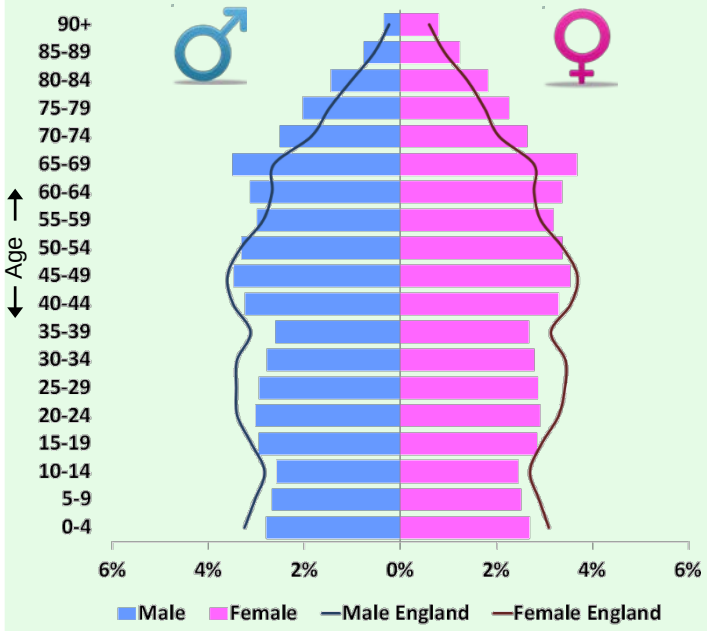

**69.4** per 100,000 people below the age of 75 die each year of circulatory conditions


**54%** of dementia cases are diagnosed

www.norfolk.gov.uk/hwbstrategy

# Population – 2013

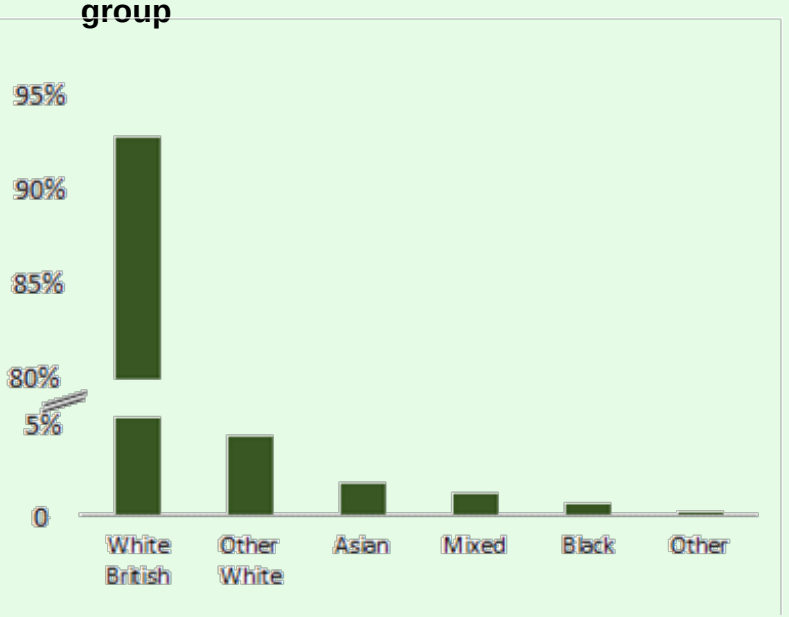
**Percentage of resident population by five year age groups 2013 compared with England**




## Age Structure

The estimates for mid-2013 confirm that Norfolk's population has a much older age profile than England as a whole, with 23.0% of Norfolk's population aged 65 and over, compared with 17.3% in England. - See more at: http://www.norfolkinsight.org.uk/jsna/population

**Percentage of resident population by ethnic group**




Source: Office for National Statistics © Crown Copyright 2013

# Health

## General Health

General health is a self-assessment of a person's general state of health. People were asked to assess whether their health was very good, good, fair, bad or very bad. This assessment is not based on a person's health over any specified period of time.

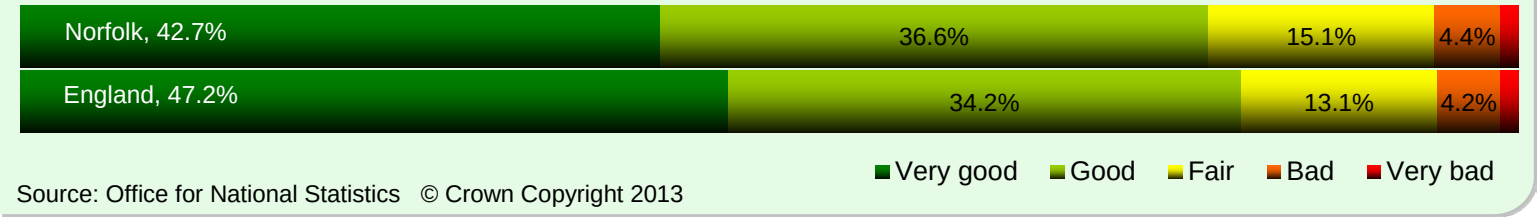
General health in Norfolk is worse than the national average. 79.3% of people described their health as good or very good, compared with 81.4% in England, and 5.6% as bad or very bad, as against 5.5% in England.

## Long-term health problem or disability

A long-term health problem or disability that limits a person's day-to-day activities, and has lasted, or is expected to last, at least twelve months. This includes problems that are related to old age. People were asked to assess whether their daily activities were limited a lot or a little by such a health problem, or whether their daily activities were not limited at all.

Norfolk is worse than the national average. 9.1% said their activities were limited a lot, compared with 8.3% in England. This is not the case for people of working age. 3.5% of 16-64 year olds said that their activities were limited a lot, compared with 3.6% in England. 4.1% of households had dependent children and one person with a long-term health problem or disability, against 4.6% in England.

**Residents' self-assessment of general state of health**




Source: Office for National Statistics © Crown Copyright 2013

The chart below shows how the health of people in Norfolk compares with the rest of England. Norfolk's result for each indicator is shown as a circle. The rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in Norfolk is shown as a grey bar. A red circle means that Norfolk is significantly worse than England for that indicator; however, a green circle may still indicate an important health problem.

- **Significantly worse than England average**
- **Not significantly different from England average**
- **Significantly better than England average**
- **No significance calculated**


| | | Profile for Norfolk | No of people per year | County Value | England Average | ED Worst | Norfolk Range | ED Best |
|---|---|---|---|---|---|---|---|---|
| Our community | 1 | Life expectancy at birth for males | n/a | 79.7 | 78.9 | 73.8 | | 83.3 |
| | 2 | Life expectancy at birth for females | n/a | 83.6 | 82.8 | 79.3 | | 87.8 |
| | 3 | Income Deprivation 2010 | 110,828 | 13.0 | 14.7 | 34.5 | | 5.1 |
| | 4 | General Health - bad or very bad | 48,233 | 5.6 | 5.5 | 8.9 | | 2.5 |
| | 5 | Circulatory conditions including heart attack and stroke | 1,741 | 69.4 | 78.2 | 169.4 | | 28.2 |
| | 6 | Deliveries to teenage mothers | 836 | 1.9 | 1.5 | 5.1 | | 0.0 |
| | 7 | Provision of 50 hours or more unpaid care per week | 23,207 | 2.7 | 2.4 | 4.5 | | 0.8 |
| | 8 | Anti-social behaviour incidents | 5,445 | 6.3 | n/a | 37.6 | | 1.2 |
| | 9 | Domestic Abuse | 16,576 | 22.9 | n/a | 77.6 | | 5.4 |
| | 10 | Violence against the person | 3,718 | 4.3 | n/a | 21.3 | | 0.8 |
| Early years | 11 | Child Poverty | 26,237 | 18.3 | 21.8 | 48.2 | | 7.3 |
| | 12 | Child Development at age 5 | 4,226 | 46.0 | 52.0 | 19.7 | | 73.0 |
| | 13 | Admissions for injuries in under 5s | 3,233 | 142.6 | 139.6 | 229.8 | | 70.4 |
| | 14 | Emergency admissions in under 5s | 21,050 | 150.9 | 150.0 | 249.4 | | 87.5 |
| | 15 | A&E attendances in under 5s | 42,104 | 301.8 | 509.5 | 692.7 | | 168.4 |
| | 16 | Breastfeeding * | 3,914 | 0.4 | 0.5 | 0.5 | | 0.3 |
| | 17 | Obese Children (Reception Year) | 2,233 | 8.8 | 9.4 | 14.3 | | 2.9 |
| | 18 | Children with excess weight (Reception Year) | 5,801 | 23.0 | 22.4 | 32.3 | | 14.4 |
| Obesity | 19 | Obese adults | n/a | 23.8 | 23.0 | 28.3 | | 11.8 |
| | 20 | Healthy eating adults | n/a | 59.1 | 56.3 | 25.7 | | 74.7 |
| | 21 | People diagnosed with diabetes | 46,704 | 6.5 | 6.2 | 10.2 | | 3.2 |
| Dementia | 22 | Deaths from dementia and alzheimer's disease | 2,476 | 80.3 | 85.5 | 259.8 | | 20.1 |
| | 23 | Estimated diagnosis rate for people with dementia | 8,916 | 54.0 | 52.5 | 31.1 | | 85.1 |

Source: See health indicator notes on page 4

## Health indicator notes

**Community assets supporting health and wellbeing:** Types of assets by address from the OS Addressbase dataset.

**Life expectancy at birth by deprivation decile:** Life expectancy at birth has been calculated for each population decile from the most deprived 10% of the population to the least deprived 10%. An inequality slope has been calculated (line of best fit using the least squares method) which highlights the life expectancy difference in Norfolk. The England average life expectancy has been included as an illustration of total equality, points below this line show a worse than average life expectancy. Source: ONS PCMD and IMD2010

**Health & wellbeing summary:**
**1)** Average male life expectancy at birth (years) 2011-2013 - Primary Care Mortality Database;
**2)** Average female life expectancy at birth (years) 2011-2013 - Primary Care Mortality Database;
**3)** The percentage of the population living in low income families reliant on means tested benefits – IMD 2010;
**4)** The percentage of question respondents who stated 'very bad' or 'bad' when asked about their general health – Census 2011;
**5)** Early deaths from circulatory conditions (deaths aged under 75 including heart attack and stroke) DSR 20011-2013 - Primary Care Mortality Database;
**6)** Percentage of delivery episodes where the mother is aged under 18 years 2008/09-2012/13 - HSCIC;
**7)** The percentage of question respondents who stated '50 hours or more of unpaid care per week' when asked if they provide unpaid care – Census 2011;
**8)** Anti-social behaviour incidents per 1,000 population October 2014 - December 2014 - Norfolk Constabulary;
**9)** Recorded crime and non-crime domestic abuse incidents per 1,000 population aged 16+, 2014 - Norfolk Constabulary;
**10)** Violence against the person incidents per 1,000 population October 2014 – December 2014 - Norfolk
**11)** Children 0–15 living in income-deprived households as a percentage of all children 0–15 – IMD 2010;
**12)** The percentage of children with a good level of development: 78 points across all 13 EYFSP scales (including a minimum number in particular areas of learning and development) at the end of the academic year in which they turn 5 2013/14 – Department for Education;
**13)** Crude rate of hospital admissions caused by unintentional and deliberate injuries in children (aged under 5 years), per 10,000 resident population. 2008/9 – 2012/13 – ONS;
**14)** Crude rate of emergency hospital admissions for children (aged under 5 years), per 1,000 resident population. 2010/11-2012/13 – ONS;
**15)** A&E attendance rate per 1,000 population aged 0-4 years. 2010/11-2012/13 – ONS;
**16)** The % of mothers breastfeeding at 6 to 8 weeks 2013/14 - NCHC and ECCH;
**17)** Number of children classified as obese as a percentage of all children measured. 2011/12-2013/14 – NCMP;
**18)** Number of children classified as overweight or obese as a percentage of all children measured. 2011/12-2013/14 – NCMP;
**19)** % adults classified as obese – Active People Survey 2012;
**20)** The estimated percentage of the population aged 16+ that eat healthily. Healthy eating is defined as those who consume 5 or more portions of fruit and vegetables per day. Active People Survey 2012 – APHO;
**21)** The % of the population registered with GP practices aged 17 and over with diabetes. 2014 – QOF database;
**22)** Directly standardised rate of deaths from Dementia and Alzheimer's disease per 100,000 people (ICD 10 codes F01, F03 & G30) 2011-2013 - PCMD;
**23)** Estimated diagnosis rate expressed as a percentage (number of people diagnosed/estimated prevalence) 2014/15 – HSCIC;
**Notes:** Directly Standardised Rate (DSR) – The age-specific rates of the subject population are applied to the age structure of the standard population. This gives the overall rate that would have occurred in the subject population if it had the standard age-profile. EYFSP: Early Years Foundation Stage Profile.

## Find out more

### Key information links

There is much more information available to inform you on health and wellbeing issues in your area. There are nationally produced profiles:

Public Health England publish a range of nationally produced profiles including:

- Local Authority Health Profiles
- General Practice Profiles
- Child Health Profiles
- Injury Profiles
- Community Mental Health Profiles

fingertips.phe.org.uk

Norfolk County Council and the Public Health team also produce information on related issues, which can be found in Norfolk's online JSNA. This includes:

- 2011 Census information and analysis
  www.norfolkinsight.org.uk/census
- CCG profiles and information
  www.norfolkinsight.org.uk/jsna/ccg
- Children and Young People Profiles for Norfolk
  www.norfolkinsight.org.uk/jsna/youngpeople

# Norfolk Health and Wellbeing Strategy

## Strategy Progress Report June 2015

www.norfolk.gov.uk/hwbstrategy

| | Strategic Intention | Performance |
|---|---|---|
| | **Social and emotional wellbeing of preschool children** | |
| **C1** | Improve the promotion of and opportunities for breastfeeding, healthier diets, physical activity and tooth brushing in 0-5s | **Amber** |
| **C2** | Promote the support parents and particularly fathers in vulnerable groups such as young fathers, war veterans and offenders | **Amber** |
| **C3** | Develop arrangements for integrated commissioning of universal and targeted services for children aged under 5 | **Green** |
| **C4** | Ensure the social and emotional wellbeing of under 5s is assessed - JSNA | **Green** |
| **C5** | Support & encourage development of parental & child literacy | **Green** |
| **C6** | Ensure that maternal mental health is assessed and any issues identified are addressed at an early stage | **Amber** |
| **C7** | Promote early intervention with potential perpetrators and victims of domestic abuse and coordinate identification of abuse and referral training | **Green** |
| **C8** | Develop a single programme which addresses empowerment and self-esteem in relation to domestic abuse, relationships and risk taking behaviour in teenagers | **Green** |
| **C9** | Improve contact between substance misusing parents and treatment services | **Amber** |
| **C10** | Promote projects addressing child safety in the home | **Amber** |
| | **Preventing obesity** | |
| **O1** | Develop a comprehensive countywide obesity strategy | **Green** |
| **O2** | Put in place an individual to co-ordinate activity on obesity | **Complete** |
| **O3** | Undertake engagement activity to better understand perceptions of obesity in high prevalence areas and what messages and services will be effective | **Amber** |
| **O4** | Agree a local "obesity branding" - partners to have a shared vision | **Green** |
| **O5** | Ensure those working with local communities are aware of the importance of preventing and managing obesity, and that they advocate for action | **Amber** |
| **O6** | Work with local businesses & partners to increase access to healthy food choices | **Amber** |
| **O7** | make the most of the planning system to create a healthier built environment | **Amber** |
| **O8** | Work with registered social landlords to implement the practical action (Design Council and the National Housing Federation) - to provide opportunities for people to be more active and enjoy the space outside | **Grey** |
| **O9** | Engage with communities and promote behaviour change | **Green** |
| **O10** | Provide ongoing training and awareness raising to combat prejudice and discrimination against obese people in the workplace | **Grey** |

| | Strategic Intention | Performance |
|---|---|---|
| | **Making Norfolk a better place for people with dementia and their carers** | |
| **D1** | Ensure that a JSNA informs strategic planning | **Complete** |
| **D2** | Ensure that the needs of hard to reach groups are recognised and addressed in all localities…. Work with Norfolk Community Transport and bus companies to ensure access for all | **Green** |
| **D3** | …encourage joint working and sharing of expertise so that services are person-centred services and duplication reduced. | **Green** |
| **D4** | Make sure that new services are robustly evaluated | **Amber** |
| **D5** | Improve the awareness and understanding of memory loss | **Green** |
| **D6** | Promote and support communities, councils, agencies and businesses to be dementia friendly | **Green** |
| **D7** | Ensure the public, independent and voluntary sector workforce, including housing, who support older people and people with dementia are required to have appropriate levels of dementia training. | **Amber** |
| **D8** | Include people with dementia and their carers in service planning (coproduction). | **Amber** |
| **D9** | Improve the rate of timely diagnosis of dementia. | **Green** |
| **D10** | Ensure continuity of care to deliver patient-centred care, especially for those who have other co-existing health problems. | **Amber** |
| **D11** | Ensure a range of professional services is available 24/7 for all people with dementia & their carers, and tailored to their stage of dementia and their age | **Amber** |
| **D12** | Ensure all acute hospitals have a dementia strategy, a dementia lead, a holistic view of the person with dementia and other co-existing long term conditions and a coordinated approach to treatment by different specialists. | **Green** |
| **D13** | Develop and implement an individualised and planned approach to end of life care for people with dementia and their carers so that they have an integrated health and social care plan in place to meet their needs and preferences | **Amber** |
| **D14** | Ensure high quality information, advice and advocacy on maintaining ***general*** wellbeing and independence are provided in different ways for older people including those with dementia and their carers. | **Amber** |
| **D15** | Establish and maintain sustainable, low level, preventative services. | **Amber** |
| **D16** | Recognise and address loneliness and social isolation in people with dementia. | **Amber** |
| **D17** | Ensure independent and voluntary home care agencies provide high quality care for their clients who have dementia. | **Amber** |
| **D18** | Identify, assess and meet the ongoing health and wellbeing needs of carers of people with dementia, and treat them as valued and equal partners. Ensure that they have access to a choice of affordable, flexible breaks and respite including emergency respite, to peer support (including web-based forums), to training on providing personal care and managing dementia-related behaviours, and to therapy and counselling. | **Amber** |
| **D19** | Ensure commissioners of sheltered housing, housing with care, care homes and nursing homes incorporate best practice design for people with dementia. | **Amber** |
| **D20** | Ensure residential care and nursing homes provide high quality care for their residents. This should include signposting to an independent advocate, co-ordination across organisations, provision of activities, promotion of dementia friendly design, and a culture and leadership focused on providing high quality care and on treating people with dignity and respect. | **Amber** |

**Red** = Barriers to progress – action from the board required

**Amber** = Some progress – monitoring required

**Green** = Progress is being made – on course

**Grey** = Not a priority at the moment – as agreed with board champion, to be reviewed

# Joint Strategic Needs assessment (JSNA) Annual Summary Report 2014/15

## Cover Sheet

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

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

The Board has requested an Annual Report to understand progress made and future plans for the development of the Joint Strategic Needs Assessment.

## Key questions for discussion

What are your views on:

- Progress made to date?
- Future plans for 2015/16?

## Actions/Decisions needed

The Board needs to:

- Consider the report and give views on the progress in developing the JSNA and its future direction.

# Joint Strategic Needs assessment (JSNA) Annual Summary Report 2014/15

Report of the Interim Director of Public Health

**Summary**
This report provides the Board with an update on the Joint Strategic Needs Assessment (JSNA) since its review and refresh reported in July 2014.

**Action**
The Health and Wellbeing Board is asked to:

Consider the report and give views on the progress in developing the JSNA and its future direction.

## 1. Background

1.1 The JSNA continues to be developed on behalf of the Board by the multi-agency JSNA Working Group building the resources available to inform strategic planning across Norfolk.

1.2 An interim management arrangement is now in place after the retirement of the JSNA Manager in April 2015. Recruitment will shortly be underway to enable the development and improvement plans for the JSNA to be continued.

1.3 A link to the front page of JSNA is available here: www.norfolkinsight.org.uk/jsna.

## 2. Key Developments for 2014/15

2.1 A range of **Health Needs Assessments and Health Profiles** were published on topics which included;

- Offender Health – Commissioned on behalf of the Rehabilitation of Offenders Board, the needs assessment is raising awareness and understanding of offender health needs. Further work is required in this area particularly around housing.
- Cancer Profiles – contributing to the surveillance role of the DPH, looking at outcomes for the most common cancers,
- Tackling Obesity – this needs assessment supports the thematic strand of the HWBB Strategy and is also intended to inform the development of a new integrated lifestyle behaviour change service,
- Domestic Violence and Abuse where Children and Young People are Affected – commissioned by the Interim DPH to inform the work of the Domestic Abuse and Sexual Violence Board and to broaden the perspective on the impacts of domestic

violence the needs assessment examines the evidence base around interventions which might break cycles of violence.

- Tobacco control and a JSNA tobacco control support pack produced by Public Health England,
- Dual-diagnosis – requested as part of a re-examination of primary mental health services and substance misuse services
- Living in Norfolk with Dementia – underpins the work in the dementia section of the Strategy.

2.2 **Quality Control.** A Quality Assurance policy for health needs assessment is now in place in NCC Public Health which provides guidance and a framework to follow when identifying a new requirement for a Health Needs Assessment. This is being published and made available to all users of the JSNA. Every Public Health led needs assessment will have oversight and sign off from a Consultant in Public Health to ensure that the necessary rigour has been applied in analysis and recommendations.

2.3 **Public Health Outcome Framework (PHOF) Summary Reports.** These reports add a wider analysis to the nationally published figures and combine related measures to give a picture of the issue for Norfolk.

2.3 PHOF Summary Reports made available in 2014/5 include Excess Winter Deaths, reoffending rates, preventable sight loss, violent crime, statutory homelessness, breast feeding, under 18 conceptions, injuries and falls amongst many others. More detailed reports including Norfolk's Child Poverty Needs assessment, Road Casualties in Norfolk, migration trends and Norfolk's Story provide informative reference resources to inform strategic decision making.

2.4 **Publication of public-facing JSNA Summary Report –** This report using images and symbols presenting key information contained in the JSNA has been published as a full report and as slides which can be used in other reports / presentation.

2.5 **The JSNA Briefing sessions** programme continued through 2014/15 and sessions were well attended. A review and evaluation was carried out through an online survey. Results have been used to inform the ongoing programme to incorporate a more workshop style allowing attendees to input and progress the work.

2.6 **District/ City/ Borough Council JSNA sessions** were completed through 2014/15, exploring recently added features and reminding partners of how the JSNA can be best used. Other partners have also been visited including the Voluntary and Community sector and The Older People's Forum.

2.7 **Web Pages** on *Norfolk Insight* dedicated to Older People and Housing were launched. Content is being informed by specialists in these areas to ensure relevant and current information is available, supporting a shared ownership of the JSNA.

2.8 **Refresh of Health and Wellbeing Electoral Division Profiles** and the Norfolk Profile and Health and Wellbeing Strategy Progress Monitoring Report are now available identifying the current position of health and wellbeing in Norfolk.

## 3. Future Plans for the JSNA 2015/16

3.1 **A structured audit** is being planned to review and refresh the contents of the JSNA pages on Norfolk Insight. Updates on existing content and important gaps will be identified and be used to prepare an action plan to steer development of the JSNA as a resource.

3.2 The **JSNA Working Group** terms of reference and membership will be reviewed to ensure we work in an integrated way with other key intelligence teams across the County.

3.3 **Housing** continues to be an important developmental area in the online JSNA, moving towards co-ownership of web page content in specialist fields. Leadership and how this can be developed will be identified to maintain momentum.

3.4 **Health Needs Assessment Guidance Policy** will be published and promoted to guide future requests for Health Needs assessment.

3.5 **Recruitment to the JSNA Manager role** in the NCC Public Health department will be progressed along with any restructuring plans to help NCC deliver priorities this year

## 4. Action

4.1 The Health and Wellbeing Board is asked to:

- Consider the report and give views on the progress in developing the JSNA and its future direction.

**Officer Contact**

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


| Name | Tel | Email |
|---|---|---|
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| Deborah Elliott | 01603 638393 | deborah.elliott@norfolk.gov.uk |


IN TRAN communication for all

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

# Locally-led health improvement

# Cover Sheet

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

Building on earlier locally-led improvement work, in July 2014, the Health & Wellbeing Board agreed to allocate the further sum of £200k for asset-based health improvement using a locally-led approach.

Funds were allocated to city, district and borough councils to work with the Director of Public Health and local partners to commission activities that will result in a demonstrable improvement in one or more of the Board's strategic priorities and goals.

This report provides an update from each local council on what the funding has been used for and what is being achieved.

## Key questions for discussion

Q.1 Are these locally-led health improvement activities making a demonstrable impact on the H&WB's strategic priorities?

Q.2 Are communities being empowered to influence and lead on improving their own health and wellbeing and/or is capacity being built to enable them do so?

Q.3 How are local councils mainstreaming their health improvement activity?

## Actions/Decisions needed

The Board needs to:

- Consider the contribution being made the Board's strategic priorities and goals
- Identify areas for future collaboration between partners and/or opportunities for shared learning across Norfolk

# Locally-led health improvement

Representatives from each of the district, city and borough councils in Norfolk

**Summary**
This report brings together updates on the impact being made across Norfolk through locally-led, asset-based health improvement activity. The report includes an update by each of the district, city and borough councils, who have been working with the DPH and local partners to commission activities that will result in a demonstrable improvement in one or more of the Board's strategic priorities and goals.

**Action**
- Consider the contribution being made the Board's strategic priorities and goals
- Identify areas for future collaboration between partners and/or opportunities for shared learning across Norfolk

## 1. Background

1.1 At its meeting on 17 April 2013 the Health & Wellbeing Board agreed that £290,000 funding should be used for locally-led health improvement activity in 2013/14. Building on this initial work, at its meeting in July 2014, the Board agreed that a further £200,000 funding should be used in a similar way for the year 2014/15.

1.2 The funding was allocated to city, district and borough councils to work with the Director of Public Health (DPH) and their local partners to commission activities that will result in a demonstrable improvement in one or more of the Board's strategic priorities and/or overarching goals. In the same way as the previous year, the funding was split on the basis of the Public Health (PH) Allocation formula - which builds in accepted national information on comparative health needs.

1.3 The H&WBs **priorities** are:

- Promoting the social and emotional wellbeing of pre-school children
- Reducing obesity
- Making Norfolk a better place for people with dementia and their carers

The H&WB's **overarching goals** are:
- Prevention - providing help at the earliest possible stage before problems become acute
- Reducing inequalities in health and wellbeing outcomes
- Integration – partners working together to provide effective, joined up services

1.4 In addition, it was agreed that the allocation should be aimed at encouraging and further developing:

- Empowered communities able to proactively influence and lead on improving their own health and wellbeing

- The capacity of the community and voluntary sector to contribute to the achievement of health and wellbeing outcomes
- Good and effective working relationships between partners at a local level,
- Increased awareness of, and share learning about issues faced, and approaches taken, across Norfolk.

## 2 What is being achieved?

2.1 Each local council has been invited to provide a brief update on what the funding has been used for and what is being achieved in their area, in collaboration with the DPH and local partners. Updates were to indicate which priority(s) are being addressed, what improvements are being seen, and the legacy arrangements in place for when the project/initiative ends. Local councils were also asked to confirm how the initiative/activity has added value including, where appropriate, how it has added value to work already underway.

2.2 The progress reports from each district/city/borough council are attached as follows:

- Breckland - Appendix A
- Broadland – Appendix B
- Great Yarmouth – Appendix C
- North Norfolk – Appendix D
- Norwich – Appendix E
- South Norfolk – Appendix F
- Kings Lynn & West Norfolk –Appendix G

2.3 In addition to these updates, an open invitation was made for 2 or 3 local councils to come forward to make a short presentation at the H&WB meeting about some of their projects and the outcomes being achieved – to help share learning and good practice of what works here in Norfolk. Due to pressure on the Board's agenda it is not practicable for all areas to present at the meeting but the invitation was made on a 'first come first served' basis and several areas will be presenting key aspects of this work.

## 3. Action

3.1 The Health & Wellbeing Board is asked to:

- Consider the contribution being made the Board's strategic priorities and goals
- Identify areas for future collaboration between partners and/or opportunities for shared learning across Norfolk

**Officer Contact**

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


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|---|---|---|
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|---|---|---|
| **Sonia Shuter –** North Norfolk District Council | 01263516173 | Sonia.Shuter@north-norfolk.gov.uk |
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**Appendix A**

**Name of council: Breckland District Council**
**Name of H&WB sponsor: Cllr Lynda Turner**
**Sum allocated: £28,520**

## Section 1 – Summary of what the funding was used for and why

The Health Profiles for Breckland at District and Ward level were used to inform the design and delivery of the following projects:

1) Dementia Carers and Cared For Project: **'Our Day Out'**
2) Childhood Obesity Project: **'Breckland Fit Families'**

Our Day Out

Our Day Out is a positive activity programme managed by Breckland Council, aiming to create shared experiences and memories between people with mild / moderate dementia and their carers.

Monthly sessions will be led by experienced professionals to host activities such as: Dancing, Games, Arts & Crafts, Reminiscence, Museum visits and much more!

Each session will last up to two hours, with time for tea and a chat with the group after each activity.

Breckland Fit Families

The six week 'Fit Families' initiative has been created by Breckland Council, in partnership with local activity experts Aspire PE, to encourage children and their families to get more active and eat healthily.

Families will each be given access to a range of information about exercise and nutrition and be offered opportunities to gain new skills try new things and consider how they can make their lifestyles healthier.

The support on offer will include being given a specially created information and activities homework folder. Participants will be invited to weekly information sessions held at the school by Breckland officers and Aspire PE staff, to give people a chance to consider ways they can put the theory into practice by changing their meals and getting more active as a family.

Parents will also be invited to take part in cookery classes, delivered by the county's Joy of Food project, to help them hone their culinary skills and try some brand new dishes.

Families will be set fun 'homework', such as taking a selfie together while out for a walk or trying a new healthy meal, and will be invited to share their successes via a dedicated Facebook page. The forum will enable them to talk about the activities they've found enjoyable, support other families to try new things, and complete healthy living challenges to be in with a chance of winning free swimming passes and other rewards.

## Section 2 – Summary of impact & outcomes locally

The projects address the following H&WB strategic priorities:

Our Day Out:

Making Norfolk dementia friendly

The project will be evaluated by the UEA and has used recognised self-evaluation surveys to assess participant's health and well-being before they commence the programme. This will be measured at the end to identify the value that has been added.

Immediate outputs are that 30 people across 3 market towns currently attend the sessions each month and it is hoped that in time this will extend to cover all 5 market towns.

Breckland Fit Families:

Promoting the wellbeing of pre-school children

Reducing Obesity

The project was launched at Westfield Infants School, Watton and engaged with 90 reception age children who were presented with their own interactive folders and also a 'Fit Families' t-shirt and also their parents.

Overall, 90 families (circa 400 participants) engaged in regular/weekly 'healthy behaviour change' (food/exercise) activities over the 6 weeks.

The project received numerous posts to the school specific Facebook page during the 7 week period evidencing a wide variety of healthy behaviour change 'soft outcomes' achieved, eg:

**Westfield Infants Reception**

> 'So that's official 3 weeks for alfie with no sugar, 1 snack of crisps a day and any other snacks which use to be sweets and cakes have for 3 weeks been replaced with fruit or veg even low sugar yogurt drinks:-) thank you Breckland Fit Families alfie has loved it'

> **'**My daughter is so excited about this. She's been running laps of our cul-de-sac and has taken her folder to bed with her!'

It is now being delivered at Carbrooke Primary School and will then look to engage with pre-school children at Watton Sure Start.

Again, the longer term outcomes of the project will be evaluated by the

**Name of council: Broadland District Council**
**Name of H&WB sponsor: Cllr. Andrew Proctor**
**Sum allocated 2014/15: £23,240**

## Section 1 – Summary of what the funding was used for and why

To date, the partners that have been involved with the Broadland District Council's weight management programme; Why Weight? have been;

- Norfolk's Living Well; promoting the programme and providing resources for the course, e.g. living well plate poster.
- Local GP surgeries specifically Acle, Sprowston and Spixworth in referring patients to the programme and advertising it in their surgeries.
- Joy of food have been approached to run one session for each course on healthy cooking
- B-eat have been approached to run one session for each course on emotional overeating
- Health trainers have been advertising the programme in the Broadland area and clients that attend the Why Weight programme have been told about health trainers as well.
- Active Norfolk are promoting the weight management programme and vice a versa, Why Weight is promoting all activities that they provide
- Broadly Active is promoted through the Why Weight Sessions and some individuals that attend the broadly Active sessions have been referred to the Why Weight programme.

So far funding has been spent on staff time and expenditures related to, venue costs and printing/stationary costs, equipment and the hiring of external provision.

There is no expected under or over spend.

## Section 2 – Summary of impact & outcomes locally

The H&WB's overarching goals are:

- Prevention – providing help at the earliest possible stage before problems become acute
- Reducing inequalities in health and wellbeing outcomes
- Integration – partners working together to provide effective , joined up services

All are addressed within this project.

One of the H&WB's priorities is:

- Reducing obesity

This is directly addressed through this project.

Overall Aims

- Empowered communities able to proactively influence and lead on improving their own health and wellbeing
- Good effective working relationships between partners at a local level

These are also a key element to the Why Weight programme

There are 54 current regular attendees for round 1 of the Why Weight programme – the majority of those that attend the programme are losing weight and reducing their BMI. The first

programme has yet to come to a full conclusion so percentage weight loss etc. is not yet known. However, it is anticipated the current clients will lose around 4% of their bodyweight over the 12 weeks.

"I have lost the weight easily, especially with the support of the group" – Lorna

Six weeks into the delivery of the programme; subjectively Why Weight? Clients have said that they are feeling positive and good about themselves.

"A very friendly atmosphere, lots of information given" – Jackie

"The most important factor is the informality of the groups. We can interact with one another and share ideas/thoughts about food" – Stephen

The groups will be forming community continuation groups once 12 weeks have been completed. The participants are currently in discussion about how they would like the groups to continue.
Currently, ideas have been deliberated on having a fitness class, a 'get together' and talk, cooking classes and regular weigh in's. These sessions will not just include those that have attended the Why Weight programme but will also be open to the wider community. Once each 12 week programme has been completed by future Why Weight attendees they will be able to take part in these community groups as well.

The programme has added value in regards to the Broadly Active scheme. Those that attend the Broadly Active scheme and/or the Fun and Fit programmes provided by Active Norfolk have attended the Why Weight programme and Vice a versa; Why Weight clients have been referred to the fitness programmes provided by the Broadland Council, Active Norfolk and other local schemes that run independently, for example Acle Community Gym.

# Name of council: Great Yarmouth Borough Council
# Name of H&WB sponsor: Penny Carpenter
# Sum allocated 2014/15: £28,100

## Section 1 – Summary of what the funding was used for and why

### Background

Funds have been used to develop and build upon a recent 1 year pilot in Great Yarmouth - the 'Family Connectors'. The original pilot focused on Early Help and building resilience in neighbourhood and community settings. Local residents were involved in the original design and the evaluation of the Connector initiative, and have championed the development of his work in the borough.

Recent project evaluation has demonstrated the success of the model for building stronger families and more connected communities, using an asset-based community development (ABCD) approach. In the evaluation the family based work was commended by Norfolk Public Health team, partner district authorities and Norfolk County Council, in addition to community based groups and voluntary sector organisations. Pilot work has also demonstrated the benefit of having this work underpinned by good quality community development support, enabling connectors and the informal groups they begin to work with to grow and develop sustainably.

### Use of funds

The funds have been used to extend the work by piloting a Community Connectors 'Wellbeing' scheme, focussing on maximising the impact on people's health. This was felt to be a natural next step in the exploration of the initiative, following the reflection that wellbeing was a more appropriate framework the work and the outcomes. All of the funds have been spent on part time employment of 5 people for a 6 month period (April- Sept 2015), employed through the VCS (Voluntary Norfolk and Future Projects).

Whilst statistics show the concentration of greatest health inequalities are in the urban wards of Great Yarmouth and Gorleston the borough also consists of 21 rural parishes, with their own challenges around community health and wellbeing. Therefore we have focussed the Wellbeing work in South and Central Yarmouth, Cobholm, Southown and Halfway House urban neighbourhoods and Hemsby Village.

### How it works

The connectors work on a peer level. They are employed to find out what interests people and what they care about, using this information to start subsequent conversations, make introductions to other residents, and make links to existing local activity. They are informed with current and relevant health based information in the widest sense, including knowledge of community based self- help groups and networks, in addition to service led initiatives.

They undertake 'connecting' activity- building relationships at various community locations- school gates, bus stops, etc. undertaking generic conversations with local residents, with the bigger intention of generating familiarity, developing relationships and facilitating links to others.

Connectors also work with individuals on a general 'life' level, recognising that people often have multiple and complex needs, and if 'health' is one of them, it may not be their immediate priority. By working with a person on something they care about, whilst also supporting someone to address their self-identified life challenges, connectors aim to support people to make the first steps to positive behaviour change towards leading healthier and happier lives.

This approach has been applied particularly when connecting with people in food banks and in associated community cafes and food based drop ins across Great Yarmouth.

**Key project objectives**

1. Make new connections and develop relationships with rural GY residents, to better link people to one another, into their community, and to appropriate local health initiatives (community and service led)
2. Work with people to identify things that matter to them, and support them to progress steps to achieve related aims
3. Support people to learn to manage self- identified 'life' challenges, to lead to positive behaviour change

**Intended outcomes**

- People feel that they now have more people to 'call on' should they need neighbourly support
- People feel better connected to their community, and take part in community activity
- People feel better able to cope with a range of life challenges, improving levels of wellbeing as a result

**Section 2 – Summary of impact & outcomes locally**

Since April 2015:

**114 people have developed relationships with connectors**

**374 different connections have been recorded (with an estimated 200+ unrecorded)**

In the last 3 months connectors have organised and run:

**1 neighbourhood fair**

**4 youth sessions at the travellers site**

**4 bus stop 'bookshops'**

**36 coffee mornings**

**And numerous street engagement activities.**

Connectors are linked in to:

**Schools, school fetes, community events, lunch clubs, volunteer fairs, local campaigning groups, arts and cultural groups, food banks, community groups and informal networks.**

| H&WB goals, aims and priorities | Case study outcomes for people |
|---|---|
| **Prevention - providing help at the earliest possible stage before problems become acute** | **Marjan** has been known to a connector for a while. The connector has put in effort to subtly ensure Marjan knows there is support on hand if needed. Marjan finally felt confident enough to reach out for help with two large issues, one being personal finances and the other being mental health. The connector was able to take Marjan to appointments, support her emotionally and be there for advice and support. Marjan has reported feeling she has more support now and more confident with the services she accessed were she to use them again. M has achieved Wellbeing indicators 1, 3 and 4. |
| **Reducing inequalities in health and wellbeing outcomes** | **Sina** has had to deal with a major mental health illness for several years, which has led to a significant setback in her education, career, social network and confidence. The Connector's engagement with her lead to Sina volunteering at the Neighbourhood Fair, dealing with large numbers of adults and children, communicating to groups and one to one. Sina found this experience thoroughly fulfilling and a great boost to her confidence. Self-recognition of skills and capabilities has been enhanced and she has expressed a keen desire to be involved in a wide range of community activities in the future. Following her success at the Fair Sina took an active role in the new 'Neighbourhood Lunch', helping the organisers to prepare and talking about and discovering with new people issues in the local area. |
| **Promoting the social and emotional wellbeing of pre-school children** | **Jan,** a parent**,** started to attend informal coffee mornings with a connector. She met new friends and has become a key person at these weekly meets. She has begun to invite other parents along and taken on a nurturing role with other attendees. Through connecting in this way she has also taken notice of her own skills and begun volunteering in her community. She regularly advertises community events, getting her out and about in the neighbourhood. She has taken on a lead role in a holiday club community group, putting her skills to use by developing activities which have included those that get families with children of all ages active together outdoors. J has achieved all of the wellbeing indicators. |
| **Empowered communities able to proactively influence and lead on improving their own health and wellbeing** | **Karen** was an acquaintance of a connector who was encouraged to come along to coffee mornings at a community centre whilst off work with an injury. Karen attended regularly, meeting new people and also becoming increasingly more interested in running the centre itself. Through the last few months Karen has become a key volunteer at community centre events and is currently planning a summer youth club with others in the community, to attract young people to the facility and get them active through sports on the common. Karen has recognised that she has the skills to lead on this and has gone from support activity to taking a lead strategic role in directing the development of community based resources. Karen has fulfilled all |

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|---|---|
| | Wellbeing indicators. |
| **The capacity of the community and voluntary sector to contribute to the achievement of health and wellbeing outcomes** | **John** had been sleeping rough for 2 days before meeting the Community Connector. Through liaising significantly with a local community group, VCS organisations, the police and private landlords, John found accommodation. Further to this, John worked on developing confidence as he suffered with anxiety, and over the 5 days he worked with the connector he changed from a person who was unable to talk with someone he didn't know on the phone, to a person who was arranging his own appointments and create a mental list of priorities. He even stopped physically shaking and expressed a much more positive outlook to life. |
| **Integration – partners working together to provide effective, joined up services** | **Graham** is well known to many housing services locally as someone who struggles to keep to structured routines because of alcohol dependency, and has been evicted from housing across the borough due to erratic behaviour when drinking. The Connector worked closely with Herring House Trust, Great Yarmouth Borough Council and the Housing First Network (via the South Yarmouth Community Development Worker) to develop a clearly defined framework for assisting with people who are homeless, allowing the Connector to deliver "first steps" goals with the individual, whilst housing services works to find accommodation. This is collaborative approach is more affective, benefiting the individual and services. Through the Connector's ongoing work with Graham a new collaborative support approach will be taken that is self-set, addressing his priorities with a level of support he is comfortable with.<br><br>**Robert** isn't currently seeking personal development, but he has been a great source of advice as someone with a good knowledge of local services and housing. He has also facilitated connections to new people at the food banks and has given support and guidance to Graham when looking for housing. Robert is a prime example of an informal community connector. |

**Added value**

All connectors working in the urban wards have been embedded within an existing Neighbourhood Management infrastructure. This is on a locality level and coordinated by a GYBC manager, with frontline delivery led by Community Development Workers employed through Voluntary Norfolk. Local residents, alongside ward councillors and partners, guide the work of the programmes via established neighbourhood boards. Embedding connector posts within the existing frameworks ensures that their work adds value to the capacity building developmental work of the CDWs, and is also strategically aligned and linked to locally identified priorities in neighbourhoods. NB. The rural work is attached to one of the NM programmes, but does not currently have the support of a dedicated Community Development Worker.

**Legacy plans**

Following the initial family connector pilot, GYBC knew that the connector model was a critical element of a community development approach to working in Neighbourhoods. Along with a group of 7 commissioned partners from the VCSE and the public sector, GYBC has led a bid to the Big Lottery Fund for a 5 year funded scheme, focussing on building resilience, transforming support based services, and improving employability in neighbourhoods within GY. The connector model is firmly incorporated into the programme design and any delivery will build up on and reflect learning from both this Wellbeing pilot and the previous Early Help pilot.

**Monitoring**

Below is the monitoring framework used by all of the connectors, with examples of the type of information captured and the links to wellbeing indicators. As wellbeing is interpreted in a multitude of ways it was seen as helpful to break it down into the 5 ways to Wellbeing. Conversations and connections are recorded at the end of each day in a 'Creating Wellbeing' conversation log, and state whether it relates to or has achieved specific indicators.

| Aim | **Wellbeing Indicator** | Examples | Why? |
|---|---|---|---|
| **Connecting** | **The person now knows more people, feels that they have more people to call on, feels valued by someone else, or is involved in community activity.** | I know more parents at my child's school<br><br>I speak to more people than I used to at the lunch club<br><br>I've started to go to coffee mornings and other events at the community centre<br><br>Our kids now go to youth club | There is strong evidence that indicates that feeling close to, and valued by, other people is a fundamental human need and one that contributes to functioning well in the world. Social relationships are critical for promoting wellbeing and for acting as a buffer against mental ill health. |
| **Being active** | **The person has changed everyday behaviours to incorporate physical activity** | I get off the bus one stop earlier<br><br>I go do down to the community garden<br><br>We always take the stairs now<br><br>I meet neighbours every day to walk the dogs | Regular physical activity is associated with lower rates of depression and anxiety across all age groups. Exercise is essential for slowing age-related cognitive decline and for promoting well-being.<br>It doesn't need to be particularly intense for you to feel good – eg. Just walking, can have the benefit of encouraging social interactions as well providing some level of exercise. |

| | | | |
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| **Learning** | **The person has learned something new, accessed a course, or improved their skills** | I went on a 'Joy of food' course, and now I can cook better<br><br>I learned about the credit union, and now I save every week<br><br>I have set a goal for the year<br><br>I feel more confident about applying for a job | Continued learning through life enhances self-esteem and encourages social interaction and a more active life.<br>Everyone is good at something, so identifying, recognising and utilising your own assets aids confidence and self esteem.<br>The opportunity to engage in work or educational activities particularly helps to lift people out of depression.<br>The practice of setting goals, which is related to adult learning in particular, is strongly associated with higher levels of wellbeing. |
| **Taking notice** | **The person recognises their own assets, feels more confident about their abilities, and is aware of priorities in their community** | I now realise I'm a good listener<br><br>I never knew there were so many things going on at our community centre<br><br>I'm good at being organised, so I'm going to help the lunch club by doing the sign in sheets<br><br>There is a lot of unemployment in our estate. We could start a community project to xxx? | Being aware of what is going on in the present directly enhances your well-being.<br>Heightened awareness also enhances your self-understanding, your understanding of others and allows you to make positive choices based on your own values and motivations. |

| | | | |
|---|---|---|---|
| **Giving** | **The person is volunteering in their community, offers support and advice to friends, neighbours, and peers, or signposts others to appropriate support services/networks** | I gave a new parent a phone number so that they could sign up for youth club<br><br>I supported someone to attend an appointment at DIAL<br><br>I get the bin in for my elderly neighbour<br><br>I helped organise a community event with MIND<br><br>I've now got a specific role on the community centre committee | Participation in social and community activity is central for wellbeing.<br>People who report a greater interest in helping others are more likely to rate themselves as happy.<br>Research into actions for promoting happiness has shown that committing an act of kindness once a week over a six-week period is associated with an increase in wellbeing. |

**Name of council: North Norfolk**
**Name of H&WB sponsor: Cllr. Annie Claussen – Reynolds**
**Sum allocated 2014/15: Approx. £20,900**

## Section 1 – Summary of what the funding was used for and why

Following last year's successful initiatives the funding is again being used to deliver and evaluate two projects aimed at increasing physical activity and fitness as well as knowledge about maintaining a healthy weight and lifestyle.

Health and Fitness Roadshows

The Health and Fitness Roadshows are aimed at key stage 2 pupils – aged 7 – 11 years. A target of 10 schools was identified to sign up to the roadshows, this has been achieved. The roadshows started in April 2015 and so far have been successfully delivered in five schools. The Roadshows in the remaining five schools started in June and will be completed in July.

The Roadshows consist of a five week programme of delivery each session last for an hour and covers exercise, food and diet. Free swim vouchers are given to encourage extracurricular activity.

The programme consists of the following:

Week 1: Introduction of the scheme, brief description, hand out work books and activity cards, and talk to children about how the body works using laminated cut out picture of "Jimmy". Explain how the heart work, why it beats faster, ask children to take their own pulse. Children then complete a 'bleep test'; scores written down in work books. Instructor explains that the children should try to complete at least 20 out of school sessions of sport/exercise over the five week period and fill these in on their activity cards. These should be signed by a coach, parent, instructor, and also counter-signed by the school teacher. Any children completing at least 20 sessions over the five weeks will receive a free swim and an extra free swim for every 10 sessions over and above that.

Week 2: The Heart and Lungs circuit. The children complete an obstacle course of the 'Heart and Lungs' circuit, pretending to be blood cells travelling around the body, carrying oxygen (red balls) from the lungs through one side of the heart to the muscles, then carrying carbon dioxide (blue balls) through the other side of the heart and back to the lungs. They do this in two groups and are timed and try to beat the "World Record". Instructor explains how the heart and lungs work in workbook. Children then fill in workbooks relating to the practical session.

Week 3: Food and diet. Instructor explains the food plate, and that there are no "bad foods". They then complete a circuit session, completing exercises (press ups, sit ups, star jumps, etc) that are related to the different food groups. They then complete their workbooks.

Week 4: Playground games. The children get into groups of four, and can select one piece of sports equipment (ball, rope, hoop, etc). In their groups they must invent a playground game that involves their entire group, uses the sports equipment, gets the participants slightly out of breath and they must come up with a name for their game. Once completed they all demonstrate their games to the other children, and each vote which game is the best.

Week 5: Children complete the bleep test again, and mark score down. All those that improve their score from week one, will receive a free swim at one of our swimming pools. Children then hand in their activity cards and instructor hands out free swims as appropriate. Children then take part in a fun sports quiz, and are handed information about local clubs and activities as exits routes so that they can continue with their participation.

Sports Centre Fitness Initiative

Based at Stalham Sports Centre this initiative will start in September 2015 and offer two courses of fitness type activities. The aim of the initiative is to offer a range of activities at the centres which are not sports focussed e.g. dance, zumba, yoga etc. The project will be aimed at people that do not traditionally participate in activity. Focus groups and surveys have identified the types of activities that people would like to do. The activities will be offered at times that have been identified as most suitable for people and at a low cost e.g. they may coincide with an existing session or activity for children so parents can have an activity class for them whilst the children are already participating in a separate activity.

Health Trainers will be aware of the classes and will recommend them to the people they are working with.

## Section 2 – Summary of impact & outcomes locally

Approximately 50% of the funding has been spent to date, the remainder will be spent when the sports centre initiative starts.

The projects targets the Health and Wellbeing Board reducing obesity priority.

Evaluation of the schools initiative is ongoing but feedback so far from the schools has been very positive. Participation has been high and the children have shown improved fitness, knowledge and understanding re healthy eating and exercise.

Unfortunately the project will only be sustained if the schools wish to fund future roadshows from their own budget.

The Sports Centre Fitness initiative will start in September therefore impact and evaluation data not yet available. If particular activities are popular and there is sufficient demand and uptake the classes may be sustainable by forming part of the sports centres regular offer. Class cost may rise but if people identify a benefit to them they are more likely to continue even at a higher charge.

**Name of council: Norwich City Council**
**Name of H&WB sponsor: Cllr. Gail Harris**
**Sum allocated 2014/15: £40,240**

## Section 1 – Summary of what the funding was used for and why

- This sum was effectively match funded by NHS Norwich CCG to give, in the end, an overall award of £85,000
- The Norwich Locality Board, comprising key public and voluntary sector partners, agreed use the Healthy Norwich steering group to allocate funds against the key priorities of that initiative:
    - Smoking cessation
    - Healthy weight / active lifestyle, and
    - Affordable warmth, plus
    - Overarching aims to reduce health inequalities
- These had been agreed by the HN partnership comprising the CCG, public health and the city council based upon, for example, health profile data
- Requests for applications from voluntary and community groups were requested to target these themes and, if appropriate, focus upon some key geographical areas demonstrating health, income and social inequalities as agreed by the city council Cabinet in March 2015
- All funding has been allocated to be spent in 2015 / 16 and distributed across just over 20 groups and wherever possible organisations have been linked into other existing provision for support (such as health trainers, pre-existing programmes such as Walk Norwich etc.)
- Most of the successful applications supported broad active lifestyle / healthy eating programmes and some were targeted very specifically at residents who may be less able to access universal service provision or who needed additional support to do so

## Section 2 – Summary of impact & outcomes locally

- Primarily most awards of funds have been around the broader obesity / healthy weight activity. However when assessing awards attention was paid to addressing inequalities in health, provision or access
- Local priorities around smoking cessation were also addressed
- Additionally some new and potentially valuable contacts have been made to enable effective promotion of healthy lifestyle and choices through community radio project's tying in with the grants awarded, enabling them to be advertised to a wider audience
- In some cases awards were to extend existing provision across a diverse range of voluntary and community groups. Some others were to support existing groups to undertake additional work
- It is too early to say at this stage what direct impact has been made, although evaluation will be undertaken at project end. Given the relative small amounts of monies awarded these evaluations will be proportionate to the awards and likely impacts

**Name of council: South Norfolk District Council**
**Name of H&WB sponsor: Cllr. Yvonne Bendle**
**Sum allocated 2014/15: £23,040**

## Section 1 – Summary of what the funding was used for and why

### Scene Setting

1.1 South Norfolk Council has welcomed the opportunities provided by the healthy communities programme to enhance the Health and Wellbeing agenda in South Norfolk, through its role as a deliverer and influencer of services.

1.2 In the first round of funding for district councils we developed an enhance Fit4Work programme which has engaged with local businesses, with the objective of encouraging employees to increase their level of physical activity and adopt healthy lifestyles. This programme has long term sustainable aims of improving the Health and Wellbeing of South Norfolk residents.

1.3 The second round of funding has been used to develop a loneliness project in the District. This project is set to make a positive difference around helping vulnerable people to achieve independent living; maximising the role of volunteers and the local community. It is also about tackling isolation to support young people and families so they are able to thrive and get the best opportunities in life. Loneliness can be a particular issue in rural communities and has many negative impacts in terms of health and wellbeing and longevity.

1.4 A number of building blocks have been put in place which will ensure the long-term sustainability of this project. They have been:

- The creation of a Community Capacity Building team. By engaging the community we can facilitate locally relevant solutions, this will be essential to the success of this project.
- An organisational “focus area” of wellbeing and early interventions so that all SNC staff are working through an approach that promotes independent living and prioritises early interventions for young people and families and vulnerable adults.
- The employment of Community Connectors in Diss to connect residents to activities and groups in the area. Adverts are now out to extend these arrangements into Costessey and Wymondham.

### Assessing the need for a loneliness project

1.5 South Norfolk Council takes an Early Help approach to supporting its residents and the formation of the Early Help Hub allows us to achieve the outcomes of both the Joint Health and Wellbeing Strategy and our own Health and Wellbeing Strategy more effectively. Early Help underpins how we are utilising the £23,040 funding.

1.6 A mapping exercise of existing local community and volunteering opportunities was carried out to assess level of provision that already exists in this area.

1.7 A consultation exercise into the effects and extent of loneliness took place with members of the public at South Norfolk on Show. It identified how our residents perceived the effects of loneliness and how prevalent they felt the issue was.

1.8 Local research by officers explored the feasibility of developing a project to tackle loneliness and social isolation. Our research revealed that in South Norfolk:

- 13.5% of the population aged over 65 years now live alone
- 23.7 of the population are over 65 years of age and this is predicted to rise to 25.7% in the next ten years.

1.9 Front line officers who have day to day contact with older residents said many of them have no family connection with South Norfolk. This will continue to be the norm as people choose to move into the area for their retirement. Incoming retirees who have no pre-existing family or friend base in the area are therefore at greater potential risk of isolation and loneliness in old age; than those who have well established connections.

1.10 Loneliness does not just affect those over 65. It is an issue that can affect all age groups and is more of a problem among vulnerable and isolated residents.

1.11 The research identified that there are well founded mental and physical health reasons which would justify a project to tackle loneliness and social isolation. The overarching objective of the project will be to alleviate loneliness and isolation and there-by increase positive health and well-being outcomes.

**How the project will be delivered**

1.12 We are using the fund to enable our residents to access services, groups and support that will help them to avoid social isolation and reduce loneliness. This could take the form of a link working process and will utilise our successful Early Help approach.

1.13 The project will benefit from existing council resources and will be match funded 'in-kind' through building on this existing provision. We have also investigated accessing supplementary resources to further strengthen our position and are engaged in conversations with partner agencies.

1.14 Research has shown that there is no one size one size fits all solution to alleviating loneliness. To ensure this is a sustainable project we will continue to monitor and evaluate its progress throughout its development. To guarantee that our project meets the needs of the community and our partners as we develop it further we will:

- Continue to engage the voluntary and community sectors.
- Prioritise the local loneliness issue(s) that are to be tackled with an emphasis on interventions being intelligence led
- Determine and co-produce solutions to make best use of resources and to have the maximum impact
- Deliver a plan of action that uses best practice and supports successful interventions used by others.

1.15 The next stages of the project will be:

- The identification and training of new volunteers in local communities to enhance what is already in place and to work to fill any gaps in volunteering services.
- To produce case studies to show the impact of the project on loneliness on individuals households and communities in terms of their outcomes and financial savings to the public sector.

## Section 2 – Summary of impact & outcomes locally

2.1 From the work we have already done it is clear that:

- People of all ages and backgrounds can be lonely and feel isolated.
- Prolonged loneliness and isolation can be debilitating.
- Loneliness can lead to coping behaviours that are harmful to health e.g. excessive consumption of alcohol and/or food.
- Loneliness related coping behaviours can have an impact on health budgets.

2.2: The project will be supportive of Norfolk H&WB goals, and in particular:

- Provide help and support at the earliest possible stage before problems with loneliness and isolation become acute.
- Improve health and wellbeing outcomes.
- Make best use of partnership working to provide an effective and joined up service.

2.3 This project will deliver against the Joint Health and Wellbeing Strategy Priority 2: *Making Norfolk a better place for people with dementia and their carers*. It is widely recognised that both people with dementia and their carers are at an increased risk of social isolation.

2.4 This project will deliver against South Norfolk Council's own Health and Wellbeing Strategy - Outcome two: *Older people live independently in their own home*. Social isolation is a proven inhibiter of independent living.

2.5 It will also have a positive impact on Outcome Three of our strategy*: Residents of South enjoy increased health and wellbeing and avoid of delay demand on higher cost health and social care services*. Loneliness has a large impact upon physical and mental health and by addressing it early we can alleviate the costs of formal health care.

2.6 The over-arching outcome of this project is that it contributes towards a reduction in the experiences and negative effects of loneliness for vulnerable South Norfolk residents and as a result reduces the impact this issue has on people's health and wellbeing. This in turn reduces the impact on services and resources.

2.7 We have been keen to ensure that the funding for this project did not simply get used for a one off piece of work that had short term benefits. The funding is being used in a way that will ensure sustainable long term positive outcomes for the South Norfolk community.

2.8 The individual performance outcome measures for this project will be finalised as part of the continuous development process.

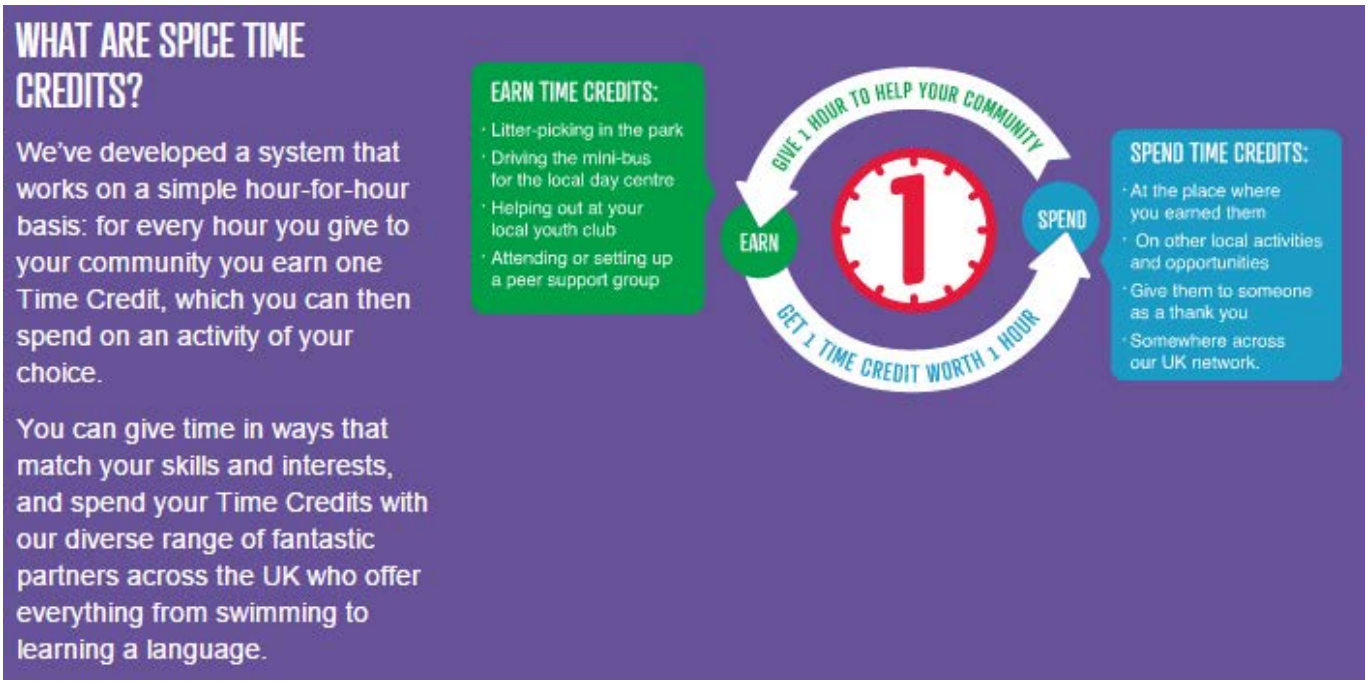
**Name of council: Borough Council of King's Lynn and West Norfolk**
**Name of H&WB sponsor: Cllr Elizabeth Nockolds**
**Sum allocated 2014/15: £35,960**

**Section 1 – Summary of what the funding was used for and why**

In West Norfolk any third party funding of this nature is handled as follows:

- The Borough Council's Policy and Partnerships Team acts as 'banker' and responsible body
- The funding is reported to the West Norfolk Partnership, which acts as an informal 'senior management team' for the public sector in West Norfolk., working to improve quality of life and support collaboration. Meeting monthly is oversees funding and budgets, partnership projects, and monitors the impact of policy in West Norfolk
- The partnerships major work programmes are overseen by steering groups. In the area of health improvement and social care this is the West Norfolk Alliance. Together with the West Norfolk Partnership this ensures the engagement of the local CCG, hospital community services, community health, GP's, voluntary sector etc.
- The partnership have long advocated allocating resources on the basis of need so again welcomed this approach to devolve some of the funding from the HWBB.
- We have allocated this funding to specifically add value to, and enhance, some work we had piloted around volunteering for health using 'time credits'.

The funding was allocated towards extending our 'Time Credits' programme which had been successfully trialled in West Norfolk. Time credits doesn't ask people to identify a particular skill they may have to offer, as in traditional time banking schemes, rather to simply offer an hour of their time towards a defined activity in their community. For each hour they give they get one time credit. They can then spend their credits in the community, with local corporate providers (leisure facilities are the most popular) and with training providers. The purpose is to engage those who haven't traditionally engaged productively in their community and who are predominantly new to volunteering.




In West Norfolk we have used Time Credits to target health and social care and attainment with an underpinning theme of supporting people into work. In this latter respect volunteering can be the first step on a journey into work, which for many people can be a long and daunting journey. For some this is the important first step towards increasing self-confidence, possible enabling them to undertake training or work. And all of these elements have resulting positive impacts on health (see impact statistics below).

**Section 2 – Summary of impact & outcomes locally**

This has directly and indirectly contributed to the HWBB goals, priorities and aims. This is clearly a preventative approach, and we have targeted children and families, obesity and older people through the scheme. It has also empowered people and communities to take control of their lives with associated health benefits. It has helped us to strengthen and grow the community sector in West Norfolk. In particular participants have reported a number of unexpected benefits relating to their overall health and well-being. For example, of those earning time credits:

- 65% say their quality of life has improved
- 45% feel healthier
- 19% say they have been to their doctor less often
- 49% feel less isolated

For more information please see the attached* evaluation report. This was completed nationally but the results were drawn from all areas participating in the scheme and were shown to be common across all those areas. The funding has enabled the scheme to grow during the year as follows:

- 96 new volunteers
- 46 corporate partners
- 16,580 volunteer hours given

This has added value to the Time Credits programme because it has enabled us to continue to extend the work beyond the pilot phase and into new geographical parts of West Norfolk. It has helped ensure that the good work in setting up the programme is not lost, and is instead harnessed and built upon. We have now been able to secure additional funding

through to the end of 2015/16 and hope to have embedded the programme within West Norfolk and its communities by then.

Representatives from Spice, the social enterprise who developed the time Credits model, and the Borough Council and local partners would be more than happy to present to a future meeting of the HWBB on this programme in more detail, should that be of interest. More information can also be found by visiting http://www.justaddspice.org/ or http://www.west-norfolk.gov.uk/default.aspx?page=26770 or by contacting Rosie Farrah at Spice rosie@justaddspice.org or Ian Burbidge at the Borough Council of King's Lynn and West Norfolk ian.burbidge@west-norfolk.gov.uk.

*Attachment: Executive Summary of the national evaluation of Spice Time Credits

Evaluation of Time Credits_Exec Summa

# Re-Imagining Norfolk – the Council's strategy for change

## Cover Sheet

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

Local government is at a cross-roads in terms of its future and that there is a small window in which to make significant changes. It is clear to the County Council that the future lies in working effectively across the whole public service on a local basis.

The Health and Wellbeing Board brings together a wide range of key partners to help improve the health of people in Norfolk. The Board acts as a forum for collaboration to drive health and wellbeing improvement and is the place for whole systems action and, as such, is a key partnership to help with shaping and designing a new future for Norfolk.

## Action needed

The Board needs to:

- Note the MD's report on NCC's strategy for change
- Offer comments on the strategy
- Consider its engagement with this programme of change and agree that work on priorities and the outcomes sought be brought to the next Board meeting

# Re-Imagining Norfolk – the Council's strategy for change

Report of the Managing Director, Norfolk County Council

**Summary**
This report sets out the County Council's completely new strategic direction - Re-Imagining Norfolk - which will radically change the role of the authority and the way it delivers its services. It outlines the Council's vision and priorities for Norfolk, and makes clear that the future lies in working effectively across the whole public service on a local basis.

**Action**
The Health and Wellbeing Board is asked to:

- Note the MD's report on NCC's strategy for change
- Offer comments on the strategy
- Consider its engagement with this programme of change and agree that work on priorities and the outcomes sought be brought to the next Board meeting

## 1. Background

1.1 In February this year, the County Council agreed its budget for 2015/16 and in so doing recognised that the next planning cycle would need a significantly different approach given the likely financial prospects ahead.

1.2 The financial prospects for local government is one of continued austerity. Even after a sustained period of unprecedented efficiencies, savings and cuts, projections show a need for the Council to find just under £149m over the next three years. The Council has already identified and agreed savings over the same period of £33m, leaving a net shortfall to find of just under £111m. However, whilst this amounts to a 15% reduction, the Council's committees are being asked to draw up plans to make savings of £169m. This represents a 25% reduction in addressable spend in order to give 'headroom' to make choices between different priorities.

1.3 In June, the Council's Policy & Resources committee agreed the start of what will be an extensive and wide-ranging planning cycle which will involve shaping the future, in partnership with stakeholders, customers and residents. The intention is to provide a strategic framework for the County Council to re-focus its role and pursue its priorities within a radically reduced level of resources.

## 2. Re-Imagining Norfolk – a Strategy for Change

2.1 Local government is at a cross-roads in terms of its future and there is a small window in which to make significant changes. Re-Imagining Norfolk sets out a strategy for change which covers every aspect of the Council's role and functions. It essentially aims to re-design the Council and its services, since nothing less will ensure it can continue to deliver quality services that make a difference to people's lives.

2.2 Despite the reduction in expenditure going forward, the Council will still be a billion pound organisation, and it needs to ensure that every penny of that money is invested where it can have the most impact for the people of Norfolk. It will become a multi-year strategy with a clear outcomes framework, underpinned by annual financial plans with spending targets.

2.3 The Council's strategy for Re-Imagining Norfolk has three elements:

**a)** **Norfolk's Ambition and Priorities** – our priorities place the people of Norfolk at the forefront of our plans and investments and we must ensure that everything the Council does improves people's opportunities and well-being.

**b)** **A 'Norfolk public service'** – The people of Norfolk require a seamless continuum of services, targeted to those who need them most, and regardless of the multiple and separate institutions responsible for delivering them. By re-imagining services, the county can work with communities and other public services to redesign services around people's lives, achieving better outcomes at less cost.

**c)** **Improving the Council's internal organisation** - addressing the need for the Council to continue its journey of improving efficiency and modernisation, radically re-shaping its capacity while taking out costs.

2.4 Further information around each of these three elements is set out below - full details are set out in my detailed report to the Council's Policy & Resources Committee, which can be accessed at this link.

**a) Norfolk's Ambition and Priorities**

2.5 Norfolk County Council's **ambition** is for everyone in Norfolk to succeed and fulfil their potential. By **putting people** first we can achieve a better, safer future, based on education, economic success and listening to local communities. Our **priorities** are:

- **Excellence in education** – We will champion our children and young people's right to an excellent education, training and preparation for employment because we believe they have the talent and ability to compete with the best. We firmly believe that every single child matters.

- **Real jobs** – We will promote employment that offers security, opportunities and a good level of pay. We want real, sustainable jobs available throughout Norfolk.

- **Good infrastructure** – We will make Norfolk a place where businesses can succeed and grow. We will promote improvements to our transport and technology infrastructure to make Norfolk a great place to do business.

- **Supporting vulnerable people** – we will work to improve and support quality of life, particularly for Norfolk's most vulnerable people

2.6 Given the seismic change needed in local government, the Council and partners have to find ways of working which support communities and individuals to become more self-sufficient – and these priorities do just that. **Re-Imagining**

**Norfolk** aims to get a sharper, sustained focus on achieving these priorities. Having greater clarity of purpose on our priorities will also provide the Council with a framework against which it can make what will be some very difficult political decisions ahead.

2.7 The **devolution of powers** and budgets to local areas is likely to be a dominant issue on the agenda for local government with Manchester's new powers over housing, transport, skills and policing services and the recent announcement in the Queen's speech of a new 'Cities and Local Government Devolution Bill' to extend similar arrangements across England. Discussions about possible devolution will shape Re-Imagining Norfolk going forward.

**b) One 'Virtual' Public Service for Norfolk**

2.8 Many of the Council's services were designed in a very different era and national policy framework. Funding no longer reflects demographic or socio-economic changes and local government is expected to become self-sufficient, depending on Council tax and a share of business rates to fund services.

2.9 At the same time as funding has been reduced, our population continues to grow and the pattern of family life has changed. Medical advances are huge – people live longer and have access to many more medical specialists than in the past. People move around more for jobs than in previous generations, so families cannot always be near to older relatives to help and care. Families are under increasing pressure, and society's concern for children's and adult's safety has placed additional responsibilities on local authorities for ensuring their protection.

2.10 The impact for our social care services – like many other areas – has been to see an increase in our spending on the more intensive type of services. As well as being costly, it is - more importantly - increasingly at odds with what people want.

2.11 Services of the future need to promote independence and provide support which helps people to stay in control of their own lives and in the majority of cases living in their own homes. This requires a shift from finding needs and meeting them, to building on people's strengths, making them experts in charge of their own lives. It also requires a model of working with partners and communities which sees multi-disciplinary teams, ideally co-located, looking at the same data on families or individuals and giving them the most appropriate support, regardless of which agency takes the lead.

2.12 With fewer resources, the goal is for people to experience a coherent 'public service' across Norfolk guided by achieving the best results for them, regardless of jurisdictions or constraints about who does what.

**c) Improving the Council's internal organisation**

2.13 This element of Re-Imagining Norfolk is about the Council addressing the need for it to continue its journey of improving efficiency and modernisation, radically re-shaping its capacity while taking out costs. The financial challenge facing the Council is equivalent to delivery with 75% of our addressable spend. Despite this, the Council will still have just under £1billion, and that spending power needs to be targeted towards achieving the best possible outcomes for Norfolk.

2.14 As a precursor to discussions with the wider community about how best to target spending and resources for the future, the Council has adopted a framework for a systematic review of our spending on services which has a series of strategic approaches:

- **Cutting costs through efficiencies** – re-setting expectations and accountabilities for all managers to strengthen leadership, financial management, data analysis, and accountability for delivering outcomes

- **Better value for money through procurement and commissioning** - more than half of our spending is on contracted services, therefore procuring the right services at the best cost is critical.

- **Enabling communities and working locally** – the Council has a duty to promote the health and well-being of the population. It can only do so by working closely with the community, looking at how we can reduce reliance on high cost services. There is more scope for building on assets and strengths that are already evident; shifting our focus to a locality approach which allows a more integrated service model. Reducing costs by taking a 'whole system' approach that includes the customer and community in the value chain – this is particularly relevant where many local services are working with the same families or individuals.

- **Service Redesign: Early help and prevention** - which promotes independence, supports people into employment, supports them to get good qualifications; moves the first point of contact 'upstream'; understands and uses the 'triggers' or early indicators of service demand to act sooner with a less costly intervention.

- **Customer Services: Channel shift -** there is much more that the Council can do to introduce technology into the design of our services. We must organise our services around customers, reflecting the more mainstream expectations that people have in accessing services in today's world.

- **Raising Revenue: a business strategy** – we need to accelerate the development of our financial systems and commercial acumen to successfully sell products and services to external customers.

## 3. What happens next and how partners will be involved

3.1 Detailed work will continue over the summer and during the autumn on the different elements of Re-Imagining Norfolk, as it develops into a medium term strategy and financial plan. This will lead to the County Council considering and agreeing its new multi-year strategy, and annual budget, in February 2016.

3.2 The Council is clear that the scale of change is such that it can only meet the challenges articulated in Re-Imagining Norfolk by shaping and designing a new future in partnership with others. It is our intention to involve partners in designing what will be a three-year programme of engagement and dialogue.

3.3 A key part of the initial work of developing the strategy will be external collaboration and challenge with input and scrutiny from external sources. This

will include testing and developing priorities and new ways of working with partners through round tables, partnership meetings and negotiations. For example, this will include round table discussions with public and third sector partners to look at closer collaboration in localities – towards one virtual public service.

## 4. Action

4.1 The Health and Wellbeing Board is asked to:

- Note the MD's report on NCC's strategy for change
- Offer comments on the strategy
- Consider its engagement with this programme of change and agree that work on priorities and the outcomes sought be brought to the next Board meeting

**Officer Contact**

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

| **Name** | **Tel** | **Email** |
|---|---|---|
| Dr Wendy Thomson, Managing Director | 01603 222001 | wendy.thomson@norfolk.gov.uk |

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**Report to Norfolk Health and Wellbeing Board**

**15 July 2015**

**Item 11**

# Integration and the Norfolk Better Care Fund Plan

## Cover Sheet

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

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

## Key questions for discussion

Q.1 What are the key issues arising for the Board in relation to performance and challenges?

Q.2 What actions can the Board take to bring a whole-systems approach to addressing the those issues?

## Action needed

The Board is asked to:

- Consider the key issues arising from the information provided in this report
- Note the submission to NHS England for the period 1 January to 31 March 2015, and the recent re-confirmation of the target reduction in admissions as agreed in the Norfolk BCF Plan
- Consider what actions are needed and how the Board/partners can bring a 'whole systems' approach to addressing the key issues arising

# Integration in Norfolk and the Better Care Fund Plan

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

**Summary**

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

**Action required:**

The Board is asked to:

- Consider the key issues arising from the information provided in this report, including the examples of good practice identified in the case studies
- Note the submission to NHS England for the period 1 January to 31 March 2015, and the recent re-confirmation of the target reduction in admissions as agreed in the Norfolk BCF Plan
- Consider what actions are needed and how the Board/partners can bring a 'whole systems' approach to addressing the key issues arising

## 1. Background

1.1 At its meeting in February 2015, the Health and Wellbeing Board was informed that the Norfolk Better Care Fund Plan met all the requirements set out by the Department of Health and had been approved on 23 January 2015. A copy of the approved plan is available on-line at the following link. The Health and Wellbeing Board is the body accountable for delivering the Norfolk Better Care Fund.

1.2 At its meeting on 29 April 2015, the Health and Wellbeing Board noted the recent national guidance on the operation of the Better Care Fund in 2015/16 including reporting and monitoring requirements for the fund. The Board noted the existing governance arrangements and agreed to set up a BCF sub group for the purpose of meeting the quarterly reporting requirements.

1.3 It was also agreed that, having moved from development to implementation of the BCF Plan, the Board should have a regular item on its agenda about the impact of integration in Norfolk, including the BCF. This would focus on:

- Looking at what is being delivered - illustrated, for example, via case studies and/or showcasing initiatives which are examples of good practice
- Identifying any barriers to progress or blockages in the system and agreeing how to tackle them
- Reviewing trends in BCF performance
- Evaluating what overall is being achieved
- Agreeing what further action is needed by partners and/or the Board as a whole to meet our strategic aims for Norfolk

## 2. Impact of integration through the Better Care Fund Plan

2.1 The BCF plan in Norfolk involves a £65m pooled commissioning fund for the provision of integrated health and community care services. It has a priority purpose of reducing unplanned admissions to hospital and performance measures have been agreed for avoidable hospital admissions, residential admissions, delayed transfers of care, effective reablement and a local priority of dementia assessments.

2.2 The purpose of the Better Care Fund is to build better health and social care services. This is in line with the Board's priorities and underpins much of what we are working to deliver through our Joint Health & Wellbeing Strategy. Having overseen the development of the BCF plan, the Board has now moved into its systems leadership role in ensuring delivery of the plan eg through:

- Providing the overall strategic direction
- Monitoring the impact of integration through the BCF, and
- Securing sustainable improvement on the ground in Norfolk

2.4 Delivering the BCF plan relies on a transformation of health and social care services in Norfolk and re-configuring community services in Norfolk will be an important part of getting it right. The Board will wish to assure itself that the necessary transformation of services is addressing the challenges and delivering the outcomes needed.

2.5 At the Board meeting in July, a presentation will be given which includes case studies illustrating the impact being made from some initiatives, an outline of overall trends in performance in relation to non-elective admissions to hospital, and some barriers and blockages identified at this stage. The presentation is attached at **Appendix A.**

2.6 Attached at **Appendix B** is the information submitted to NHS England on 29 May for the first BCF quarterly report. This followed final sign off by the Board's BCF sub-group. The template issued by NHS England was a temporary arrangement for the purposes of this submission only (ie for the period 1 January 2015 to 31 March 2015). The template includes an outline of the position in relation to the Disabled Facilities Grants, the s75 Agreements and information relating to the national conditions. No metrics, income or expenditure information is included at this stage. A progress update on the position since the first quarterly BCF update was submitted is at **Appendix C**.

2.7 In a recent email from the Better Care Support Team National Programme Director, all areas were asked to confirm if there were any changes to their target reduction in non-elective admissions in agreed BCF Plans. This request was due to discrepancies arising about the alignment of BCF admissions targets with the planning assumptions included in final CCG operational plans. There is no change to the agreed target in the Norfolk BCF Plan and this was confirmed to NHS England on Friday 19 June.

## 3. Action required

3.1 The Board is asked to:

- Consider the key issues arising from the information provided in this report
- Note the submission to NHS England for the period 1 January to 31 March 2015, and the recent re-confirmation of the target reduction in admissions as agreed in the Norfolk BCF Plan
- Consider what actions are needed and how the Board/partners can bring a 'whole systems' approach to addressing the key issues arising

**Officer Contact**

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

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# Better Care Fund

Norfolk Health and Wellbeing Board

Wednesday 15th July 2015

Norfolk County Council

NHS Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

## The Out of Hospital Team, Gorleston: A Case Study

- Initial Assessment in under 2 hours
- Appropriate care provision organised same day
- Full care package implemented within 12 hours
- Regular care reviews ensuring person centred care

Following a successful implementation in Lowestoft, Norfolk County Council are working with a community provider to deliver an Out of Hospital Service in Great Yarmouth.

By September 2015, an inter disciplinary team of health and social care professionals including community nurses, occupational therapists, physiotherapists, rehabilitation support workers and social workers that works 24 hours a day, 7 days a week will be in place

Supporting people going through a crisis, the team will take referrals from health and other professionals to:

- ✓ **Avoid a patient being admitted to a hospital bed in the first place**
- ✓ **Get the right support in place to enable the person to get home sooner if they are admitted**

***This is the beginning of the story where the case studies are still being captured so the following case study evidences what an established and fully staffed team can deliver.....***

Interviews are currently taking place

Norfolk Social Care aims to be fully established in under 12 weeks

# Norfolk BCF Aims - A Reminder

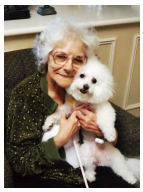
- **People will be able to access effective and co-ordinated care which is delivered at home or in their local community:** This will see services delivered closer to home and where they need to be provided in a specialist acute setting, time spent there will be minimised through the support of a co-ordinated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

Norfolk County Council

NHS Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

## The Out of Hospital Team, Gorleston: A Case Study



Before -
- Taken to her bed
- Malnourished
- Dehydrated
- Not taking medication
- Dog and human faeces

Joint Assessment within 2 hours of referral

After – 2 weeks later
- Medically stable
- Managing medication
- Self caring – x1 daily carer
- Attendance allowance
- Safe and clean home

Norfolk County Council

NHS North Norfolk Clinical Commissioning Group

## Integrated Working in North Norfolk: A Case Study

**Referral to Integrated Care Co-ordinator (ICC)**

Ali, one of the North Norfolk Integrated Care Co-ordinators, received a referral for Mrs B from her GP practice for an urgent assessment of falls/ admission avoidance.

Ali

**Mrs. B's story on referral**

Mrs B, who had lost her husband six months earlier, was finding it difficult , and very scary, living on her own. Mrs B had also fallen many times and needed another falls assessment to see why her balance was so bad. Part of the problem was that her house was very large with many steps and a vast living area; rather than using mobility aids, she was using the furniture to help steady herself.

**Physiotherapy assessment**

**OT assessment**

On same day

Ali contacted Mrs B for a chat on the phone and realised that she was still grieving for the loss of her husband . A few tears were shed but Mrs B agreed a falls referral to the physio would be a good place to start. Ali organised this for the same day as the occupational therapist's visit to check the equipment. The physio spent time talking with Mrs B as well as looking round her house. She concluded that Mrs B was feeling terribly upset and lonely after he husband's death and that this had caused her to become housebound and very withdrawn.

As a result of their assessments, the community team met to see how Mrs B could remain living at home while staying safe and well. Ali referred Mrs B to the local Red Cross Older People's team who carried out a thorough assessments in Mrs B's homes and reported back to the community team. The physio referred Mrs B to a group called Extend which runs a free 6 week class to encourage better mobility and socialising. Ali contacted Mrs B to check her progress. This led to a referral to Cruise for counselling to help with loneliness and isolation.

- Red Cross OP Team assessment
- Extend 6 week mobility course
- Cruse counselling

**Voluntary Norfolk**

This is not the end of the story..... So inspired was Mrs B by the help and support she received, she decided to become a volunteer herself through Voluntary Norfolk.

YourNorwich

NHS Norwich Clinical Commissioning Group

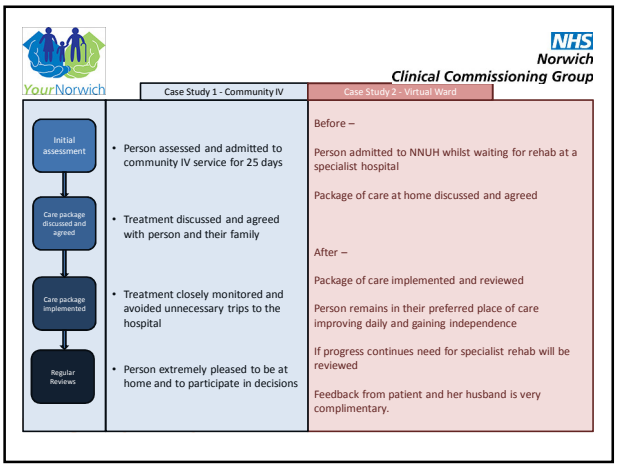
## HomeWard

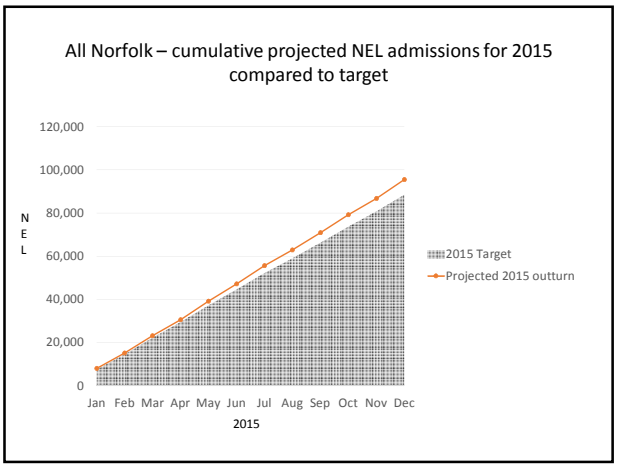
Rapid Response, Virtual Ward, Community IV

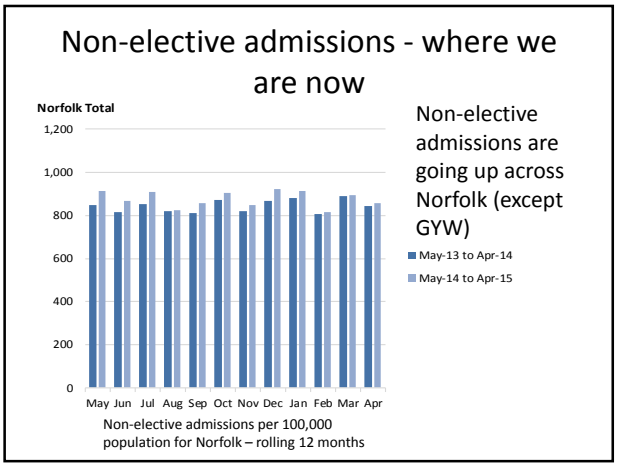
**Rapid Response**: - a community based rapid response service responding to people with a short term illness, exacerbation of a chronic condition or palliative care symptoms or at end of life in their usual place of residence

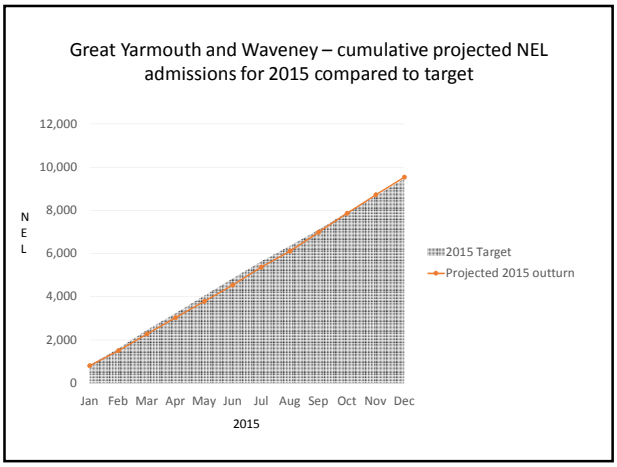
**Community IV Therapy:** - expanding IV therapy service to enable more people to receive treatment in their usual place of residence

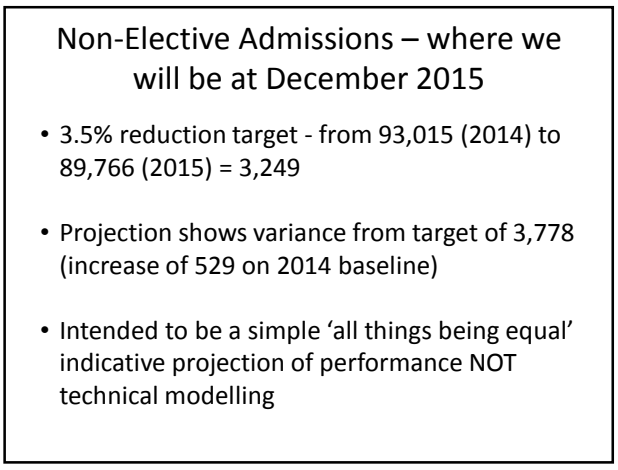
**Virtual Ward:** - providing step up and step down care to people in their usual place of residence

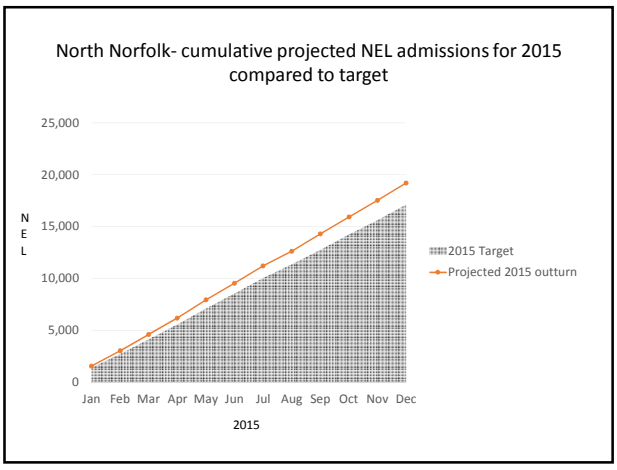

YourNorwich
NHS
Norwich
Clinical Commissioning Group
Case Study 1 - Community IV
Case Study 2 - Virtual Ward
Initial assessment
Care package discussed and agreed
Care package implemented
Regular Reviews
• Person assessed and admitted to community IV service for 25 days
• Treatment discussed and agreed with person and their family
• Treatment closely monitored and avoided unnecessary trips to the hospital
• Person extremely pleased to be at home and to participate in decisions
Before –
Person admitted to NNUH whilst waiting for rehab at a specialist hospital
Package of care at home discussed and agreed
After –
Package of care implemented and reviewed
Person remains in their preferred place of care improving daily and gaining independence
If progress continues need for specialist rehab will be reviewed
Feedback from patient and her husband is very complimentary.


All Norfolk – cumulative projected NEL admissions for 2015 compared to target
NEL
120,000
100,000
80,000
60,000
40,000
20,000
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec
2015
2015 Target
Projected 2015 outturn

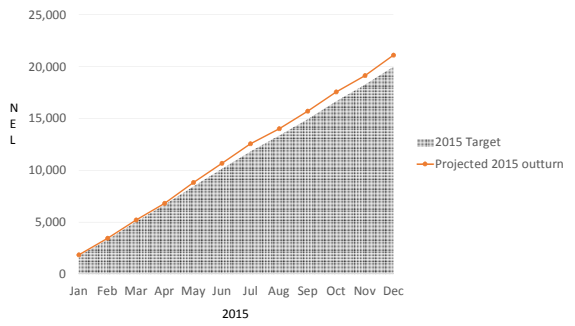

Non-Elective Admissions - where we are now
Norfolk Total
1,200
1,000
800
600
400
200
0
May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
Non-elective admissions per 100,000 population for Norfolk – rolling 12 months
Non-elective admissions are going up across Norfolk (except GYW)
May-13 to Apr-14
May-14 to Apr-15


Great Yarmouth and Waveney – cumulative projected NEL admissions for 2015 compared to target
NEL
12,000
10,000
8,000
6,000
4,000
2,000
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec
2015
2015 Target
Projected 2015 outturn


Non-Elective Admissions – where we will be at December 2015
• 3.5% reduction target - from 93,015 (2014) to 89,766 (2015) = 3,249
• Projection shows variance from target of 3,778 (increase of 529 on 2014 baseline)
• Intended to be a simple 'all things being equal' indicative projection of performance NOT technical modelling


North Norfolk- cumulative projected NEL admissions for 2015 compared to target
NEL
25,000
20,000
15,000
10,000
5,000
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec
2015
2015 Target
Projected 2015 outturn

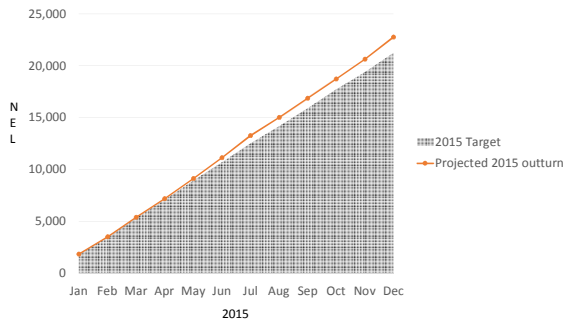
Norwich – cumulative projected NEL admissions for 2015 compared to target




## Challenges

- Capacity – additional project support in place
- BCF has struggled for priority amidst other requirements
- Further work to do to clarify anticipated impact and actual benefit delivered from schemes
- Struggling to achieve envisaged benefits from some schemes originally devised early in 2014 – developing new initiatives

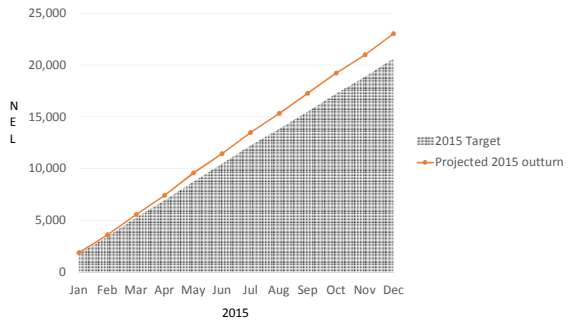
South Norfolk – cumulative projected NEL admissions for 2015 compared to target




## Reporting and Assurance

- NHSE quarterly reporting regime submitted in May – this didn't require metrics / income and expenditure
- NHSE have queried disparity between non elective admissions BCF plan and CCG Plans
- Next return due 29 Aug
- Local Partnership Boards established to govern S75 agreements (See next slide)

West Norfolk – cumulative projected NEL admissions for 2015 compared to target




## Governance at local level and who is round the table (1 of 2)

Each CCG operates a Partnership Board to Govern the scope of their Section 75 agreement including the pooled fund

- **NN CCG** - CCG Chief Executive (Mark Taylor), CCG Chief Finance Officer (Helen Stratton), Director of Integrated Commissioning (Catherine Underwood), NCC Finance Business Partner (Neil Sinclair), Pooled Fund Manager (John Everson) – First meeting to be held in July when the S75 is signed
- **GY&W CCG** - Director of Operations (Kate Gill), Chief Finance Officer (Zoe Pietrzak), Director of Integrated Commissioning (Catherine Underwood), Finance Business Partner (Neil Sinclair), Pooled Fund manager (Geoff Empson) – Meeting monthly at present
- **SN CCG** - CCG Chief Executive (Ann Donkin), CCG Chief Finance Officer (Jim Hayburn), Chief Operating Officer (Jocelyn Pike), Asst Director Out of Hospital Commissioning (Chris Coath), Director of Integrated Commissioning (Catherine Underwood), NCC Finance Business Partner (Neil Sinclair), Pooled Fund Manager (Rob Cooper) - Meets every 4-6 weeks.

## Governance at local level and who is round the table (2 of 2)

Each CCG operates a Partnership Board to Govern the scope of their Section 75 agreement

- **WN CCG-** CCG Chief Executive (Sue Crossman), CCG Chief Finance Officer (John Ingham), Director of Operations (Kathryn Ellis), Director of Integrated Commissioning (Catherine Underwood), NCC Finance Business Partner (Neil Sinclair), Pooled Fund Manager (Roger Hadingham) – Meeting Monthly
- **Norwich CCG** - Director of Integrated Commissioning (Catherine Underwood), Director of Clinical Transformation NCCG (James Elliott), Acting Finance Director NCCG (Robert Kirton), Head of Integrated Commissioning & Pooled Fund Manager (Mick Sanders), Finance Business Partner NCC (Neil Sinclair), Acting Chief Executive NCCG (Jo Smithson), Integrated Commissioning Programme Manager NCCG (Jane Walsh) - Inaugural meeting 18th May subsequent meetings arranged at 6 weekly intervals.

## Great Yarmouth and Waveney Scheme Update

| Scheme Name | Key Change Deliverables / New Services from the Scheme | Money (Investment in Services) | Progress |
|---|---|---|---|
| GYW1 Supporting Independence by the provision of community based interventions | The key deliverables for the total scheme are to enable people to live at home for as long as possible thereby reducing admissions to care homes and acute hospitals - the key change relates to development of integrated home support and hospice at home services | £3.1m | A significant proportion of this overall scheme relates to "protecting social care" and sustaining existing services / packages of care and these elements are on target. |
| GYW2 Integrated Community Teams and Out of Hospital Teams | The key deliverables for the total scheme is reduction in emergency admissions to acute hospital | £1.5m | Some health and social care teams now co-located. Out of Hospital Team in implementation with some staff in post and remainder being recruited, service will be fully functioning by Sept. |
| GYW3 Urgent Care Programme | Builds on resilience schemes developed as part of winter planning - key deliverables are reduction in demand on acute services both in terms of emergency admissions and delayed transfers of care. | £2m | Work is in hand to take forward individual projects within the overall scheme. Bids for funding to maintain some of these services have yet to be approved. |
| GYW4 Support for people with dementia and mental health problems | Flexible Dementia Service - urgent homecare for people with dementia in crisis - key deliverables are prevention of admission to care homes or acute hospital. | £530k | Pilot run and closed down as not financially viable, however achieved the key deliverables so alternative model being investigated |

## West Norfolk Scheme Update

| Scheme Name | Key Change Deliverables / New Services from the Scheme | Money (Investment in Services) | Progress |
|---|---|---|---|
| WN1 Integrated Care Organisation | Standardisation of best practice across West Norfolk's MDTs, including risk profiling, so that patients with high needs receive care which is consistently proactive, seamless and integrated<br>Care Navigator service provided to support high needs patients to self-manage through use of existing community based services (1 year pilot) | £2,481,000 | Proposal for standardised process developed following consultation with providers (Completed)<br>New approach to be trialled in Practice areas<br>Care Navigator service delivered by different providers (to trial different approaches). Referral pathways from GPs, Community Matrons, Social Workers and other MDT workers being utilised - 1 year pilot commenced Feb 2015 |
| WN2 Reablement | Closer working achieved between the two main reablement services in West Norfolk – NCC Norfolk First Support (six week reablement package for individuals) and Borough Council Home Improvement Agency (housing-related reablement) | £1,784,000 | Objective met with joint awareness of each service and pathways for cross referrals. Complete |
| WN3 Acute Admission Avoidance/Discharge incl 7 day working | Enhancement to Rapid Assessment Team (RAT); extending weekend hours at hospital 'front door'<br>Creation of 'Home from Hospital Partnership' to expedite discharge by resolving practical / housing / social issues | £3,523,000 | Recruitment underway for 2 additional RAT staff Commences Sept 2015<br>Specification being drafted for Home from Hospital Partnership, in consultation with key stakeholders Commences October 2015 |
| WN4 Promoting Independence | Provision of high quality information on the availability of community-based low-level support services<br>A linked brokerage service to connect individuals to community-based services, identify resource shortfalls and stimulate the growth of additional local low-level "by the community, for the community" support services. | £981,000 | Living Independently in Later Years (LILY) service up and running Complete<br>Further development of service (LILY Plus) being taken forward by King's Lynn and West Norfolk Borough Council (including community volunteer navigators and community access points) |
| WN5 Dementia | To establish a dementia diagnosis and support model based around primary care that encourages referrals for diagnosis, provides a diagnosis in a setting local and familiar to the patient, and wraps around this process a knowledgeable and empowering support network. | £1,646,000 | Dementia diagnosis rates have improved from 33% (2013/14) to 53% (May 2015)<br>Support to GPs to increase diagnosis rates through utilisation of algorithm to diagnose dementia in persons with obvious cognitive and functional impairment<br>Primary Care diagnosis and medication initiation and Post Diagnostic service improvements have commenced. End of Life work commencement expected December 2015 |

## North Norfolk Scheme Update

| Scheme Name | Key Change / Deliverables / New Services from the Scheme | Money (Investment in Services) | Progress |
|---|---|---|---|
| NN1: Risk Stratification | New risk profiling tool roll-out in progress: Project Board approval for Integrated Care Packs by 31/11/15. Risk profiling and Shared Access project to be completed 31/03/16.Benefit target: Reduction of 505 avoidable admissions (42 per month) for 2015/16 when compared to the 2015/16 baseline(2014/15 actual + 2.9% growth). Reduction in residential placements to 326 in 2015/16. | £0.000m | Original Predictive risk stratification tool established in all practices. April 2015 avoidable admissions higher than target. Exploring ways of reducing these with Integrated Care Programme Board including targeting avoidable admissions for UTIs and palliative care patients. |
| NN2: Integrated Care Teams | Four extra ICCs to be employed, total 8 by 31/08/15. Virtual hubs to be physical integrated teams from Health/ NCC adult care. New Service start date 14/12/15. Benefits as in NN1 above. | £1.516m | Integrated Care Teams set up in 4 virtual GP hubs. 4 Integrated Care Co-ordinators recruited. MDTs being used for high risk/need patients (target 2%). |
| NN3: Voluntary Sector and Self-Care Programme | Voluntary sector services targeted to maintain independence & wellbeing: Projects include: Self-Care & Self-Management strategy for patients & carers; review of assistive technology; locality homecare model and new spec for housing support. All to be achieved by 31/03/16.Benefit: To increase proportion of older people who are still at home 91 days after discharge from hospital into reablement / rehabilitation services to 90%. | £4.346m | New volunteer service commissioned to support integrated care patients. Mobilisation and review of new volunteering service referrals and outcomes.<br>Not achieving reablement targets at present. To meet with Rapid Response service at NCC to discuss ways of improving this. |
| NN4: Fall Prevention Programme | Increased effectiveness of RACs service: Review of NCH&C Falls pathways by 31/07/15. Enhanced Falls Communications Plan by 31/08/15. Close management of RACs outcomes by 30/09/15. | £1.088m | Establishment of local NN Falls reference group linking to countywide group. Remodelling of acute falls pathway. Falls targets on track for April – monitoring required. |
| NN5: Dementia Support Programme | The development and strengthening of community hubs and dementia friendly communities. Focus on improved support for carers, including building business case for dementia advisors and admiral nurses.<br>Benefit: Increased dementia referral rate to 66.7% by 31/03/16. Dementia rates below target. Working with NGT to ensure memory clinic diagnoses are counted. | £1.100m | 1st dementia friendly community hub achieved by 31/08/14 (total 6). Information pack developed following 6 months engagement with stakeholders, carers and service users launched 11/05/15. Signposting event for NN and rural Broadland held 01/06/15. |
| NN6: Urgent Care Programme | Timely / 7 day social care acute discharge planning and post discharge support by 31/03/17. Remodelled local community beds provision (End of Life care, CHC, acute rehabilitation & dementia).Linking with Domino project to achieve by 31/03/16.<br>Benefit: Reduced Delayed Transfer of Care. | £2.382m | Clinical network group established to identify local needs & priorities. Mental health frequently attending / admitted patient scheme in place at NNUH but no future funding for the enhanced service which has had to be discontinued.<br>Delayed transfers of care well within target. |
| NN7: Improving Mental Health Outcomes Programme | Provision of Alternative to Admission schemes. New Primary MH service goes live Sept 15. Will form part of integrated care teams. Service will be accessible directly to patients via self-referral. Pilot accelerated ambulance transportation system for mental Health patients. Benefit: Reduced avoidable admissions as in NN1 above. | £1.121m | Accelerated ambulance transportation in place and early results show waiting times for most severe patients decreased to an average of 24 mins for the ambulance to arrive on scene and begin conveyancing of the patient. |

## Norwich Scheme Update

| Scheme Name | Key Change Deliverables / New Services from the Scheme | Money (Investment in Services) | Progress |
|---|---|---|---|
| NCH1 – Primary Care | Risk stratification system (April 2015.)<br>New electronic prescribing system (all 22 GP practices by end March 2016).<br>GP practices aligned to specific care/nursing (April 2015.)<br>Locally commissioned services. | £1,143 | System live at 17 GP practices.<br>3 pilot GP practices using electronic prescribing system.<br>34 of 35 care/nursing homes aligned to a GP practice.<br>LCS – discussions in progress with GP practices to identify opportunities. |
| NCH2 – Integrated Community Health & Social Care | Enhanced roles and co-ordination between, multi-disciplinary teams and integrated care co-ordinators (November 2015).<br>New signposting for patients and service users.<br>Improved dementia diagnosis rates.<br>Improved palliative and end of life care (March 2016). | £6,353 | Recruitment of 2 further ICCs underway. Case management pathways updated for HomeWard. Admiral nurse recruited.<br>Integrated end of life care options developed.<br>Falls pathway being redeveloped. |
| NCH3 – Intermediate Care | Initial review of intermediate care and proposals for redesign (June 2015).<br>Final review of intermediate care system and report.<br>Virtual "HomeWard" operational taking step-up and step-down patients (March 2015).<br>HomeWard evaluation (December 2015).<br>Community IV therapy service live (April 2015). | £3,676 | Draft evaluation report including redesign options for intermediate care produced.<br>Rapid response, Virtual Ward and Community IV Therapy initiatives combined under HomeWard to ensure full integration. Rapid Response live.<br>Community IV Therapy service live. |
| NCH4 – Community Assets | 12 week intensive volunteer support initiative.<br>Personal Health Budgets pilot (November 2015).<br>Integrated carer support (August 2015).<br>Improved information and advocacy for patients (October 2015). | £1,073 | Age UK pilot live October 2014. Lottery funding for older people withdrawn.<br>Personal budgets pilot launched.<br>Carers Agency Partnership delivering carers action plan for Norwich. Review August 2015.<br>Supporting self-care project initiated. |

## South Norfolk Scheme Update

| Scheme Name | Key Change Deliverables / New Services from the Scheme | Money (Invested) in Services)* | Progress |
|---|---|---|---|
| SN1 – Integrated locality based teams | Supporting GPs and Primary Care to offer effective care close to home through investing in pathways, teams and services in localities | £3,757,000 | An integrated hub for health and social care has been introduced with a single access point being developed. MDT arrangements are being audited and a number of practices will work on a best practice MDT model from July 2015. A team of Integrated Care Coordinators has been set up. A new service is being set up from July 2015 to pilot low level support to reduce falls |
| SN2 – Supporting independence, wellbeing and self-care | Closer working between primary care, secondary care and prevention services including information, advice and support for people with long term conditions, support for carers, help to manage medication | £1,287,000 | A pilot service has been established in half of the GP practices offering advice and access to other supports for older people. Social care at home is being remodelled with new services from March 2016 |
| SN3 – Integrated care for people with dementia | Ensuring effective services and help that can be accessed by people with dementia and their carers including specialist nursing, respite at home, dementia beds and information and advice | £1,630,000 | A number of dementia services and initiatives have been established on an interim basis, are being piloted and/ or are being reviewed to inform commissioning intentions for 2016. These include an Admiral dementia nursing service covering all SN localities. The approach supports patient care and increases the confidence of GPs to diagnose |
| SN4 – Urgent care | Establishing effective interventions which reduce unplanned hospital admissions and facilitate discharge | £2,692,000 | Leads are promoting the provider initiatives and pathways which have been established as part of joint planning dialogue with localities around admissions reduction |
| SN5 – Mental health | Ensuring good and timely mental health services which promote recovery and self-management | £1,380,000 | A coproduction scheme is underway to identify the assets and community resources which contribute to recovery and mental well- being. This will report in February 2016 |
| SN6 – End of Life care | Patients and carers are able to plan and ahead and supported to be in control of their end of life care | £939,000 | The lead project is to roll out use of EPaCCS patient held care plans to all GP Practices by March 2016 across South Norfolk CCG to enable sharing of information necessary to ensure co-ordination of palliative and end of life care. Expected outcomes include improved care co-ordination and reduction in unplanned admissions to acute hospital at end of life. |

# Quarterly Reporting Template - Guidance

## Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics from the Health & Wellbeing Board plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 29th May 2015

This initial Q4 Excel data collection template focuses on the allocation, budget arrangments and national conditions. Details on future data collection requirements and mechanisms (including possible use of Unify 2) will be announced ahead of the Q1 2015/16 data collection.

To accompany the quarterly data collection we will require the Health & Wellbeing Board to submit a written narrative that contains any additional information you feel is appropriate including explanation of any material variances against the plan and associated performance trajectory that was approved.

## Content

The data collection template consists of 4 sheets:

**1) Cover Sheet** - this includes basic details and question completion
**2) A&B** - this tracks through the funding and spend for the Health & Wellbeing Board and the expected level of benefits
**3) National Conditions** - checklist against the national conditions as set out in the Spending Review.
**4) Narrative -** please provide a written narrative
To note - Yellow cells require input, blue cells do not.

## 1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 4 cells are green should the template be sent to england.bettercaresupport@nhs.net

## 2) A&B

This requires 4 questions to be answered. Please answer as at the time of completion.
Has the Local Authority recived their share of the Disabled Facilites Grant (DFG)?
If the answer to the above is 'No' please indicate when this will happen.
Have the funds been pooled via a s.75 pooled budget arrangement in line with the agreed plan?
If the answer to the above is 'No' please indicate when this will happen

## 3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance are still on track for delivery (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/). Please answer as at the time of completion.

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' and 'No - In Progress' that these are on track. If 'No' or 'No - In Progress' is selected please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31 March 2016.
Full details of the conditions are detailed at the bottom of the page.

| Cover and Basic Details |
|---|
| Q4 2014/15 |

| | |
|---|---|
| Health and Well Being Board | Norfolk |

| | |
|---|---|
| completed by: | Andrew Pettitt |
| e-mail: | andrew.pettitt@norfolk.gov.uk |
| contact number: | 01603 228973 |
| Who has signed off the report on behalf of the Health and Well Being Board: | Dr Ian Mack |

**Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB.xls' for example 'County Durham HWB.xls'**

| | No. of questions answered |
|---|---|
| 1. Cover | 5 |
| 2. A&B | 4 |
| 3. National Conditions | 16 |
| 4. Narrative | 1 |

Selected Health and Well Being Board:

| Norfolk |
|---|

Data Submission Period:

| Q4 2014/15 |
|---|

| Allocation and budget arrangements |
|---|

| | |
|---|---|
| Has the housing authority received its DFG allocation? | No |
| If the answer to the above is 'No' please indicate when this will happen | 30/06/2015 |
| Have the funds been pooled via a s.75 pooled budget arrangement in line with the agreed plan? | No |
| If the answer to the above is 'No' please indicate when this will happen | 12/06/2015 |

Selected Health and Well Being Board:

**Norfolk**

Data Submission Period:

**Q4 2014/15**

**National Conditions**

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a comment in the box to the right

| Condition | Please Select (Yes, No or No - In Progress) | Comment |
|---|---|---|
| 1) Are the plans still jointly agreed? | Yes | Plans are still jointly agreed. |
| 2) Are Social Care Services (not spending) being protected? | No - In Progress | S75 agreements in place with WN, GY&W and Norwich CCGs. North & South Norfolk CCGs have committed to the HWB to sign S75 agreements. (mid June). |
| 3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering? | No - In Progress | All plans are in place and are developing on track to deliver an approach and implement key 7 day services in Norfolk. This is building and sharing on the learning from Great Yarmouth's earlier adopter site which has the components in place. |
| 4) In respect of data sharing - confirm that: | | |
| i) Is the NHS Number being used as the primary identifier for health and care services? | Yes | NHS number is the primary identifier for health and care services. |
| ii) Are you pursuing open APIs (i.e. systems that speak to each other)? | Yes | Given the complexity of the Health and Social Case system in Norfolk there are a variety of approaches to share data underway at different stages. |
| iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2? | Yes | Appropriate IG controls are in place. |
| 5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional? | No - In Progress | All 5 CCG Localities have work in progress to provide joint assessment and care planning to the top 2% of the patient population. Work is at a different stage of delivery in each locality and this will be closely monitored by the HWB |
| 6) Is an agreement on the consequential impact of changes in the acute sector in place? | No - In Progress | The three actute hospitals in the Norfolk system have acknowledged the impact of the BCF plan. NNUH - the impact of changes to activity has been agreed with NNUH and is reflected in SRG planning. James Padget hospital is aware of the potential impact. QEH has acknowledged the impact of targeted reduction. |

**National conditions - Guidance**

The Spending Round established six national conditions for access to the Fund:

**1) Plans to be jointly agreed**

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

**2) Protection for social care services (not spending)**
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

**3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends**
Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

**4) Better data sharing between health and social care, based on the NHS number**
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sha of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

**5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional**

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

**6) Agreement on the consequential impact of changes in the acute sector**
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Selected Health and Well Being Board:

| Norfolk |
|---|

Data Submission Period:

| Q4 2014/15 |
|---|

| Narrative | remaining characters | 31,254 |
|---|---|---|

**Please provide any additional information you feel is appropriate to support the return including explanation of any material variances against the plan and associated performance trajectory that was approved by NHS England.**

Better Care Fund programme delivery is progressing as agreed. The local integration boards are established and are managing programme delivery. There is recognition that some schemes will need to be revised on the basis of progress and opportunity which we see is a sign of maturing the programme

However, the health system in Norfolk has been under considerable pressure over recent months, CCG's are experiencing financial challenge and working closely with NHS England to ensure plans to address this are robust and assured, one of the acute hospitals and the mental health trust in special measures. An impact on the BCF has been a delay in signing two of the s75 agreements but there is assurance these will be signed by 12th June on the basis of testing the impact of urgent care initiatives on the modelling of metrics.

This report reflects a summary for the County. There are variations in answers to the questions from each locality and so local responses differ in some cases from the county wide answer given in this report.

Instructions on how to receive the full amount of DFG grant have been provided to Norfolk's seven district councils with the council now just awaiting the relevant invoices. It is anticipated that funds will be claimed and paid by the end of June in order to prevent districts from having cash flow implications.

All the Health and Social Care organisations in Norfolk are committed to the safe sharing of information. Work is at different stages across the County.

**Appendix C**

**Health and Well Being Board – Progress Update on Responses given in the First Quarterly BCF Report**

## Allocation and Budget Arrangements

Q 1) Has the housing authority received its DFG allocation?

**Answer given 29/05/15**: No - Expected to be complete by 30th June 2015

**Update**: Invoice still awaited for Norwich City and Breckland District Councils all other DFG payments made:

| Name | Detail | Description | Amount | Status |
|---|---|---|---|---|
| Broadland District Council (Thorpe Lodge) | Invoice 509110 | Disabled Facilities Grant 2015/16 | 414,367.00 | Paid 27th May |
| Kings Lynn & West Nfk Borough Council P O Box 26 | Invoice MISC013351 | Disabled Facilities Grant 2015/16 | 759,403.00 | Paid 16th June |
| North Norfolk District Council (PO Box 2) | Invoice NORF0005A0000425 | Disabled Facilities Grant 2015/16 | 594,970.00 | Paid 13th May |
| South Norfolk District Council (Swan Lane) | Invoice 0701063203 | Disabled Facilities Grant 2015/16 | 409,871.00 | Paid 18th May |
| Great Yarmouth Borough Council (Revenue Services) | Invoice 2211567176 | Disabled Facilities Grant 2015/16 | 567,369.00 | Paid 25th June |

Q 2) Have the funds been pooled via a section 75 pooled budget arrangement in line with the agreed plan?

**Answer given 29/05/15**: No - Expected to be complete 12th June

**Update:**

North Norfolk CCG: In progress. Expected to be signed by 24th July.

South Norfolk CCG: SNCCG anticipates being able to sign the S75 by 20th of July

West Norfolk, Norwich and GY&W: S 75 agreements all in place prior to 31st May.

## National Conditions

Q 1) Are the plans still jointly agreed?

**Answer given 29/05/15**: Yes - Plans are still jointly agreed.

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

**Answer given 29/05/15**: No - In Progress - S75 agreements in place with WN, GY&W and Norwich CCGs. North & South Norfolk CCGs have committed to the HWB to sign S75 agreements (mid-June).

**Update:** Outstanding as above Allocation and Budget Q2

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

**Answer given 29/05/15**: No - In Progress . All plans are in place and are developing on track to deliver an approach and implement key 7 day services in Norfolk. This is building and sharing on the learning from Great Yarmouth's earlier adopter site which has the components in place.

**Update**: Norfolk BCF is linking the implementation of seven day services to implementation of the 10 NHS clinical standards for seven day working in acute hospitals. Various interim measures are in place through system resilience interventions.

Acute hospitals were required to complete an NHS IQ toolkit on 7 Day Services and implement 5 higher priority standards by April 2016 and the remaining 5 by April 2017. Clinical Standard 9 relates to social care support to discharge and is the key link to 7 day social care provision.

The James Paget hospital, has elected to deliver all 10 standards by April 2016. As an 'early implementer' the JP will have an 'Out of Hospital' service working 7 days a week, fully in place by September 2015.

The Queen Elizabeth Hospital has completed the NHS IQ self-assessment toolkit and discussions are underway regarding inclusion of Clinical Standard 9 within the QEH for 2015-16.

The Norfolk and Norwich University Hospital completed the NHS IQ self-assessment toolkit in 2014/15. It is not yet clear to the BCF programme which of the 10 Clinical Standards the NNUH have chosen to implement during 2015/16.

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

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

**Answer given 29/05/15:** Yes - NHS number is the primary identifier for health and care services.

ii) Are you pursuing open APIs (i.e. systems that speak to each other)?
**Answer given 29/05/15:** Yes - Given the complexity of the Health and Social Case system in Norfolk there are a variety of approaches to share data underway at different stages.

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

**Answer given 29/05/15:** Yes - Appropriate IG controls are in place.

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

**Answer Given 29/05/15:** No - In Progress. All 5 CCG Localities have work in progress to provide joint assessment and care planning to the top 2% of the patient population. Work is at a different stage of delivery in each locality and this will be closely monitored by the HWB

**Update**:

GY&W CCG: No – In Progress - The Out of Hospital team developments will support those most at risk by providing a coordinated and timely care plan. This will be complete end September 2015.

WN CCG: Yes - there is Care Coordination in place for high risk patients via MDTs

Norwich / South Norfolk CCG's: Yes, though the Care Management Programme, 2% of patients are care planned with a named GP though the national enhanced service (all Norwich practices have signed up).

NN CCG: No – In Progress - The infrastructure and integrated teams are in place to enable this. Next step actions are on course to embed this approach:

- Integrated Care Teams set up in 4 virtual GP hubs. 4 Integrated Care Co-ordinators recruited. MDTs being used for high risk/need patients (target 2%).
- Four extra ICCs to be employed, total 8 by 31/08/15. Virtual hubs to be physical integrated teams from Health/ NCC adult care. New Service start date 14/12/15.

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

**Answer given 29/05/15:** No - In Progress. The three acute hospitals in the Norfolk system have acknowledged the impact of the BCF plan. NNUH - the impact of changes to activity has been agreed with NNUH and is reflected in SRG planning. James Paget hospital is aware of the potential impact. QEH has acknowledged the impact of targeted reduction.

**Update**:–

GYWCCG: No In Progress - Actively managing capacity within the system supported by an innovative out of hospital team. This service is provided by Social Care and the community provider to manage the impact of the reduction in the number of non-elective acute admissions.

WN CCG: No – In Progress – Some reporting in place, plan to provide reports on all schemes to the WN Systems Resilience Operational Group by end September 2015.

Norwich / South Norfolk CCG's: Yes. Implementing the Project Domino Plan in line with cross system Strategic Resilience Group (SRG) planning. Co-ordinating integrated working across the system through the Your Norwich programme. NCCG is meeting its Parity of Esteem commitments through 15/16 contracting.

NN CCG: Yes - The impact of changes to activity has been agreed with NNUH and reflected in Systems Resilience Group planning.

**Report to Norfolk Health and Wellbeing Board**
**15 July 2015**
**Item 12**

# Children's Services Improvement and Performance

## Cover Sheet

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

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

## Actions/Decisions needed

The Board is asked to:

- Consider and comment on the information contained in this report

# Children's Services Improvement and Performance

Report of the Interim Director of Children's Services,
Norfolk County Council

**Summary**
This report provides an update on operational performance within children's Services including Support for School Improvement and Social Care and Safeguarding. It also updates on partnership arrangements.

**Action**
The Board is asked to:

- Consider and comment on the information contained in this report

## 1. Children's Services Performance

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

1.2 **What's going well?**

1.2.1 Early Years settings continue to be slightly above the national average for the percent of settings and child-minders judged good or better and the percentage of Children's Centres judged good or better is similar to the national average.

1.2.2 For primary schools the percent judged good or better improved by 5% from summer 2014. The percentage judged good or better for secondary schools has remained the same as for summer 2014 at 62%. Over the course of the academic year this rose by 3% and then dropped as a result of a very small number of inspections. Special schools remain in line with the national average at 91%.

1.2.3 Further improvement is predicted for children and young people at every Key Stage of school.

1.2.4 The use of Family Support Plans (FSP) is more equitable across the County.

1.2.5 The overall number of contacts has decreased across April and May to 2723 which is the lowest number in the past 8 months. This may be an indication that our work with partners around understanding of thresholds is having an impact, but we would need to see sustained reduction over time to be confident that is the case. The number of contacts from individual agencies remains variable month-to-month and a NSCB audit has identified that most of the contacts we receive relate to agencies simply seeking advice.

1.2.6 A substantive Exec. Director has been appointed and our reorganisation is ongoing, with the majority of existing staff already accommodated within the new structure.

1.3 **What are we worried about?**

1.3.1 The transition to the new organisation has impacted performance in some key areas.

1.3.2 Looked After Children numbers remain high with resulting financial pressures.

1.3.3 The final implementation date for the new structure has meant a pressure on the agency social worker budget

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

1.4.1 Ensure we are using the current staff and structures as effectively as possible.

1.4.2 The admission to care panel process has been refined to challenge entries into care, we have developed structured plans for each team re: LAC reduction and will be applying additional, focussed Independent Reviewing Officer resource to work exclusively on LAC reduction casework.

## 2. Children & Young People's Strategic Partnership Board

2.1 The C&YPSB has recently reviewed its Terms of Reference and structure and in addition to the main Board has adopted a sub-group model. The eight sub-groups are as follows:

- C&YP Health & Wellbeing Group
- Involving & engaging C&YP
- Joint Commissioning Forum
- Integrated working
- Vulnerable persons
- Education challenge
- Early Help
- Youth offender Management Board

2.2 The Partnership believes that:

- Its relationship with the Heath & Wellbeing Board should be strengthened, by the sharing of key membership, including the Chair of each Board and reporting that enables each to hold the other to account.
- The Children's Partnership should be able to put items on the H&WB Board Agenda and vice versa.
- It should consider the Joint Health and Wellbeing Strategy to ensure outcomes for children are an integral part of it.

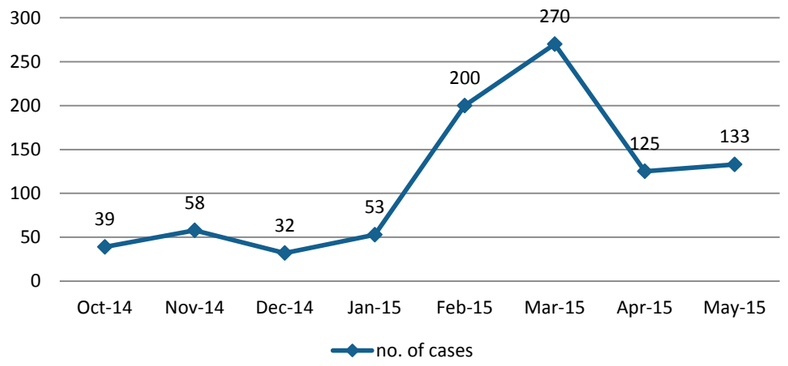
## Appendix A - The proportion of schools judged good or better

| | | July 2012 | | July 2013 | | July 2014 | | December 2014 | | | April 2015 | | | July 2015 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Norfolk Actual | National (June 2012) | Norfolk Actual | National (June 2013) | Norfolk Actual | National | Norfolk Actual | Norfolk Target | National | Norfolk Actual | Norfolk Target | National | Norfolk Actual | Norfolk Target | National | Latest Norfolk |
| % should increase | %Early Years settings judged good or better | 83% | 78% | 81% | 82% | 85% +↑ | 83% | 87% +↑ | 78% | 86% | 89% | 80% | | | 82% | | 89% |
| | %Childminders judged good or better | 74% | 71% | 76% | 75% | 80% +↑ | 78% | 84% +↑ | | 82% | 89% | 80% | | | 85% | | 89% |
| | %Children's Centres judged good or better | 82%+ | 69% | 73%+↓ | 69% | 71% +↓ | 67% | 71% +↓ | | 67% | 65% | 70% | | | 72% | | 65% |
| | %Primary phase schools judged good or better | 60% | 69% | 64% ↑ | 78% | 70% ↑ | 81% | 72% ↑ | 75% | 82% | 74%↑ | 77% | | | 80% | | 75%↑ |
| | %Secondary phase schools judged good or better | 47% | 66% | 63% ↑ | 72% | 62% ↓ | 70% | 60%↓ | 65% | 71% | 65% ↑ | 67% | | | 69% | | 62% ↑ |
| | %Special schools judged good or better | 91% | 81% | 82% ↓ | 87% | 91% +↑ | 90% | 91% + | 91% | 90% | 91% + | 91% | | | 91% | | 91% + |
| % should decrease | Reduce % of schools in an Ofsted category | 3% | 3% | 4% ↑ | 3% | 4% | 3% | 4% | 3% | 2% | 3% ↓ | 3% | | | 2% | | 3% ↓ |
| | Reduce % of schools judged to Require Improvement | 37% | 28% | 32% ↓ | 19% | 25% ↓ | 17% | 26% ↑ | 23% | 17% | 23% ↓ | 21% | | | 19% | | 24% ↓ |

# Norfolk Early Help Management Overview Dashboard May 2015

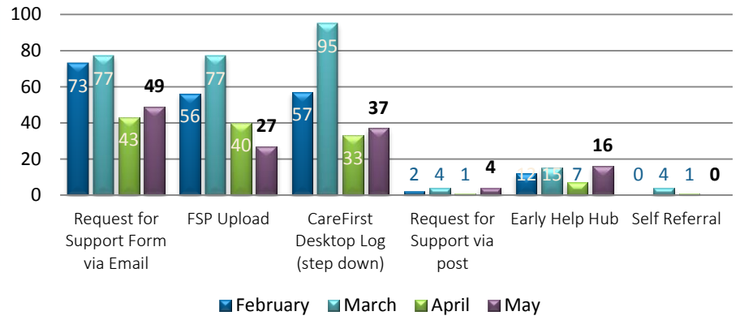
Appendix B

## Number of New Cases Highlighted per Month



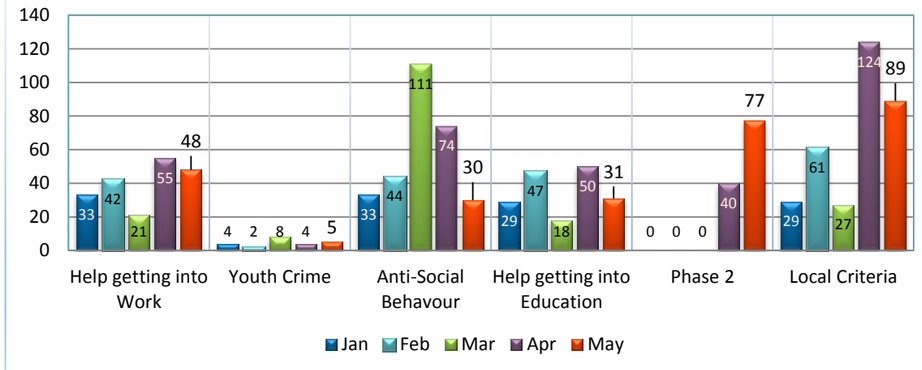

The April drop in referrals was predicted to be due to the Easter holidays, with a predicted slow rise, limited by the bank holidays. This appears to be the case. Further monitoring will clarify.

## Early Help Profile - Routes for highlighting families



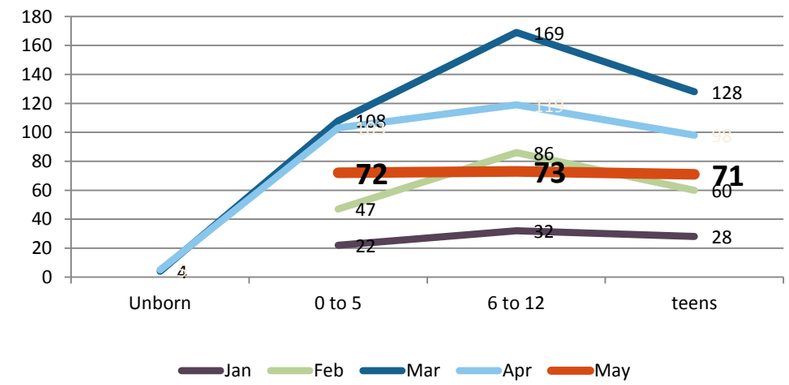

The evidence suggests that electronic methods of highlighting families is preferred. Not all FSP's received require NEHFF assistance.

## Early Help Profile- Needs identified for PbR entry




April was the beginning of Phase 2 of the PbR programme, which in practice widens the criteria for which we can accept families, by increasing the scope of the local criteria. 58 claims are still to be analysed to confirm eligibility for phase two.

## Early Help Profile- Child Age Split




In May we see an even split between age groups. No expectant families.

## Early Help Profile - Who is Referring

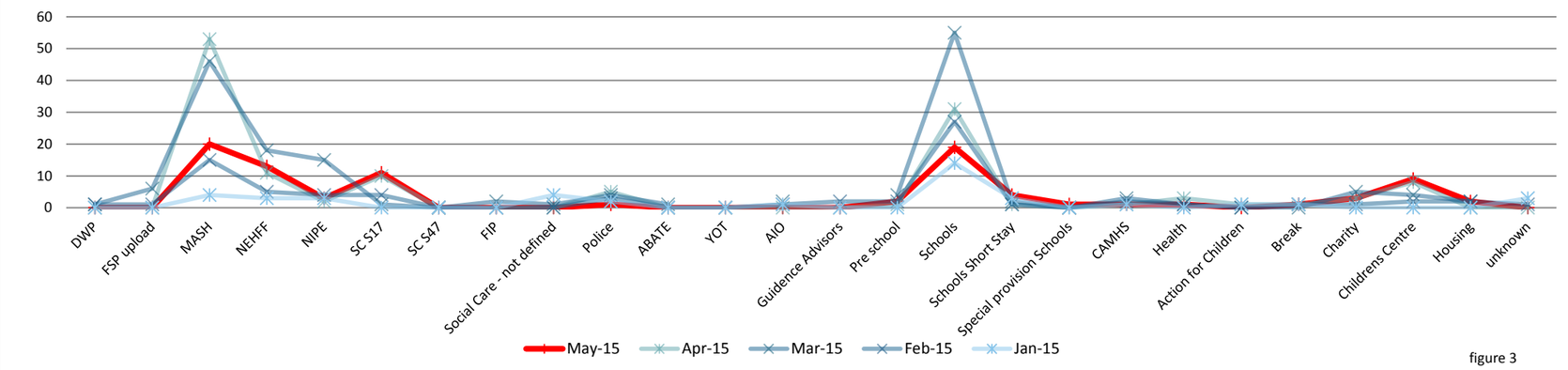
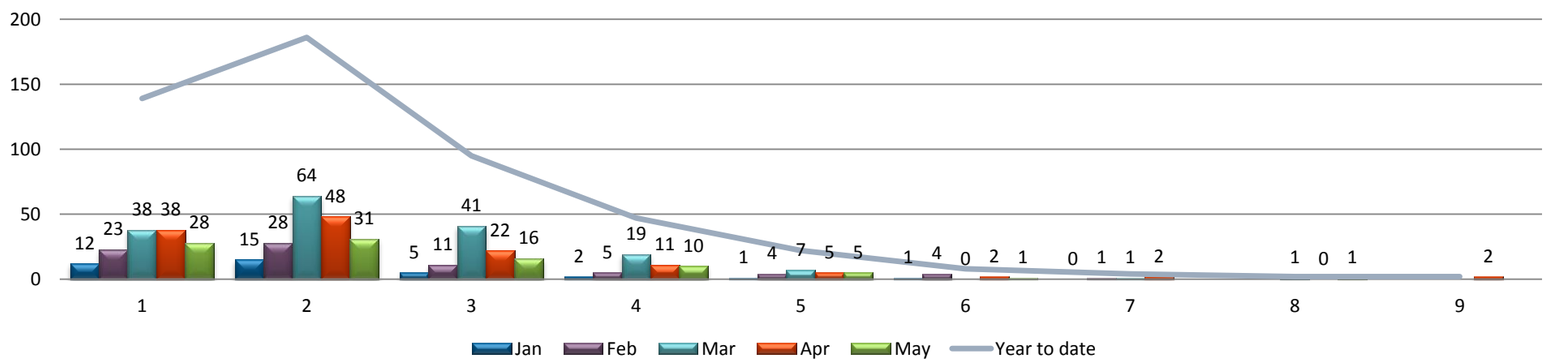



figure 3

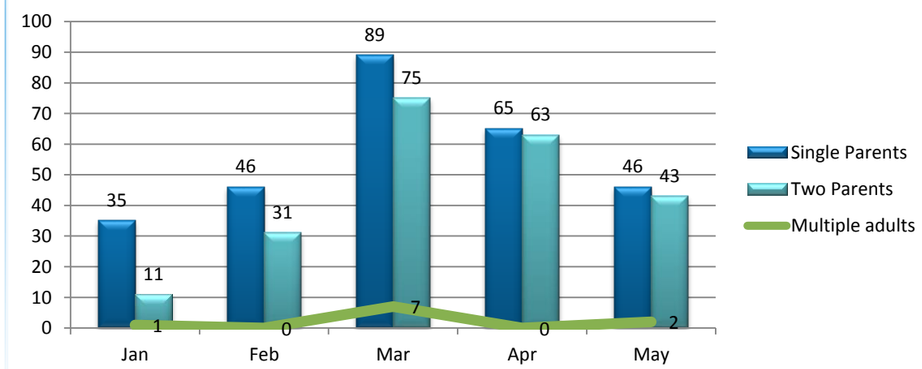
The lower school referrals are in line with school holidays, however, since January school are responsible for 29% of referrals while MASH are responsible for 25%.

## Early Help Profile - No. of Children in Household




The cases received in May have an average of 2.4 children, as is the average for the year to date. The largest family size is 8 children. 37% of families have 2 children. 25% of families have 1 child. Only 7% of families have over 4 children.

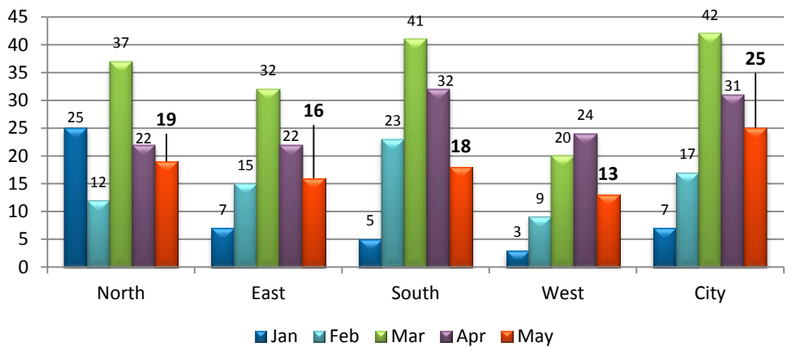
## Early Help Profile -No of Adults in Household




The split between Single and two parent families has remained consistent from the beginning of the year.

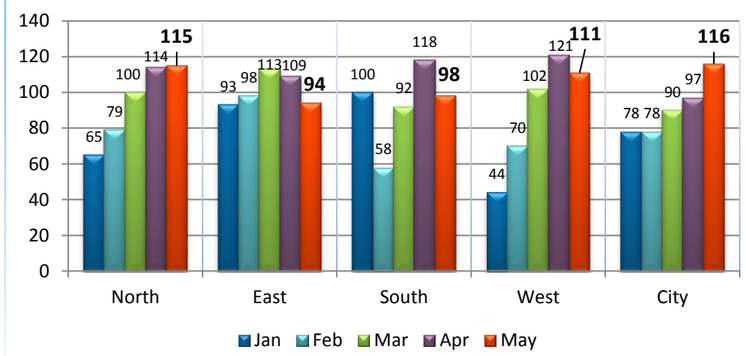
# Norfolk Early Help Management Overview Dashboard May 2015

## Early Help Profile - Monthly Area Case Allocation



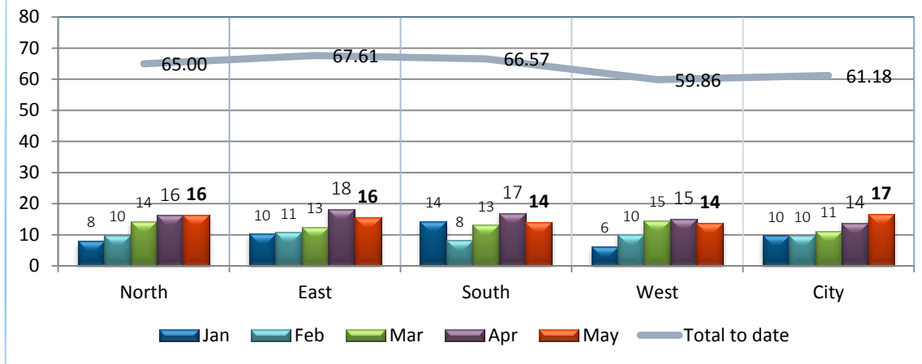

The area spread of the new cases received to be worked with by TF is even across the areas. City being the team with the highest new caseload, of 27% and the West receiving the lowest amount of new cases. 14%

## Current Caseload Area Splits



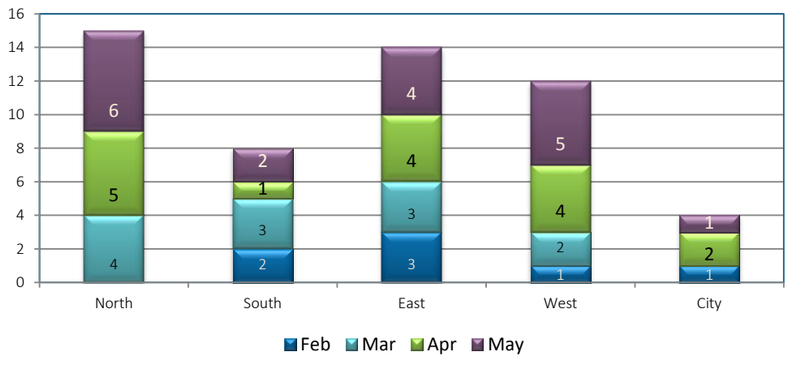

City have seen a 21% increase in caseload.

## Average caseload - per practitioner



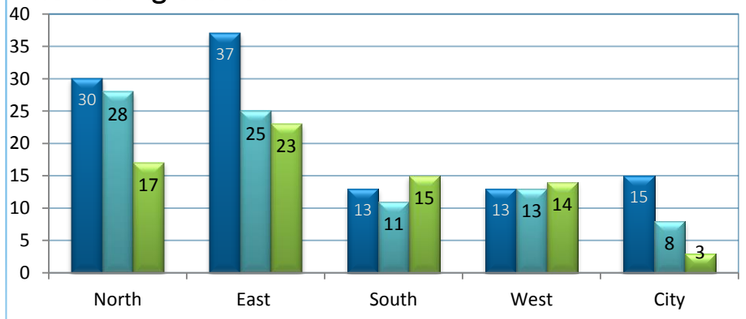

Caseloads have remained consistent over the last 5 months

## Referrals made to monitoring



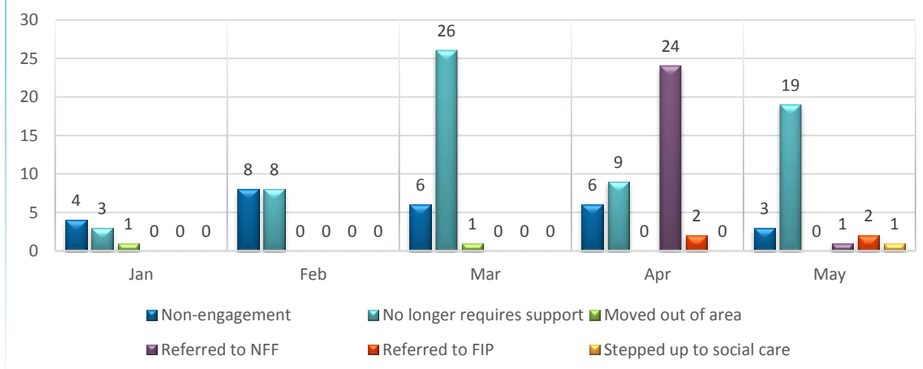

Over the last couple of months there has been a consistent flow of cases referred to monitoring.

## Monitoring Caseload




The service has 72 families in active monitoring. To date, 228 families have taken advantage of the monitoring service prior to exiting the service.

## Monitoring - Exit Profile




A great month, In May we have seen 73% of cases leaving the service and returning to the Universal Pathway no longer needing support. 4% returned to the NFF service, while 8% returned to the FIP service. 4% were stepped up to social care.

## Scorecard

| | Identified in May | | | Active | No | No. | No. | No. | Timeframe | No. |
|---|---|---|---|---|---|---|---|---|---|---|
| | Families considered for entry into the programme (Requests for TF support) | Troubled Families Register: No of Families identified for Support | Numer of Phase 2 troubled families identifed. *The target for year one is 960 families. | Family Support Process FSP's received that are externally supported | Cases Worked with by operational teams | Re referrals back into the NEHFF since April 2013 | Re referrals back into the NEHFF in May | Cases Stepped down from Social Care during May | Central Referral to operational teams to allocate. | Cases awaiting allocation by operational teams at the end of May. |
| County | 133 | 73 | 654 (68%) | 40 | 534 | 11 | 4 | 37 | 10 days | 5 |

For phase one of the Troubled Families programme that ended with a PbR claim in May 2015 the results are:

| TF Worked With | Families "Turned Around" as at 31 May 2015 **100%** | | |
|---|---|---|---|
| Troubled Families Register: No of Families worked with by NEHFF/partners | Youth Crime/ASB/Education | Progress to work | Continuous Employment |
| 1700 | 290 | 0 | 1 |

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

Appendix C

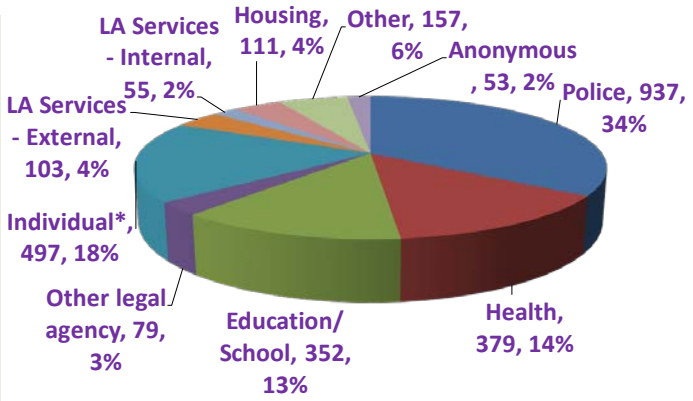
## Contacts and Initial Assessments:

### Initial Contacts by Source:

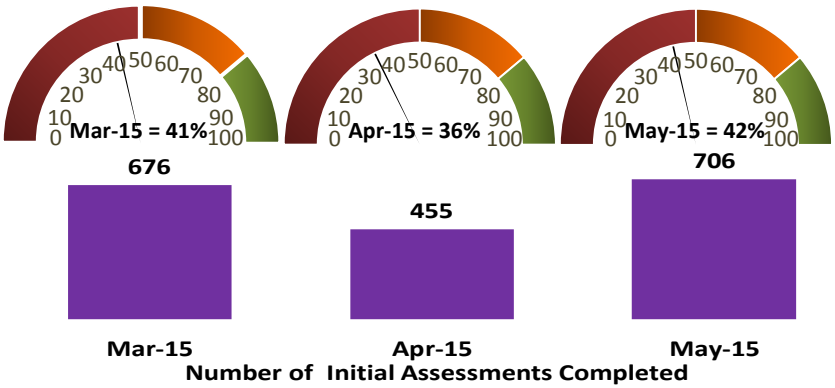
| | Mar-15 | Apr-15 | May-15 |
|---|---|---|---|
| Police | 907 | 1041 | 937 |
| Health | 443 | 403 | 379 |
| Education/ School | 571 | 286 | 352 |
| Other legal agency | 88 | 83 | 79 |
| Individual* | 504 | 544 | 497 |
| LA Services - External | 76 | 66 | 103 |
| LA Services - Internal | 91 | 79 | 55 |
| Housing | 89 | 84 | 111 |
| Other | 173 | 201 | 157 |
| Anonymous | 83 | 49 | 53 |
| Total | 3025 | 2836 | 2723 |

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

### Contacts in May 2015 by Source



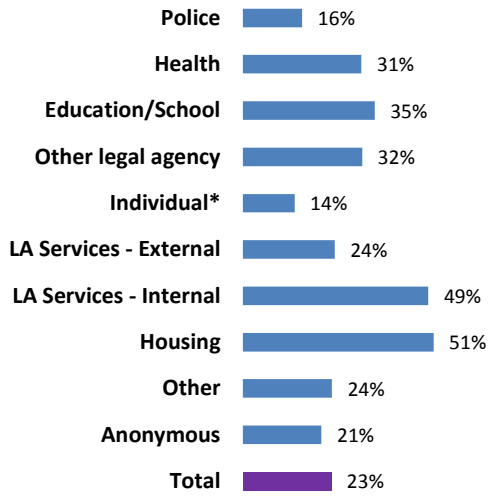

### Initial Assessments Completed in Timescales:




### Percentage of Re-Referrals:

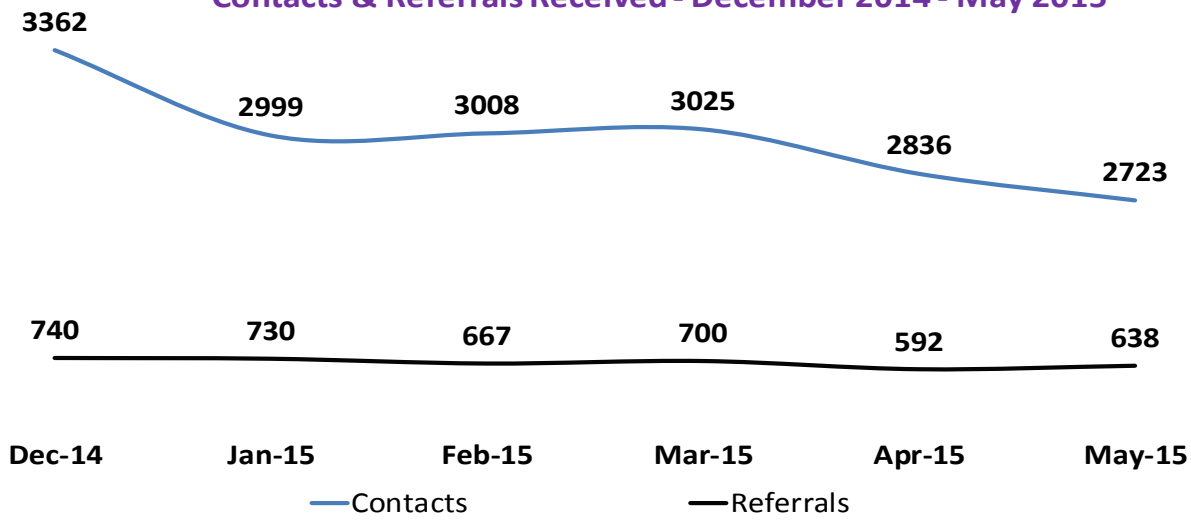
| Re-Referrals | Mar-15 | Apr-15 | May-15 |
|---|---|---|---|
| Norfolk | 24.0% | 20.4% | 24.9% |
| England 2013/14 | 23.4% | | |
| Statistical Neighbours 2013/14 | 26.1% | | |
| East of England 2013/14 | 22.4% | | |

### Conversion of Contacts to Referrals by Source:




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

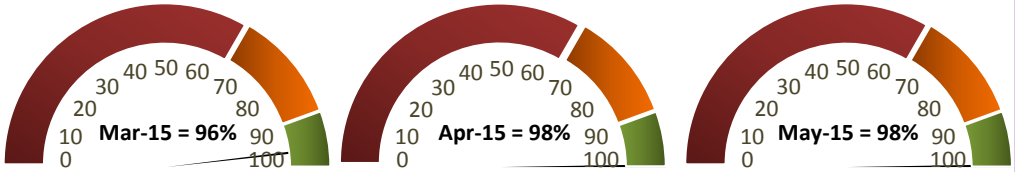
### Contacts & Referrals Received - December 2014 - May 2015



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

## Children in Need:

### Children in Need Allocated to a Qualified Social Worker:




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

| | Dec-14 | Jan-15 | Feb-15 | Mar-15 | Apr-15 | May-15 |
|---|---|---|---|---|---|---|
| No. s17 Children in Need | 1063 | 1028 | 974 | 1004 | 932 | 870 |
| No. s17 with CIN Plan | 578 | 600 | 717 | 608 | 567 | 508 |
| No. s17 without a CIN Plan | 485 | 428 | 257 | 396 | 365 | 362 |
| % with a CIN Plan | **54.4%** | **58.4%** | **73.6%** | **60.6%** | **60.8%** | **58.4%** |
| No. CWD Children in Need | 299 | 292 | 286 | 277 | 279 | 284 |
| No. CWD with CIN Plan | 245 | 239 | 248 | 225 | 231 | 229 |
| No. CWD without a CIN Plan | 54 | 53 | 38 | 52 | 48 | 55 |
| % with a CIN Plan | **81.9%** | **81.8%** | **86.7%** | **81.2%** | **82.8%** | **80.6%** |

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

### Ethnicity & Gender of Children in Need:

| Ethnicity | Female | Male | Unborn | Unknown | Total |
|---|---|---|---|---|---|
| Any other ethnic origin (please specify) | 6 | 6 | | | 12 |
| Any other mixed background | 21 | 19 | | | 40 |
| Arab | 2 | | | | 2 |
| Asian - any other background | 3 | 7 | | | 10 |
| Bangladeshi | 1 | 1 | | | 2 |
| Black - any other background | 9 | 11 | | 1 | 21 |
| Black African | 6 | 7 | 2 | | 15 |
| Black Caribbean | | | 1 | | 1 |
| Indian | 3 | 1 | | | 4 |
| Not yet Available / Unknown | 24 | 17 | 9 | 1 | 30 |
| White - other background | 74 | 71 | 1 | | 146 |
| White and Asian | 3 | 2 | | | 5 |
| White and Black African | 1 | 7 | | | 8 |
| White and Black Caribbean | 4 | 5 | 1 | | 10 |
| White British | 672 | 779 | 23 | | 1474 |
| White Irish | 2 | 1 | | | 3 |
| Total | 831 | 934 | 37 | 2 | 1804 |

### CIN Reviewed within Timescales:

| | Reviewed in Timescales | | |
|---|---|---|---|
| | In Time | Out of Time | % In Time |
| CIN Teams | 641 | 363 | **63.8%** |
| CWD Teams | 229 | 48 | **82.7%** |
| Other Teams | 246 | 397 | **38.3%** |

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

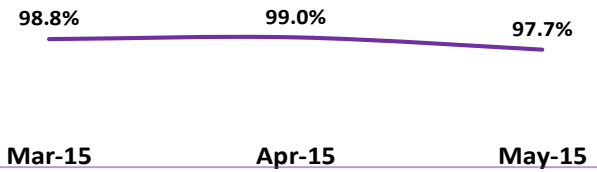
| | Mar-15 | Apr-15 | May-15 |
|---|---|---|---|
| Norfolk (Current) | 288.3 | 292.3 | 284.0 |
| England 13/14 | | 346 | |
| Statistical Neighbours 13/14 | | 339.0 | |

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

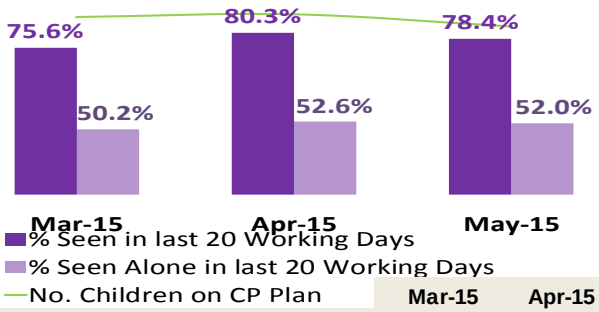
## Child Protection:

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

| | Mar-15 | Apr-15 | May-15 |
|---|---|---|---|
| No. Children on CP Plan | 582 | 588 | 562 |
| No. Allocated to Qualified Social Worker | 575 | 582 | 549 |
| % Allocated to Qualified Social Worker | 98.8% | 99.0% | 97.7% |

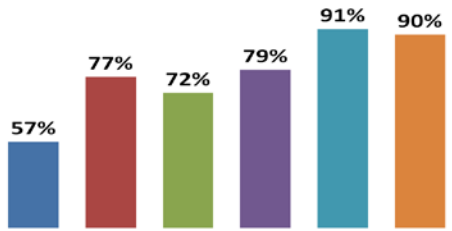



### Social Worker visits to Children on a Child Protection Plan in Timescales:




| | Mar-15 | Apr-15 | May-15 |
|---|---|---|---|
| No. Seen in last 20 Working Days | 440 | 472 | 423 |
| No. Seen Alone in last 20 Working Days | 292 | 309 | 252 |

### ICPCs within 15 Working Days of Strategy Discussion:

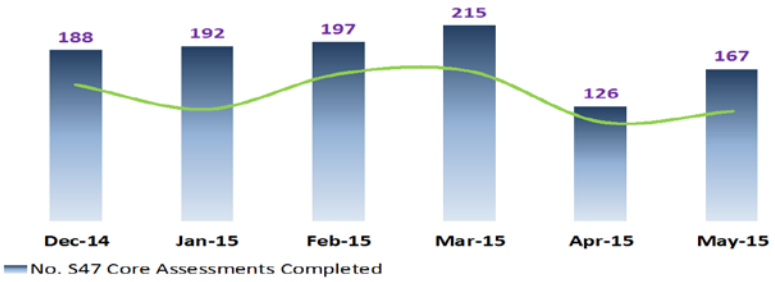



| | Dec-14 | Jan-15 | Feb-15 | Mar-15 | Apr-15 | May-15 |
|---|---|---|---|---|---|---|
| Total ICPCs | 113 | 64 | 113 | 80 | 81 | 67 |
| Within 15 Working days | 64 | 49 | 81 | 63 | 74 | 60 |
| Over 15 Working Days | 49 | 15 | 32 | 17 | 7 | 7 |

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

| | Mar-15 | Apr-15 | May-15 |
|---|---|---|---|
| Norfolk (Current) | 35.1 | 35.4 | 33.9 |
| Norfolk 13/14 | | 32.3 | |
| England 13/14 | | 42.1 | |
| Statistical Neighbours 13/14 | | 45 | |

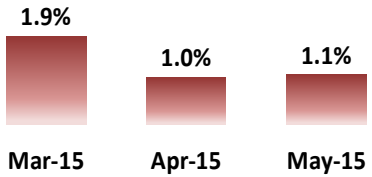
### Section 47 Core Assessments Completed in Timescales:




| | Mar-15 | Apr-15 | May-15 |
|---|---|---|---|
| No. Section 47 Core Assessments Completed | 215 | 126 | 167 |
| No. Section 47 Core Assessments Completed within 35 Working Days | 165 | 109 | 121 |
| % Section 47 Core Assessments Completed within 35 Working Days | 76.7% | 86.5% | 72.5% |

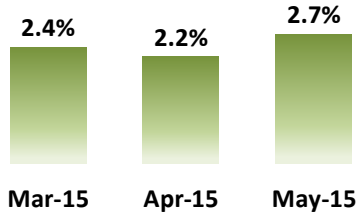
### Children on a CP Plan for 18 months & Over and Children Starting a CP Plan for a Second/Subsequent Time:

% Children on a CP Plan for 2+ Years

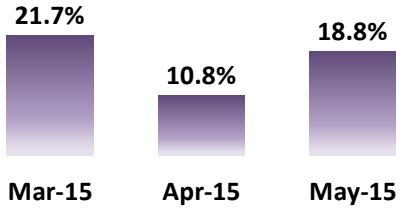



England 13/14 = 2.6%; Stat Nbr = 3.1%

% Children on a CP Plan for 18 months - 2 Years




% Children Starting CP Plan for 2nd/Subesequent Time

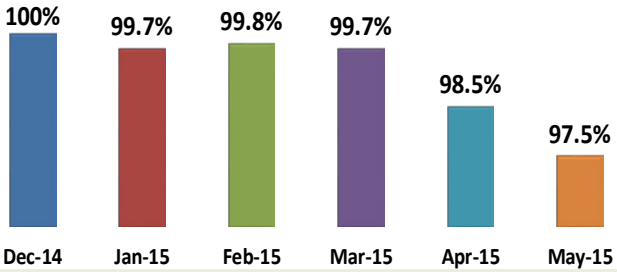



England 13/14 = 15.8%; Stat Nbr = 17.4%

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

## Looked-After Children:

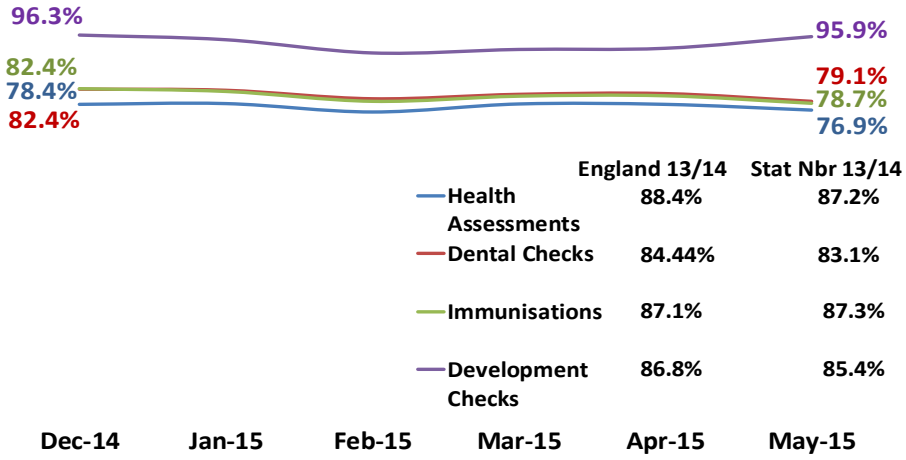
### Looked-After Children allocated to a Qualified Social Worker:




| | Dec-14 | Jan-15 | Feb-15 | Mar-15 | Apr-15 | May-15 |
|---|---|---|---|---|---|---|
| Number | 1061 | 1065 | 1067 | 1065 | 1064 | 1068 |

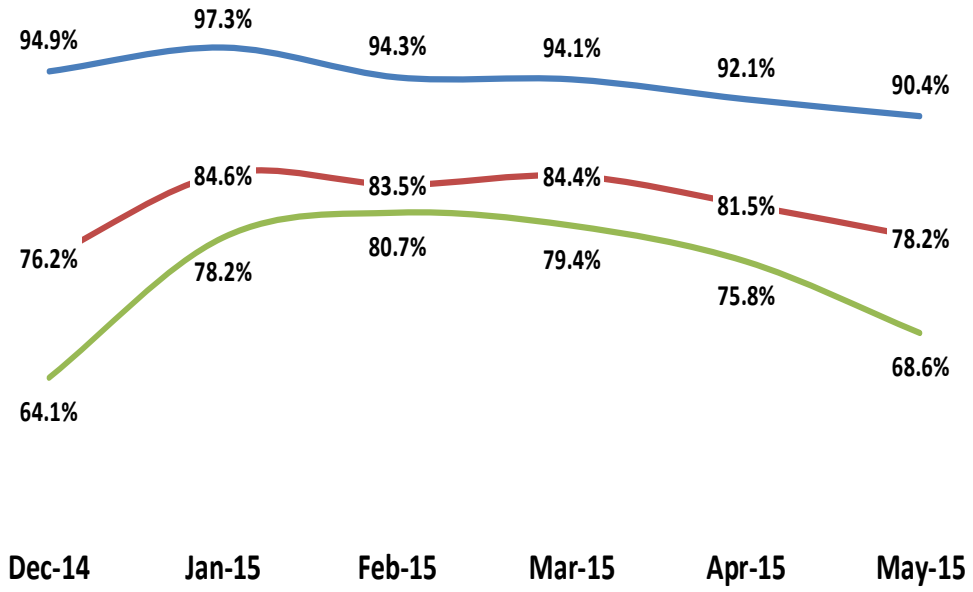
### Number of Looked-After Children:


### Health of Looked-After Children:

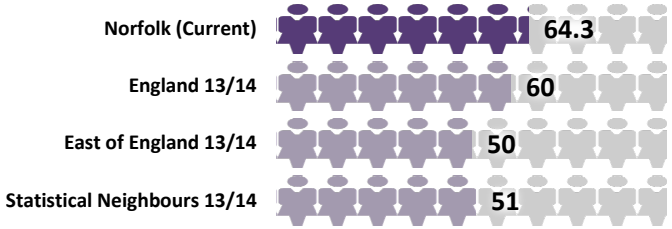



| | England 13/14 | Stat Nbr 13/14 |
|---|---|---|
| Health Assessments | 88.4% | 87.2% |
| Dental Checks | 84.44% | 83.1% |
| Immunisations | 87.1% | 87.3% |
| Development Checks | 86.8% | 85.4% |

### Care Plans, Pathway Plans & Personal Education Plans:




### Rate of LAC per 10,000 Under-18 Population



# NHS Five Year Forward View: New Models of Care

## Cover Sheet

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

The Five Year Forward View sets out a vision for the future of the NHS, and articulates why change is needed, what that change might look like, and how it can be achieved. The FYFV and supporting guidance are key to delivery of the HWB's statutory duties, in particular:

- Preparation of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy
- Duty to encourage integrated working between commissioners of health and social care services
- HWB opinion in relation to CCG commissioning plans, in relation to the Health and Wellbeing Strategy.

## Actions/Decisions needed

The Health and Wellbeing Board is asked:

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

# NHS Five Year Forward View

Report of the Locality Director, East Sub Region Team, NHS England

**Summary**

The NHS Five Year Forward View was published in October 2014 and sets out a vision for the future of the NHS. It has been developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority.

The purpose of the Five Year Forward View is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery.

The Forward View covers such areas as disease prevention, new, flexible models of service delivery tailored to local populations and needs; integration between services; and consistent leadership across the health and care system.

**Action**
The Health and Wellbeing Board is asked to note progress towards new models of care as outlined within the Five Year Forward View.

## 1. Background

1.1 The purpose of the Five Year Forward View (FYFV) is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery.

1.2 FYFV identifies three themes or gaps that must be addressed and are interlinked:

- Health and wellbeing – requiring a radical upgrade in prevention
- Care and quality – requiring new models of care
- Funding – requiring efficiency and investment.

## 2. NEW MODELS OF CARE: UPDATE AND NEXT STEPS

2.1 The *Forward View* was published in October 2014 and articulates a shared vision for the future of the NHS across seven national bodies. The challenge now is the implementation and to maintain the momentum.

Five new care models have been identified:

- Multispecialty Community Providers (MCPs) – moving specialist care out of hospitals into the community
- Integrated primary and acute care systems (PACS) – joining up GP, hospital, community and mental health services
- Enhanced health in care homes – offering older people better, joined up health care and rehabilitation services
- Acute care collaboration – local hospitals working together to enhance clinical and financial viability
- Urgent and emergency care – new approaches to improve the co-ordination of services and reduce pressure on A&E departments.

2.2 29 Vanguard projects are now underway (Appendix A), focused on the first three of the models detailed at 2.1. Recent visits to the vanguard sites demonstrated the vanguards high levels of ambition, understanding of their population's needs, strong partnership working and clear vision for improvement.

2.3 The MCP sites are currently at different stages in the design of the model. Characteristics included enhanced primary care, community integrated teams, specialist care in the community, refined access to specialist care and personalisation of care. Most intend to use multidisciplinary teams, will require information hubs, provide tools for self-care, promote public health and use technology to support health management.

2.4 The PACS sites all have community based multidisciplinary teams focused on both physical and mental health. All have strategies focused on either keeping people out of hospital or supporting care out of hospital e.g. discharge to assess. All intend to create a single care record to facilitate integration, self care and population health.

2.5 Care homes – the six sites are trying to achieve similar goals, aimed at improving the quality of life for their current and future residents and improve care planning so that care is better co-ordinated. Focus of the projects encompasses proactive assessment and care, care planning, holistic treatment, using technology to aid integration, co-commissioning, outcomes based commissioning, skilled staff, rapid response models, improving end of life care pathways, tele-health/medicine/care.

2.6 The emerging themes will form the basis of the national support package which is being designed with the vanguards and will be published in July.

2.7 The programme is now inviting expressions of interest from hospitals interested in developing new ways of delivering and improving their local acute services. The aim is to enhance the viability of local hospitals through new working arrangements between clinical specialists at different hospitals and to improve efficiency by sharing back office administration and management between different sites. It is open to all providers of acute care including smaller hospitals. The deadline for expressions of interest is 31 July 2015.

2.8 Finally, urgent and emergency care vanguards will test new approaches to delivering urgent care that aim to improve the co-ordination of services and reduce pressure on A&E departments. Some five million people are expected to be covered by the initial phase of the scheme which could be rolled out across England in the next couple of

years. The registration criteria and application process will be similar to that used for the first three vanguard models. The closing date for applications is 15 July 2015.

**ACTION**

3.1 The Health and Wellbeing Board is asked to note this update.

**Officer Contact**

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

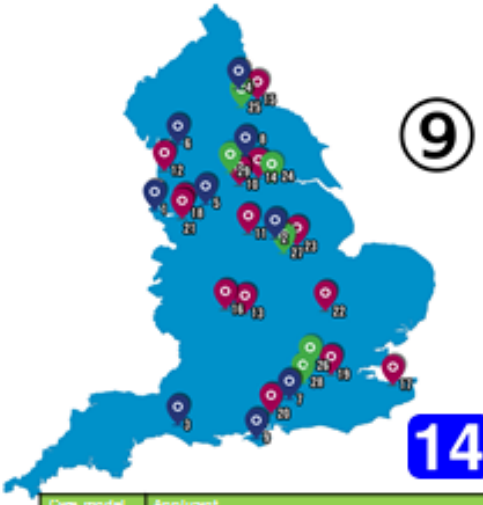
| Name | Email |
|---|---|
| Ruth Derrett | ruth.derrett@nhs.net |


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

# Five Year Forward View – Vanguard Sites

## 29 vanguards developing their visions locally

NHS




| Care model | Applicant |
|---|---|
| Care Homes | NHS Wakefield CCG |
| Care Homes | Newcastle Gateshead Alliance |
| Care Homes | East and North Hertfordshire CCG |
| Care Homes | Nottingham City CCG |
| Care Homes | Sutton CCG |
| Care Homes | Airedale NHS FT |

| Care model | Applicant |
|---|---|
| PACS | Wirral University Teaching Hospital NHS Foundation Trust |
| PACS | Mansfield and Ashfield and Newark and Sherwood CCGs |
| PACS | Yeovil Hospital |
| PACS | Northumbria Healthcare NHS Trust |
| PACS | Salford Royal Foundation Trust |
| PACS | Lancashire North |
| PACs | Hampshire & Farnham CCG |
| PACS | Harrogate & Rural District CCG |
| PACS | Isle of Wight |
| **Care model** | **Applicant** |
| MCP | Calderdale Health & Social Care Economy |
| MCP | Derbyshire Community Health Services NHS Foundation Trust |
| MCP | Fylde Coast Local Health Economy |
| MCP | Vitality |
| MCP | West Wakefield Health and Wellbeing Ltd (new GP Federation) |
| MCP | NHS Sunderland CCG and Sunderland City Council |
| MCP | NHS Dudley Clinical Commissioning Group |
| MCP | Whitstable Medical Practice |
| MCP | Stockport Together |
| MCP | Tower Hamlets Integrated Provider Partnership |
| MCP | Southern Hampshire |
| MCP | Primary Care Cheshire |
| MCP | Lakeside Surgeries |
| MCP | Principia Partners in Health |

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Norfolk County Council

**NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE**
**MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH**
**On 26 February 2015**

**Present:**

| | |
|---|---|
| Mr J Bracey | Broadland District Council |
| Mr B Bremner | Norfolk County Council |
| Mr M Carttiss (Chairman) | Norfolk County Council |
| Mrs J Chamberlin | Norfolk County Council |
| Michael Chenery of Horsbrugh | Norfolk County Council |
| Mr D Harrison | Norfolk County Council |
| Mrs M Somerville | Norfolk County Council |
| Mrs S Weymouth | Great Yarmouth Borough Council |

**Substitute Member Present**:
Ms E Morgan for Mr R Bearman, Norfolk County Council
Ms S Bogelein for Mrs C Woollard, Norwich City Council

**Also Present:**

| | |
|---|---|
| Matt Broad | Locality Director for Norfolk, Suffolk and Cambridgeshire, East of England Ambulance Service NHS Trust |
| Mark Burgis | Head of Clinical Pathway Design, North Norfolk Clinical Commissioning Group |
| Chris Cobb | Director of Medicine and Emergency Services, Norfolk and Norwich University Hospitals NHS Foundation Trust |
| Sam Revill | Research Manager, Healthwatch Norfolk |
| David Russell | Member of the public (formerly a member of the LINk ambulance group) |
| Sharon Roberts | Eastern Regional Manager of Diabetes UK |
| Suzanne Meredith | Public Health Consultant |
| Chris Walton | Head of Democratic Services |
| Maureen Orr | Democratic Support and Scrutiny Team Manager |
| Tim Shaw | Committee Officer |

**1 Apologies for Absence**

Apologies for absence were received from Mr C Aldred, Mrs A Claussen-Reynolds,

Mr R Bearman, Mr R Kybird, Dr N Legg, Mrs C Woollard and Mr A Wright.

**2. Minutes**

The minutes of the previous meeting held on 15 January 2015 were confirmed by the Committee and signed by the Chairman.

**3. Declarations of Interest**

Ms. Elizabeth Morgan declared an "other interest" in that she had been appointed by the County Council to serve on the Norfolk Community Health and Care NHS Trust Council of Governors.

**4. Urgent Business**

There were no items of urgent business.

**5. Chairman's Announcements: Members' visit to Norfolk Constabulary control room**

**5.1** The Chairman said that Norfolk Constabulary had offered another opportunity to visit the police control room for Members of NHOSC who were unable to attend previously. The visit was to observe the liaison between mental health staff and police in the control room. The potential dates were:-

Thursday 9 April 2015, 10.00am or 2.00pm
Tuesday 14 April, 2.00pm

**5.2** The Chairman added that if any more Members of the Committee were interested in visiting this service they should contact Maureen Orr who would circulate the dates by email after this meeting and confirm the one that suited most people.

**6 Diabetes Care within Primary Care Services in Norfolk**

**6.1** The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to a report from NHS England East Anglia Area Team (EAAT), with input from Norfolk County Council Public Health, on the performance of services commissioned for detection and diagnosis of diabetes and for the long term care of people with diabetes in Norfolk.

**6.2** It was noted that the officers of NHS England East Anglia Area Team who were currently responsible for the commissioning of primary care were unable to attend today's meeting and had sent their apologies. They had offered to provide written answers to any questions that the Committee wished to raise with them.

**6.3** The Committee received a presentation from Sharon Roberts, Eastern Regional Manager of Diabetes UK, who gave the charity's views about diabetes services in Norfolk. The Committee also heard from Suzanne Meredith, Public Health Consultant, Norfolk County Council who answered questions regarding prevention of diabetes and NHS Health Checks in Norfolk.

**6.4** In the course of discussion the following key points were made:

- The detailed presentation that was given by Sharon Roberts, Eastern Regional Manager of Diabetes UK, showed that across the full range of care

processes and treatments included in the Diabetes UK audit, North Norfolk and South Norfolk were the 1st and 2nd best performing areas out of 19 areas in the region. West Norfolk was 7th, Norwich was 11th and Great Yarmouth and Waveney was 19th.

- The Chairman said that Great Yarmouth and Waveney CCG area's apparently poor results in the Diabetes UK 2012-13 audit of target care processes and treatments could be raised at the Great Yarmouth and Waveney Joint Health Scrutiny Committee.
- The witnesses explained the reasons why it was important to increase the uptake of NHS Health Checks for diabetes.
- They said that GPs, and those pharmacists who were registered to give diabetes advice, were able to provide support with lifestyle choice such as how to enjoy healthy foods, how to adjust the diet and how to keep active. Health checks assisted in the detection of any early signs of diabetes so that they could be caught and treated successfully.
- It was suggested by a Member that a high visibility advertising campaign, such as at a football club, might help raise public awareness of the issue.
- The witnesses said that there were a number of risk factors for diabetes, some of which were preventable, such as weight gain around the middle, high cholesterol levels and high blood pressure.
- Losing weight, stopping smoking and reducing alcohol intake could all help to lower the risk of developing type 2 diabetes mellitus.
- In addition to these individual risk factors, certain ethnic communities and people from lower socioeconomic groups were particularly at risk.
- Factors which influenced someone's risk of type 2 diabetes included: weight, waist circumference, and age, lack of physical activity and whether or not they had a family history of type 2 diabetes.
- The witnesses did, however, say that they were unaware of any research into the links between children with diabetes and if their parents had such a condition but would investigate the matter and let Mrs Orr, the Democratic Support and Scrutiny Team Manager, know the outcome.
- Being overweight or obese was said to be the main contributing factor for type 2 diabetes. In addition, having a large waist circumference increased the risk of developing type 2 diabetes.
- Men were at high risk if they had a waist circumference of 37 inches or above. Women were at high risk if they had a waist circumference of 31.5 inches or above.
- The above classification did not apply to some population groups, such as for example, some South Asian adults. For men in this classification there was a high risk if they had a waist circumference of 35 inches.
- The witnesses said that some medications had been shown to lower the risk of type 2 diabetes amongst particularly high-risk cases, such as those with mental health issues, where lifestyles interventions alone might not be enough. There had also been research into emergence of diabetes as a side effect of certain drugs used for psychiatric disorders.

**6.5** The Committee **agreed** that information about links between drugs for mental health issues and diabetes should be circulated to Members.

**6.6** The Committee also **agreed** that NHS England East Anglia Area Team (the current commissioners of GP services) should to be invited to attend a future meeting to answer Members' questions at the meeting and not in writing.

**6.7** In addition, the Committee **agreed** that representatives from the West Norfolk Clinical Commissioning Group area should be invited to that meeting to discuss

their performance in delivering care processes and treatment targets for diabetes in primary care.

## 7 Ambulance response times and turnaround times at hospitals in Norfolk

**7.1** The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to reports on trends in ambulance response and turnaround times in Norfolk, and the action underway to improve performance. The reports were from the East of England Ambulance Service NHS Trust (EEAST), the N&N as the largest hospital in Norfolk, and the North Norfolk CCG as the lead commissioner of the N&N.

**7.2** The Committee received evidence from Matt Broad**,** Locality Director for Norfolk, Suffolk and Cambridgeshire, East of England Ambulance Service NHS Trust (EEAST), Mark Burgis, Head of Clinical Pathway Design, North Norfolk Clinical Commissioning Group, Chris Cobb, Director of Medicine and Emergency Services, Norfolk and Norwich University Hospitals NHS Foundation Trust and Sam Revill, Research Manager, Healthwatch Norfolk. The Committee also head from David Russell, Member of the public (formerly a member of the LINk ambulance group).

**7.3** The Committee received an apology for absence from James Elliott**,** Deputy Chief Executive, Norwich Clinical Commissioning Group.

**7.4** In the course of discussion the following key points were made:

- The witnesses explained the detailed ambulance response times for Norfolk, set against the agreed trajectories for each CCG, that were included in the report.
- The witnesses also explained performance trends in respect of response times, stroke 60 transport times and turnaround times at the three acute hospitals in Norfolk.
- The witnesses said that EEAST was experiencing high levels of activity. So far this year EEAST had dealt with over 133,000 calls on the 999 service. This was over 6,000 more calls than the commissioned level of activity. This high level of activity had impacted on EEASTs ability to make improvements in its services.
- However, ambulance crew recruitment and training activity was on track and more trainees were now working on the ambulances.
- The witnesses said that as well as increasing the number of ambulance crews EEAST was undertaking a review of its organisational structure to allow for more resources to be transferred to front line services. The review included the introduction of new technology at EEAST's headquarters to help run its operational services.
- Throughout 2014/2015 there had been an unprecedented rise in the demand for A&E services.
- Ambulance arrivals at A&E at the NNUH were currently showing an increase of 8% on the same period in 2013/14.
- The NNUH planned to take on 9 additional junior doctors in a staged approach with 5 to be recruited this year and 4 next year.
- The witnesses said that when ambulance handover delays occurred at the NNUH it was usually as a consequence of reduced flow throughout the hospital and/or a significantly higher than expected demand on the emergency admission areas.
- All the health and social care agencies in Norfolk relied on each other and worked together closely to resolve the issue of ambulance delays at

hospitals.

- Members said that some of the issues concerning ambulance response times appeared to relate to capacity issues at the NNUH.
- Norfolk was geographically challenging for ambulance crews in terms of the county's rural isolation, its road conditions and its elderly population.
- As the geographical conditions in Norfolk were in many ways different from those elsewhere in East Anglia, a Member suggested that ambulance response times might be improved if the county was served by a purely Norfolk Ambulance Service rather than by an East Anglia Ambulance Service.
- The witnesses said during January 2015 there had been no breaches in agreed Red 1 ambulance back up response times and only two breaches of agreed Red 2 back up response times.
- The Red 1 and Red 2 call standards were reported to the Commissioners on a simple pass / fail basis that did not reflect the length of time that a 'failed' response actually took.
- It was pointed out that the Norfolk 111 Service was amongst the top ten performing 111 Services in the country.
- The Committee was informed of the success of the measures included in Project Domino (in the central Norfolk area) together with other commissioning actions to encourage better ambulance response times and turnaround performance.
- Sam Revill, Research Manager, Healthwatch Norfolk, said that research undertaken by Healthwatch Norfolk showed that the public valued the service provided by EEAST. This research indicated that there was a 90% public satisfaction rate with the ambulance service; those who were dissatisfied with the service were mostly concerned about the time that it took for an ambulance to arrive at their home, or about the transfer from the ambulance to the hospital, rather than the service that was provided by ambulance crews.
- David Russell, a Member of the public (formerly a member of the LINk ambulance group), said that EEAST had in his opinion successfully introduced a team of staff known as Hospital Ambulance Liaison Officers (HALO) to support both EEAST and the NNUH in the turnaround of crews as quickly, efficiently and as safely as possible. In reply it was pointed out by the witnesses that the NNUH were entirely supportive of the HALO role, which was funded by winter funding monies only. EEAST had worked in close conjunction with the NNUH and senior trust management to ensure the HALO role developed and became an integrated role for both organisations.
- Mr Russell questioned the lack of information that was available regarding the fines paid by EEAST for breach of contract in relation to ambulance response times and handover times and suggested that this was something that the Committee might wish to pursue.

**7.5** It was **agreed** that the Commissioners and East of England Ambulance Service NHS Trust (EEAST) should be asked to provide the following additional information:-

1. How much have EEAST and the acute hospitals in Norfolk paid in penalty fines for breach of contract in relation to ambulance response times and handover times?
2. Which Commissioners have levied the contract penalty fines?
3. What have the Commissioners done with the money that has been paid in fines by EEAST and the acute hospitals in this context?

**7.6** The Committee **agreed** that this information should be provided in written reports as soon as convenient and would return to the subject in 12 months' time.

**8 Forward work programme**

**8.1** It was **agreed** to appoint Mrs Margaret Somerville as substitute NHOSC link member for Norwich Clinical Commissioning Group.

**8.2** The proposed forward work programme was **agreed** with the following changes:-

'Diabetes care within primary care services in Norfolk' – to be added to the forward work programme for 28 May 2015. NHS England East Anglia Area Team and West Norfolk Clinical Commissioning Group to be invited to attend.

'Ambulance response times and turnaround times in hospitals in Norfolk' to be added to the agenda for February 2016 NHOSC

**Chairman**

The meeting concluded at 1 pm


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Norfolk County Council

**NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE**
**MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH**
**On 16 April 2015**

**Present:**

| | |
|---|---|
| Mr C Aldred | Norfolk County Council |
| Mr R Bearman | Norfolk County Council |
| Mr B Bremner | Norfolk County Council |
| Mr M Carttiss (Chairman) | Norfolk County Council |
| Michael Chenery of Horsbrugh | Norfolk County Council |
| Mr D Harrison | Norfolk County Council |
| Mrs M Somerville | Norfolk County Council |
| Mrs S Weymouth | Great Yarmouth Borough Council |
| Mr A Wright | King's Lynn and West Norfolk Borough Council |

**Substitute Member Present**:
Miss J Virgo for Mrs J Chamberlin

**Also Present:**

| | |
|---|---|
| Michael Scott | Chief Executive, Norfolk and Suffolk NHS Foundation Trust |
| Debbie White | Director of Operations Norfolk and Waveney, Norfolk and Suffolk NHS Foundation Trust |
| Marcus Hayward | Locality Manager West Norfolk, Norfolk and Suffolk NHS Foundation Trust |
| Amanda Ellis | Chief Inspector, Norfolk Constabulary |
| Maureen Begley | Commissioning Manager, Integrated Mental Health Learning Difficulties Team, Norfolk County Council |
| Norman Smith | North Norfolk District Councillor. He established Norfolk Suicide Bereavement Support Group and Lifeline (a 24 hour telephone helpline for people in distress). |
| Terence O'Shea | Campaign to Save Mental Health Services in Norfolk and Suffolk |
| Clive Rennie | Integrated Commissioner |
| Michael Ladd | Chairman of Suffolk Health Scrutiny Committee |
| Chris Cobb | Director of Medicine and Emergency Services, Norfolk and Norwich University Hospitals NHS Foundation Trust |
| Dr Helen May | Associate Medical Director for Emergency Care, Norfolk and Norwich University Hospitals NHS Foundation Trust |

| | |
|---|---|
| Suzie Robinson Southey | Consultant Nurse, Emergency Care, Queen Elizabeth Hospital, King's Lynn |
| Mark Henry | Interim Director of Operations, James Paget University Hospitals NHS Foundation Trust |
| Barry Pinkney | Service Manager, Emergency Division, James Paget University Hospitals NHS Foundation Trust |
| Dr Donna Wade | A&E Consultant, James Paget University Hospitals NHS Foundation Trust |
| Chris Walton | Head of Democratic Services |
| Maureen Orr | Democratic Support and Scrutiny Team Manager |
| Tim Shaw | Committee Officer |

**1 Apologies for Absence**

Apologies for absence were received from Mr J Bracey, Mrs A Claussen-Reynolds, Mrs J Chamberlin, Mr R Kybird, Dr N Legg and Mrs C Woollard.

**2. Minutes**

The minutes of the previous meeting held on 26 February 2015 were confirmed by the Committee and signed by the Chairman.

**3. Declarations of Interest**

There were no declarations of interest.

**4. Urgent Business**

There were no items of urgent business.

**5. Chairman's Announcements: Mr John Bracey, Mr Tony Wright and Mrs Shirley Weymouth**

**5.1** The Chairman paid tribute to the significant contribution that Mr John Bracey and Mr Tony Wright had made to the work of the Norfolk Health Overview and Scrutiny Committee during their many years of service on the Committee. The Chairman said that Mr Bracey and Mr Wright were due to retire as Councillors before the next meeting of the Committee. Mr Wright had served on the Committee since its inception in 2002 and Mr Bracey had served on the Committee since 2005. They had both served as Members on many health scrutiny working groups and Mr John Bracey had served as a former Member of the Great Yarmouth and Waveney Joint Health Scrutiny Committee.

The Chairman expressed appreciation for the wise advice he had personally received from both Councillors during the time that they had been his Vice-Chairman; Mr Bracey (2009- 2014) and Mr Wright (2014-2015).

**5.2** The Chairman also congratulated Mrs Shirley Weymouth on becoming Mayor Elect of Great Yarmouth Borough Council; Mrs Weymouth would be unlikely to serve as a Member of the Committee during her year as Mayor.

## 6 Mental health services provided by Norfolk and Suffolk NHS Foundation Trust

**6.1** The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to an update from Norfolk and Suffolk NHS Foundation Trust (NSFT) on the effects of changes to services in the 2012-16 Service Strategy and action to address the findings of the Care Quality Commission's latest inspection report.

**6.2** The Committee received evidence from Michael Scott, Chief Executive, Norfolk and Suffolk NHS Foundation Trust, Debbie White, Director of Operations Norfolk and Waveney, Norfolk and Suffolk NHS Foundation Trust, Marcus Hayward, Locality Manager West Norfolk, Norfolk and Suffolk NHS Foundation Trust and Amanda Ellis, Chief Inspector, Norfolk Constabulary. The Committee also heard from Norman Smith, a North Norfolk District Councillor (Mr Smith had established Norfolk Suicide Bereavement Support Group and Lifeline, a 24 hour telephone helpline for people in distress) and Terence O'Shea**,** Campaign to Save Mental Health Services in Norfolk and Suffolk.

**6.3** In the course of discussion the following key points were made:

- It was pointed out that in the first four months of 2015 there had been a considerable overall increase in the number of referrals to the NSFT (via centralised Access and Assessment Services). This had resulted in higher caseloads, and in increased NSFT waiting times, and more pressure on multi –disciplinary community mental health services that supported people at home.
- The high referral rate for mental health services had reduced NSFT's capacity to provide ongoing monitoring and crises prevention.
- At the same time as there had been an increase in demand for its services the funding for NSFT services had continued to decline in real terms.
- The NSFT continued to press for additional funding from the CCGs for mental health services.
- The new centralised Access and Assessment service, which was a significant part of the NSFT's 2012-16 Service Strategy, was due to be decentralised by June 2015.
- The NSFT had recently opened Thurne Ward at the NNUH with 12 additional short stay assessment beds.
- During the week that preceded the Committee meeting, staffing levels on Thurne Ward had increased and the ward had now achieved full capacity.
- With the opening of Thurne Ward, the NSFT was close to achieving the total number of in- patient beds that were required in the central Norfolk area.
- In response to questions, it was pointed out that the NSFT had a strong relationship with the Norfolk Constabulary through the work of an initiative at Wymondham where the first integrated Mental Health Team in the country was established in the Police Control Centre from 8 am to 10 pm seven days a week. The witnesses said that the Police Control Centre had close links with mental health liaison services at A&E departments at the NNUH

and at the QEH, as well with the Ambulance Control Room, where a limited mental health nursing support service was available until 2 am.

- The NSFT also worked closely with MIND and Relate. The MIND crisis line was open 24 hours a day, 7 days a week.
- It was pointed out that the QEH was reviewing its liaison arrangements with the Police in the light of the initiative that had been taken in the central Norfolk area.
- Mental health staff in the King's Lynn area had a case load of between 10 and 15 cases with a mixture of case severity.
- Research had shown that more people with mental health issues attended A&E at the QEH than attended A&E at the other two acute hospitals in Norfolk. Most of those who visited the QEH with mental health problems lived within a 5 mile radius of the hospital.
- The NSFT had put together an action plan to address the issues raised in the CQC report and most of those issues that related to physical environmental constraints had been resolved.
- A payment by results policy had not been introduced for mental health services and it was unlikely for such a policy to be introduced in the future.
- NSFT staff sickness and staff recruitment rates had improved significantly in recent months but staff retention within the NSFT remained an issue to be resolved.
- Given that the NSFT was required to increase its staffing levels to maintain safe services, the NSFT was continuing to employ qualified nursing staff. In the last 12 months the NSFT had taken on some 225 new clinical staff.
- In recent years there had been significant pressure on adult acute beds in central Norfolk, with high levels of out-of-area placements. This had reached its peak in October 2014 when managerial changes to mental health social care had led to a temporary disruption in the service available to people who were supported in the community. Since that time there had been a significant fall in the number of out of county placements to between 5 and 9 out of county placements at one point in time. Most of the patients who were placed out of county were placed in Essex and Hertfordshire but there were a few cases of placements much further afield in the country. A private ambulance service was contracted to provide transport from Norwich for out of county placements.
- The witnesses said that while mental health patients were not always seen by mental health staff as often as they should be, all such patients were allocated a named care co-ordinator and given the telephone numbers for MIND and the NSFT crisis support line.
- Mr Norman Smith, a North Norfolk District Councillor who had established the Norfolk Suicide Bereavement Support Group and Lifeline, a 24 hour telephone helpline for people in distress, explained the work of this crisis support group and how it sought to provide support to those living in the community.
- Mr Terence O'Shea**,** from the Campaign to Save Mental Health Services in Norfolk and Suffolk said that the Campaign had identified what it regarded as a number of significant shortcomings in the operation of the NSFT which it considered were not being adequately addressed but was finding it difficult to engage with the management of the NSFT.
- It was pointed out that the opening of 12 beds in Thurne Ward would be off-set by the closure of beds at Carlton Court but NSFT expected that investment in community mental health services would reduce the demand for acute mental health assessment beds. The Trust aimed for zero out of area placements (except for those who required specialist services).

**6.4** The Committee noted the information contained in the report from the NSFT.

**6.5** The Committee **agreed** to continue with the planned scrutiny of West Norfolk CCG's consultation on 'Changes to mental health services in west Norfolk (development of dementia services)' on 16 July 2015 and to look at the mental health service implications of 'Changes to services arising from system wide review in West Norfolk' when the CCG reported to the Committee on that subject on 28 May 2015.

## 7 Service in A&E following attempted suicide or self-harm episodes

**7.1** The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to a report from Norfolk and Norwich University Hospitals NHS Foundation Trust, James Paget University Hospital NHS Foundation Trust, Queen Elizabeth Hospitals NHS Foundation Trust and Norfolk and Suffolk NHS Foundation Trust on the protocols used when patients who had attempted suicide or self- harm arrive in A&E.

**7.2** The Committee received evidence from Michael Scott, Chief Executive, Norfolk and Suffolk NHS Foundation Trust, Chris Cobb, Director of Medicine and Emergency Services, Norfolk and Norwich University Hospitals NHS Foundation Trust, Dr Helen May, Associate Medical Director for Emergency Care, Norfolk and Norwich University Hospitals NHS Foundation Trust and Suzie Robinson Southey**,** Consultant Nurse, Emergency Care, Queen Elizabeth Hospital, King's Lynn, Mark Henry, Interim Director of Operations, James Paget University Hospitals NHS Foundation Trust, Barry Pinkney, Service Manager, Emergency Division, James Paget University Hospitals NHS Foundation Trust and Donna Wade, A&E Consultant, James Paget University Hospitals NHS Foundation Trust. The Committee also heard from Norman Smith, a North Norfolk District Councillor.

**7.3** In the course of discussion the following key points were made:

- Witnesses from each of Norfolk's acute hospitals and from the NSFT explained the protocols and procedures used by A&E departments and the NSFT in circumstances of attempted suicide or self-harm.
- They said that no patient who was discharged from one of Norfolk's acute hospitals following attempted suicide or self-harm left hospital without a support plan having first being put in place.
- They also said that the A&E departments had jointly agreed protocols to ensure that patients who had attempted suicide or self-harm were discharged to a safe environment.
- It was pointed out that the JPH did not have a seven day a week liaison service but relied on a mental health liaison practitioner who supported the work of the JPH on a Monday to Friday basis.
- There was a small seven day a week liaison service provided to the NNUH although at weekends and out of hours this service was reduced.
- A small liaison service was available at the QEH from 8am to 11 pm, seven days a week.
- Nursing staff at the NNUH received training about attempted suicide and incidents of self-harm within 6 months of their appointment. This training was then updated on a yearly basis. Doctors at the NNUH received four monthly updates on self-harm issues. Training on how to deal with patients with mental health issues was also provided to security staff at the hospital.
- The acute hospitals and the NSFT had similar managerial plans and risk assessments for dealing with patients with a history of self-harm.

- Young people were not discharged from hospital without an assessment by a specialist. After-care programmes of support were in place for both children and adults with mandatory follow up in the week following discharge from hospital.
- The support available from charities to ex-military personnel following attempted suicide or self-harm was usually of a very high standard.
- The witnesses said that training for nurses on mental health issues was provided at the QEH in a similar way to that at the NNUH. The training of nurses at the JPH was usually undertaken on a one to one basis and made available to doctors at the JPH every two months.
- The witnesses believed that cases of attempted suicide and self-harm were no higher in Norfolk than they were elsewhere in the country. However, the number of cases throughout England had increased in recent years.
- The number of admissions to hospital in Norfolk as a result of self harm was higher than the England average.
- Mr Norman Smith, a North Norfolk District Councillor (Norfolk Suicide Bereavement Support Group and Lifeline, a 24 hour telephone helpline for people in distress) explained the work of this crisis support group in supporting people following attempted suicide and episodes of self-harm.

**7.4** The Chairman said that he was grateful to Mrs M Somerville and Ms S Bogelein for having asked for the subject of attempted suicide and episodes of self-harm to be added to the Committee's forward work programme.

**7.5** The Committee **agreed** to ask Norfolk & Suffolk NHS Foundation Trust and the three acute hospitals to provide an update report in 12 months.

**8 Forward work programme**

**8.1** The proposed forward work programme was **agreed** with the addition of an update on 'Service in A&E following attempted suicide or self-harm episodes' in April 2016.

**Chairman**

The meeting concluded at 12.40 pm

Norfolk County Council

**NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE**
**MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH**
**On 28 May 2015**

**Present:**

| | |
|---|---|
| Mr C Aldred | Norfolk County Council |
| Mr B Bremner | Norfolk County Council |
| Mr M Carttiss (Elected Chairman) | Norfolk County Council |
| Mrs J Chamberlin | Norfolk County Council |
| Michael Chenery of Horsbrugh | Norfolk County Council |
| Mr D Harrison | Norfolk County Council |
| Dr N Legg | South Norfolk District Council |
| Mrs S Matthews | Breckland District Council |
| Mrs M Somerville | Norfolk County Council |

**Substitute Member Present**:
Mrs S Young from King's Lynn and West Norfolk Borough Council

**Also Present:**

| | |
|---|---|
| Dr Sue Crossman | Chief Officer, West Norfolk Clinical Commissioning Group |
| Cllr Alexandra Kemp | County Councillor for Clenchwarton and King's Lynn South |
| Dr Anoop Dhesi | Chairman, North Norfolk Clinical Commissioning Group |
| Amanda Cousins | Associate Director of Delivery Improvement and Transformational Change, North East London Commissioning Support Unit |
| Jane Webster | Head of Commissioning, West Norfolk CCG |
| Steve Goddard | Norwich City Council |
| Fennie Gibbs | Healthwatch Norfolk |
| Becky Judge | Royal College of Nursing |
| Dr Patrick Thompson | NCH&C Governor |
| Edward Libbey | Chairman of QEH NHS FT |
| Mark Harrison | Equal Lives |
| Caroline Fairless-Price | Norwich Independent Living Group Member |
| Sally Frow | PA to Caroline Fairless-Price |
| Chris Coath | Assistant Director (Commissioning), Out of Hospital Care, South Norfolk Clinical Commissioning Group |
| Ian Monson | Member of Norfolk County Council |
| Alex Stewart | Healthwatch Norfolk |
| David Bradford | Norwich City Councillor |
| Max Bennett | North East London Commissioning Support Unit |
| Chris Walton | Head of Democratic Services |
| Maureen Orr | Democratic Support and Scrutiny Team Manager |
| Tim Shaw | Committee Officer |

**1(a) Election of Chairman**

Resolved (unanimously)
That Mr M R H Carttiss be elected Chairman of the Committee for the ensuing year.

(Mr M R H Carttiss in the Chair)

**1(b) Election of Vice-Chairman**

Resolved (unanimously)
That Dr N Legg be elected Vice-Chairman of the Committee for the ensuing year.

**2 Apologies for Absence**

Apologies for absence were received from Mr R Bearman, Mrs A Claussen-Reynolds and Mrs C Woollard.

**3. Minutes**

The minutes of the previous meeting held on 16 April 2015 were confirmed by the Committee and signed by the Chairman.

**4. Declarations of Interest**

There were no declarations of interest.

**5. Urgent Business**

There were no items of urgent business.

**6. Chairman's Announcements**

**6.1 Welcome to Mrs Shirley Matthews from Breckland District Council.**

The Chairman welcomed Mrs Shirley Matthews to her first meeting of the Committee. It was noted that Mrs Matthews had been appointed as the Member from Breckland District Council on the Committee.

It was noted that following the elections on 7 May 2015 several other district councils had yet to confirm their appointments.

**6.2 Forthcoming Induction Session for New Members**

The Chairman said that an induction session for new Members and substitute Members of NHOSC would be held in the Conference Room, South Wing at County Hall on Thursday 2 July 2015 at 2 pm. The session would also be open to all Members of the County Council and all other Members of the Committee who might wish to attend. The Head of Democratic Services and the Democratic Support and Scrutiny Team Manager would provide those attending the induction session with an introduction to health scrutiny law and the local health service context.

**6.3 Diabetes care within primary care services in Norfolk**

The Chairman said that 'Diabetes care within primary care services in Norfolk' was scheduled as an item for today's meeting but was postponed prior to publication of the agenda because NHS England Midlands and East (East) had not confirmed that they would attend the meeting. The Chairman had agreed to this postponement, after discussion with the Democratic Support and Scrutiny Team Manager, because NHS England Midlands and East (East) was the responsible commissioner of primary care in Norfolk and it was important that they should attend the Committee to answer Members questions. NHS England was scheduled to attend the Committee on 26 February 2015 but on that occasion was unfortunately unable to send a representative on the day. The regional team had been reorganised around that time and was short staffed in some areas. This was unfortunately still the case.

The Chairman added that the Democratic Support and Scrutiny Team Manager had now received an assurance from the Locality Director that NHS England Midlands and East (East) would send a representative to the Committee's meeting on 3 September 2015, should the Committee decide to put 'Diabetes care within primary care services in Norfolk' on its agenda for that meeting. (which was subsequently agreed at item 10 on this agenda).A representative from West Norfolk Clinical Commissioning Group and the Co-Chairman of the Central Norfolk Diabetes Network who were also scheduled to attend today's meeting for the diabetes item would be invited to attend on 3 September 2015.

**7 System wide review of health services in West Norfolk**

**7.1** The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to a report from NHS West Norfolk Clinical Commissioning Group on the review of health and social care systems in West Norfolk in response to financial pressures, demographic trends and rising demand for healthcare.

**7.2** The Committee received evidence from Dr Sue Crossman, Chief Officer, West Norfolk Clinical Commissioning Group and Jane Webster, Head of Commissioning, West Norfolk CCG.

**7.3** In the course of further discussion the following key points were made:

- The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH) was placed in special measures in October 2013.
- In September 2014 the Monitor Contingency Planning Team (CPT) had commenced a five month programme of work to investigate the causes of the financial and clinical sustainability problems in the QEH and the wider West Norfolk health system. By March 2015 the CPT had completed its draft report. This was due to be presented in its final form to the Monitor Board in June 2015 when Monitor was expected to consider the future status of the QEH.
- The West Norfolk Clinical Commissioning Group and the QEH were expected to publish their joint response to the CPT report at the same time as the Monitor Board was due to consider the CPT report.
- The joint response would be published on the West Norfolk CCG website and made available in other formats on request.
- The CCG awaited clarification on a number of important national issues that impacted on its plans for health and social care integration including

conflicting national comments about information sharing and risk aversion.

- Engaging with local people was a key consideration of the recovery programme. A series of drop-in events were continuing to be held to give local people the opportunity to find out more and to feed back on the work that had been done so far.
- In the course of discussion, having given due notice prior to the start of the meeting, and at the discretion of the Chairman, Cllr Alexandra Kemp, County Councillor for Clenchwarton and King's Lynn South, asked of Dr Sue Crossman the following question:
  "To improve recovery and well-being, reduce costly out-of-county placements and deliver more local care in a community setting, could the CCG pioneer funding the running of residential care farms in west Norfolk, an area rich in rural tranquillity, and farms looking to diversify, including farms in Clenchwarton and West Winch in this Division?"
  Dr Crossman gave the following answer to this question:
- Care farms were of particular benefit to people with low level mental health needs who were in a position to use their personal budgets to increase the number of care choices that were open to them. As such this issue was more a matter for adult social services than it was for the NHS which had to concentrate most of its limited resources on those with more severe mental health needs who would benefit from interventions in a hospital or home setting.
- It was not always possible to avoid making use of out of county placements; the needs of the patient were always the most important considerations.
- The challenges that were faced in west Norfolk included the rural geography of the area and a population that was ageing quicker than the national average.
- The West Norfolk CCG Alliance supported by the QEH were planning to have three or four strategically placed multi-disciplinary hubs from where it would be possible to have health and social organisations provide an integrated mental health care liaison service for those living in west Norfolk. From these hubs it would be possible to carry out crisis assessments and provide a single referral pathway into community services aimed at avoiding unnecessary admissions into acute hospital or care homes.
- The CCG valued having been given the opportunity to keep the Committee informed of developments concerning the review of health and social care systems in west Norfolk.

**7.4** The Committee noted the West Norfolk Clinical Commissioning Group confirmed that it was not expecting there would be any proposals for major service reconfiguration in west Norfolk at this stage and that it would consult with the Committee on any such proposals that might arise in future. The Committee confirmed that it did not expect the CCG to attend with further reports about the system-wide review unless a 'substantial variation' in service was proposed.

## 8 Continuing Health Care

**8.1** The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to outline proposals from Norwich, North Norfolk, South Norfolk and West Norfolk Clinical Commissioning Groups for a forthcoming consultation on changes to Continuing Health Care (CHC) policy in their areas.

**8.2** The Committee received evidence from Dr Anoop Dhesi, Chairman, North Norfolk Clinical Commissioning Group and Amanda Cousins, Associate Director of Delivery Improvement and Transformational Change, North East London

Commissioning Support Unit.

**8.3** The evidence that the witnesses presented to the Committee included a detailed PowerPoint presentation. This has been placed on the County Council's NHOSC Committee papers website.

**8.4** In the course of discussion the following key points were made:

- The witnesses said that the four CCGs were looking to provide patients and their families with a comprehensive guide to CHC that explained how the National Framework, and those local policies on CHC over which the four CCGs had discretion, would be taken forward locally. The CCGs would focus their consultation on those elements of CHC where CCGs had discretion because the CCGs were not in a position to consult on the national framework.
- This was in line with good practice elsewhere.
- During the PowerPoint presentation it was pointed out that the four CCGs collectively spent £58m on NHS CHC patients in 2014/15. The four CCGs had a combined total of 1,007 patients at the current time in receipt of NHS CHC funding. The detailed breakdown of the number of patients in receipt of CHC could be found in the PowerPoint presentation.
- In reply to Members' questions the witnesses pointed out that a patient could be discharged from the care of a consultant when their treatment had finished and that there were patients who no longer needed CHC over time or whose circumstances had changed.
- In reply to further questions the witnesses said that the local consultation was not about placing limits on CHC expenditure and that it was not possible to provide the Committee with "yes" or "no" answers to questions as to whether the consultation would result in "less" or "more" money being made available for Continuing Health Care. The eligibility for NHS Continuing Healthcare placed no limits on the settings in which a package of support could be offered or on the type of service delivery.
- Withdrawal of services when people were no longer eligible, and how the NHS could better manage the transition back to local authority or self-funding, were key elements of the consultation.
- Caroline Fairless-Price, a Continuing Healthcare Patient and Norwich Living Group Member, said that it was very difficult for anyone to meet the national criteria used to assess eligibility for continuing healthcare. She said that the group of people receiving CHC had particularly complex needs and required individual solutions to meet their needs. She said that she was concerned that the consultation might be part of a wider agenda about placing caps on health expenditure in the four CCG areas for some of the most vulnerable people in the community. Caroline Fairless-Price went on to point out that the County Council had developed the Harwood Care and Support Charter as a tool to help individuals explain their needs to organisations. In reply, the witnesses said that they would report back to the CCGs the comments that had been made about using the Harwood Care & Support Charter card to open meaningful discussions with those who required help.
- Mark Harrison, Chief Executive of Equal Lives, asked what national benchmarking data was available to show where the Norfolk CCGs' current spending on Continuing Health Care stood in comparison to CCGs in other parts of the country. In reply, the witnesses said that they would be willing to provide Members of the Committee and Mark Harrison with this information.
- The witnesses said that they would be meeting in early June with key patient groups and Local Authority leads to explain the consultation process.

**8.5** The Committee agreed that, subject to the CCGs' timetable, a consultation document on Continuing Health Care could be circulated to Members of the Committee at the time of the next meeting on16 July 2015 but that an item would not be included on the agenda for that meeting. Instead 'Continuing Health Care' would be on the agenda for the meeting on 3 September 2015 at which time representatives of the CCG & Commissioning Support Unit would attend. Representations from other interested parties could also be heard at the meeting on 3 September 2015 at which time the Committee was expected to agree its response to the CCGs.

**9 Norfolk Health Overview and Scrutiny Committee appointments**

**9.1** The Committee was asked to appoint members to Great Yarmouth and Waveney Joint Health Scrutiny Committee.

**9.2** The Committee agreed to appoint the following Members to serve on the Great Yarmouth and Waveney Joint Health Scrutiny Committee for 2015/16:

Mr M Carttiss
Mr C Aldred
Vacancy (the Great Yarmouth Borough Council appointee to NHOSC yet to be nominated by the Borough Council).

**9.3** The Committee also agreed to make the following appointments for 2015/16:-

Formal links with CCGs:-
North Norfolk CCG – M Chenery of Horsbrugh
South Norfolk CCG – Dr N Legg
Great Yarmouth & Waveney CCG – Mrs J Chamberlin
West Norfolk – M Chenery of Horsbrugh
Norwich – Mr B Bremner & substitute Mrs M Somerville

Formal links with NHS Provider Trusts
Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust – substitute link member – M Chenery of Horsbrugh
Norfolk and Suffolk NHS Foundation Trust – M Chenery of Horsbrugh
Norfolk and Norwich University Hospitals NHS Foundation Trust – Dr N Legg; substitute Mrs M Somerville
James Paget University Hospitals NHS Foundation Trust – Mr C Aldred; substitute Mrs M Somerville
Norfolk Community Health and Care NHS Trust – substitute link member – Mrs M Somerville

**9.4** The Committee agreed to make the remaining appointments at its next meeting on 16 July 2015:-

Link member for:-
Norfolk Community Health & Care NHS Trust
Queen Elizabeth Hospital NHS Foundation Trust

Substitute link members for:-
North Norfolk CCG
South Norfolk CCG

Great Yarmouth and Waveney CCG
West Norfolk CCG
Norfolk and Suffolk NHS Foundation Trust

**10 Forward work programme**

**10.1** The forward work programme was agreed with the following amendment:-

'Continuing Health Care' to be removed from 16 July 2015 agenda

The Committee noted that the 'Development of dementia services in West Norfolk' which was on the draft agenda for the meeting on16 July 2015 was expected to be a consultation from the CCG regarding permanent changes following the trial period in March 2015.

**10.2** The Democratic Support and Scrutiny Team Manager agreed to find out and let Members have details about reports in the media of a medical practice moving in Cromer.

**Chairman**

The meeting concluded at 1:10 pm

IN TRAN communication for all

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