Health and Wellbeing Board

Item 10

Report title:	**CCG Annual Reports**
Date of meeting:	**13 February 2019**
Sponsor (H&WB member):	**Tracy Williams, Vice Chair, Health and Wellbeing Board**

Reason for the Report

NHS Clinical Commissioning Groups must include a narrative in their Annual Reports about how they have contributed to the delivery of Health and Wellbeing Board priorities. The Board must also be consulted in the preparation of these narratives.

Recommendations

Each CCG in Norfolk and Waveney has submitted a draft narrative, prepared for their 2018/19 Annual Reports, about how they have supported and contributed to the delivery of Health and Wellbeing Board priorities.

The HWB is asked to:

- Agree the narratives / indicate what changes it would recommend
- Welcome the move to a single management team in 2019

1. Background

1.1 Under the Health and Social Care Act 2012, Clinical Commissioning Groups (CCGs) are required to consult the Health and wellbeing Board (HWB) about the part of their Annual Report which sets out the CCG's contribution towards delivery of the JH&WBS and each year the CCGs provide the extract of their Annual Reports for comment. The Board may also give directions as to the form and content of an Annual Report and, at the outset, the HWB gave direction that the overall form and content of the Annual Reports should be succinct and clear for the public.

2. The draft narratives

2.1 Each of the five CCGs in Norfolk and Waveney have submitted narratives for inclusion in their Annual Reports for 2018/19 about how they have contributed to the delivery of Health and Wellbeing Board priorities. The narratives are attached as follows:

Appendix A - Great Yarmouth & Waveney CCG
Appendix B - North Norfolk CCG
Appendix C - Norwich CCG
Appendix D - South Norfolk CCG
Appendix E - West Norfolk CCG

2.2 It must be stressed that CCG Annual Reports are not due to be submitted to NHS England until 18 April 2019 and these narratives remain draft and subject to minor changes up to that point, to fulfil the requirements of Governing Bodies and NHS England.

Contact

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

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Appendix A

NHS Great Yarmouth & Waveney CCG
Draft extract of Annual Report 2018-19

The CCG is a member of the Health and Wellbeing Board and has contributed to the Health and Wellbeing Strategy. The strategy has four priorities in place which are;

- A Single Sustainable System
- Prioritising Prevention
- Tackling Inequalities in Communities
- Integrating Ways of Working

The CCG has been helping to deliver these priorities in the following ways:

1. A key member of the Great Yarmouth Local Delivery Group which is accountable to the STP Primary and Community Care Programme Board and crucial to the successful delivery of the Sustainability and Transformation Plan (STP) at a local level.

2. Completed a successful procurement process to commission East Coast Community Health to provide Adult Community Health and Specialist Palliative Care Service from April 2019. The outcome base specification designed, is fully aligned to the Health and Wellbeing Board priorities to deliver improvements in the following;

   a. Peoples experience of health and care
   b. Peoples health and wellbeing
   c. Efficiency and value for money of services
   d. Integrated services across the system including primary, community and social and secondary care
   e. Self-care

3. Led and supported integrated working across organisations in the local area, to put in place services that facilitate improved discharges from the James Paget University Hospital and enable people to go home. Initiates include the development of the Integrated Discharge Hub at the JPUH and the development of reablement services to help a person to regain as much independence as possible

The CCG is a partner in the Norfolk and Waveney Sustainability and Transformation Partnership (STP), which is aspiring to become a Wave 3 Integrated Care System (ICS). See page xxx

The CCGs of Norfolk and Waveney are creating a single management team, which began with the appointment of a Chief Officer and Chief Finance Officer in early 2019. See page xxx.

Appendix B

NHS North Norfolk CCG
Draft extract of Annual Report 2018-19

Health and wellbeing strategy

NHS North Norfolk CCG is an active member of the Health and Wellbeing Board.

Decades of improvements in life expectancy and forecasts for future population growth mean that an increasing proportion of our population are elderly, have multiple illnesses and need care and support as they become frail in extreme old age. Common causes of death such as heart disease are decreasing and being replaced with conditions such as dementia. [1]

The Health and Wellbeing Strategy has four key priorities which the CCG has worked to support:

Health and Wellbeing Board Vision/ Priority	How the CCG is supporting the HWB priorities
Vision- A Single Sustainable System	The CCG is a partner in the Norfolk and Waveney Sustainability and Transformation Partnership (STP), which is aspiring to become a Wave 3 Integrated Care System (ICS). See page xxx The CCGs of Norfolk and Waveney are creating a single management team, which began with the appointment of a Chief Officer and Chief Finance Officer in the spring of 2019.
Priority- Prioritising Prevention A shared commitment to supporting people to be healthy, independent and resilient throughout life. Offering our help early to prevent and reduce demand for specialist services.	The CCG has supported patients to access the 'Broadly Active' exercise referral scheme. The activity programme is aimed at those with stable long term medical conditions who would benefit from physical activity and comprises a supervised 12 week exercise programme individually tailored to patients and working with participants to find long term sustainable exercise opportunities that fit with individual's lifestyle and medical condition. See page xxx The CCG also actively supports Public Health prevention priorities such as smoking cessation; It is the lead commissioner for a Tier 3 weight management service for tier 3 patients from the Norfolk and Norwich University Hospital for the 3 CCGs in central Norfolk. It has rolled out the National Diabetes Prevention Programme, offering targeted intervention to people most at risk of contracting diabetes. See page xxx

[1] Director of Public Health Annual Report 2018, Norfolk County Council

Priority- Tackling Inequalities in Communities Providing support for those who are most vulnerable in localities using resources and assets to address wider factors that impact on health and wellbeing.	In September 2018 the CCG worked with NHS South Norfolk CCG to launch guidance to help GP Practices to become "dementia friendly". See Page xxx A new CAN Connect Service is being delivered by Community Action Norfolk (CAN) in the North Norfolk area. Life Connectors and volunteers help people realise life goals and so tackle loneliness and isolation. Social prescribing has been rolled out across all practices, whereby patients are signposted to the right community support services to tackle the root cause of their ill health. The CCG also commissions a team based at CityReach to support people who frequently attend A&E but whose health concerns are not accidents or emergencies.
Priority- Integrating Ways of Working Collaborating in the delivery of people centred care to make sure services are joined up, consistent and makes sense to those who use them.	The CCG has developed the North Norfolk Escalation Avoidance Team (NEAT), a multi-disciplinary team that puts an integrated package of care in place for people who develop a health crisis. The CCG has invested in 'Hospice at Home' an enhanced palliative care service working in partnership with community staff, GP Practices and palliative care specialists. The Norfolk and Waveney 'Winter Room' and 'System Operation and Resilience Groups' are integrated teams of staff drawn from all NHS and social care teams to co-ordinate urgent and emergency care.

The Norfolk Health and Wellbeing Board has been consulted over the contents of this section of the report. It was sent to the February 2019 meeting of the Board and (more to follow…)

Appendix C

NHS Norwich CCG
Draft extract of Annual Report 2018-19

Health and wellbeing strategy

The CCG is an active participant in the leadership and work of the Board and contributes towards the delivery of the 2018-2022 Health and Wellbeing Strategy for Norfolk. The Chair of NHS Norwich CCG, Tracy Williams, is one of the two Vice-Chairs of the Health and Wellbeing Board.

The Health and Wellbeing Strategy has four key priorities which the CCG has worked to support:

Health and Wellbeing Board priority	How the CCG is supporting the HWB priorities
A Single Sustainable System	The CCG is a partner in the Norfolk and Waveney Sustainability and Transformation Partnership (STP), which is aspiring to become a Wave 3 Integrated Care System (ICS). See page xxx The CCGs of Norfolk and Waveney are creating a single management team, which begins with the appointment of a Chief Officer and Chief Finance Officer in the spring of 2019.
Prioritising Prevention A shared commitment to supporting people to be healthy, independent and resilient throughout life. Offering our help early to prevent and reduce demand for specialist services.	The CCG's Healthy Norwich programme continues to help people in the Norwich area lead healthier lives. This is a partnership with Norwich City Council, Broadland District Council and Public Health. Activities have included: • Healthy Norwich grants programme to support community initiatives • Smokefree Sidelines campaign • 0-4 years accident prevention in the home project • Promoting the Daily Mile in schools • Breastfeeding Friendly scheme in GP Practices • Working with practices to diagnose dementia in patients earlier, so they can access treatments and support to improve symptoms and slow down the progress of the disease Full details of Healthy Norwich activities are on page xxx The CCG actively supports Public Health prevention

	priorities such as smoking cessation; it commissions weight loss and activity programmes for patients who are overweight to prevent diabetes and CVD ill health. It has rolled out the National Diabetes Prevention Programme in Norwich, offering targeted intervention to people most at risk of developing diabetes.
Tackling Inequalities in Communities Providing support for those who are most vulnerable in localities using resources and assets to address wider factors that impact on health and wellbeing.	The Healthy Norwich partnership has supported initiatives that target communities where there are identified health inequalities: Funding for the Heartsease Healthy Living initiative to support seven community projects. The Healthy Norwich partnership works to deliver the Norwich affordable warmth strategy to reduce fuel poverty – one of the wider determinants of health. Social prescribing has been rolled out across all practices, whereby patients are signposted to the right community support services to tackle the root cause of their ill health. Voluntary Norfolk has been commissioned to pilot a health coaching scheme to support people to manage their long-term health conditions. Age UK is commissioned to run a Promoting Independence scheme, working closely with GPs and other health professionals to support people over the age of 65 to improve their wellbeing. NHS England commissions the CityReach service for people who are homeless, or otherwise do not engage with the NHS. The CCG is also piloting a team based at CityReach to support people who are frequent attenders at A&E. *One*Norwich is developing a pilot service to engage and support patients with severe and multiple disadvantages.
Integrating Ways of Working Collaborating in the delivery of people centred care to make sure services are joined up, consistent and makes sense to those who use them.	Norwich CCG and partners have developed the Norwich Escalation Avoidance Team (NEAT), a multi-disciplinary team that puts an integrated package of care in place for people who are experiencing a health or social care crisis. The CCG has developed an enhanced case management model called Community FICS (Fully Integrated Care and Support), being piloted in the City 2 area of Norwich. The CCG has invested in an enhanced palliative care service working in partnership with community staff,

	GP Practices and palliative care specialists. Referrals are made via NEAT. The CCG commissioned HomeWard, our hospital at home service, which has dedicated social care resources. The Norfolk and Waveney 'Winter Room' and 'System Operation and Resilience Groups' are integrated teams of staff drawn from all NHS and social care teams to co-ordinate urgent and emergency care.

The Norfolk Health and Wellbeing Board has been consulted over the contents of this section of the report. It was sent to the February 2019 meeting of the Board and (more to follow…)

Appendix D

NHS South Norfolk CCG
Draft extract of Annual Report 2018-19

Health and wellbeing strategy

NHS South Norfolk CCG is an active member of the Health and Wellbeing Board.

Decades of improvements in life expectancy and forecasts for future population growth mean that an increasing proportion of our population are elderly, have multiple illnesses and need care and support as they become frail in extreme old age. Common causes of death such as heart disease are decreasing and being replaced with conditions such as dementia. [1]

The Health and Wellbeing Strategy has four key priorities which the CCG has worked to support:

Health and Wellbeing Board vision/priority	How the CCG is supporting the HWB priorities
Vision - A Single Sustainable System	The CCG is a partner in the Norfolk and Waveney Sustainability and Transformation Partnership (STP), which is aspiring to become a Wave 3 Integrated Care System (ICS). See page xxx The CCGs of Norfolk and Waveney are creating a single management team, which began with the appointment of a Chief Officer and Chief Finance Officer in the spring of 2019.
Priority - Prioritising Prevention A shared commitment to supporting people to be healthy, independent and resilient throughout life. Offering our help early to prevent and reduce demand for specialist services.	The CCG has supported patients to access the 'Broadly Active' exercise referral scheme. The activity programme is aimed at those with stable long term medical conditions who would benefit from physical activity and comprises a supervised 12 week exercise programme individually tailored to patients and working with participants to find long term sustainable exercise opportunities that fit with individual's lifestyle and medical condition. See page xxx The CCG also actively supports Public Health prevention priorities such as smoking cessation; It commissions with the 3 CCGs in central Norfolk a Tier 3 weight management service for tier 3 patients from the Norfolk and Norwich University Hospital. It has rolled out the National Diabetes Prevention Programme, offering targeted intervention to people most at risk of contracting diabetes. See page xxx
Priority - Tackling Inequalities in Communities Providing support for those who are most vulnerable in	In September 2018 the CCG worked with NHS North Norfolk CCG to launch guidance to help GP Practices to become "dementia friendly". See Page xxx The Better Together Service is being delivered by

localities using resources and assets to address wider factors that impact on health and wellbeing.	Voluntary Norfolk in the South Norfolk area where volunteers help people realise life goals and so tackle loneliness and isolation. Social prescribing has been rolled out across all practices, whereby patients are signposted to the right community support services to tackle the root cause of their ill health. The CCG also commissions a team based at CityReach to support people who frequently attend A&E but whose health concerns are not accidents or emergencies.
Priority - Integrating Ways of Working Collaborating in the delivery of people centred care to make sure services are joined up, consistent and makes sense to those who use them.	The CCG has developed the South Norfolk Escalation Avoidance Team (NEAT), a multi-disciplinary team that puts an integrated package of care in place for people who develop a health crisis. The CCG has invested in 'Hospice at Home' an enhanced palliative care service working in partnership with community staff, GP Practices and palliative care specialists. The Norfolk and Waveney 'Winter Room' and 'System Operation and Resilience Groups' are integrated teams of staff drawn from all NHS and social care teams to co-ordinate urgent and emergency care.

The Norfolk Health and Wellbeing Board has been consulted over the contents of this section of the report. It was sent to the February 2019 meeting of the Board and (more to follow…)

Appendix E

NHS West Norfolk CCG
Draft extract of Annual Report 2018-19

Health and wellbeing strategy

The CCG is an active participant in the work of the Board and contributes towards the delivery of the 2018-2022 Health and Wellbeing Strategy for Norfolk.

The Health and Wellbeing Strategy has four key priorities which the CCG has worked to support:

Health and Wellbeing Board priority	How the CCG is supporting the Health and Wellbeing Board priorities
A Single Sustainable System Health and Wellbeing Board partners taking joint strategic oversight of the health, wellbeing and care system – leading the change and creating the conditions for integration and a single sustainable system.	The CCG is a partner in the Norfolk and Waveney Sustainability and Transformation Partnership (STP), which is aspiring to become a Wave 3 Integrated Care System (ICS). See page xxx The CCGs of Norfolk and Waveney are creating a single management team, which began with the appointment of a Chief Officer and Chief Finance Officer in early 2019. See page xxx
Prioritising Prevention A shared commitment to supporting people to be healthy, independent and resilient throughout life. Offering our help early to prevent and reduce demand for specialist services.	A focus on prevention and helping people to stay well is a priority for the CCG, its partners and the wider STP. The CCG has rolled out the National Diabetes Prevention Programme across West Norfolk practices, offering targeted intervention to people most at risk of developing diabetes. The CCG has also led on the development of a new five-year diabetes strategy for Norfolk and Waveney STP 2018-2023. NSFT and WNCCG have jointly commissioned a 'Mental Health Hub' (provided by West Norfolk Mind) to help support people with mental health issues before they reach crisis point. West Norfolk CCG has invested additional funding in the Norfolk First Support 'reablement' service which is provided by Norfolk County Council and helps older people to regain their mobility and confidence, for example after hospital care, which enables people to remain living independently. Additional investment has been made with CCGs across Norfolk in the Community Epilepsy service, helping to reduce the need for hospital services and providing improved care.
Tackling Inequalities in Communities Providing support for those who are most vulnerable in localities	WNCCG has supported Norfolk County Council colleagues in rolling out 'Social Prescribing' across all practices. This is supporting patients to access the right community support services that

using resources and assets to address wider factors that impact on health and wellbeing.	are best able to support them with non-medical issues. WNCCG has also invested in a Nursing Clinic to support homeless people in King's Lynn, working with the Southgates GP Practice and Homeless Charity (Purfleet Trust). NHS England and West Norfolk CCG have worked with colleagues across Norfolk and via a local West Norfolk Dementia Network to support improved dementia services. This has included a pilot project to support patients attending 7 GP Practices, delivered by the Alzheimers Society. This has also included promotion of dementia services and support via the 'Lily' service (provided by the Borough Council of King's Lynn and West Norfolk in conjunction with a consortium of local voluntary sector organisations).
Integrating Ways of Working Collaborating in the delivery of people centred care to make sure services are joined up, consistent and makes sense to those who use them.	As part of the work to transform health and care services across Norfolk and Waveney, five Local Delivery Groups (LDGs) have been established, with one in West Norfolk. The LDG meets on a monthly basis in King's Lynn. Partners include: • NHS West Norfolk CCG • Norfolk County Council • Norfolk Community Healthcare NHS Trust • Norfolk and Suffolk NHS Foundation Trust • Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust • Borough Council of King's Lynn and West Norfolk • West Norfolk Healthcare Ltd • Healthwatch • Community Action Norfolk The purpose of the LDG is to implement and monitor local delivery of transformational service initiatives identified by the STP programme. Work is moving at pace and will involve the use of population health modelling to redesign how we deliver health and care services in West Norfolk. As part of this work, WNCCG, working with its partners, is currently piloting the West Norfolk Escalation Avoidance Team – West (NEAT), a multi-disciplinary team that puts an integrated package of care in place for people who develop a health crisis.

	WNCCG has worked with Norfolk County Council to deliver Accommodation Based Reablement services, which provide support to patients who require support in a care home to regain independent living skills before returning home. WNCCG has commissioned a new In-Patient Unit, provided by Norfolk Hospice Tapping House, to deliver high quality palliative and end of life care. This works closely with our West Norfolk Integrated Palliative Care Service, which also includes Norfolk Community Health and Care, Norfolk County Council, Macmillan and Marie Curie. There has been additional investment in the 'Improving Access to Psychological Therapies' service (provided by Norfolk and Suffolk Foundation Trust) to support people with anxiety and depression, with a particular focus recently on ensuring that this support is offered to people with Long Term Conditions (such as Diabetes), in association with acute and community service providers.

The Norfolk Health and Wellbeing Board has been consulted over the contents of this section of the report. It was sent to the February 2019 meeting of the Board for information and comment.