Wellbeing Panel

Agenda

Date

Monday 18 June 2018

Time

5:30 pm

Trafford Room
Thorpe Lodge
1 Yarmouth Road
Thorpe St Andrew
Norwich

Members of the Wellbeing Panel

Mr A J Proctor
(Chairman)

Mr D Buck
Ms S J Catchpole
Miss J R Keeler
Miss S Lawn
Mrs J Leggett
Mr N C Shaw
Mr D C Ward
Mr F Whymark

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The Chairman will ask if anyone wishes to film / record this meeting

A G E N D A

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13 August 2018, 8 October 2018, 3 December 2018,
28 January 2019, 1 April 2019.

P C Kirby
Chief Executive

Minutes of a meeting of the **Wellbeing Panel** held at Thorpe Lodge, 1 Yarmouth Road, Thorpe St Andrew, Norwich on **Monday 26 February 2018** at **5:30pm** when there were present:

Mr A J Proctor – Chairman

Mr D Buck	Miss S Lawn	Mr D C Ward
Mr D Roper	Mr N C Shaw	

In attendance were the Deputy Chief Executive, the Housing Manager, the Emergency Planning Manager, the Housing, Health and Partnerships Officer, the Community Projects Officer and the Committee Officer (DM).

Also attending was Mr Rob Hetherington, Norfolk County Council Employment and Skills Team.

33 DECLARATIONS OF INTEREST UNDER PROCEDURAL RULE NO 8

Member	Minute No & Heading	Nature of Interest
Mr Buck	39 – Community at Heart Update	Local Choice – non-Pecuniary – Member of Hellesdon Parish Council and involved in their Grow Your Community Project

34 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs L H Hempsall and Mr F Whymark.

35 MINUTES

The Minutes of the meeting held on 11 September 2017 and the informal meeting held on 4 December 2017 were confirmed as a correct record and signed by the Chairman.

36 INTEGRATED EMPLOYMENT AND HEALTH SERVICE

The Chairman welcomed to the meeting Mr Rob Hetherington from Norfolk County Council's Employment and Skills Team who briefed Members on a project being developed by the County Council to support long term claimants of working age benefits with health related barriers into work. Despite high employment levels, a significant number of people were currently in receipt of Benefits. In Norfolk, this figure was 55,000 or 10% of the working age

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population. Of these, 3,700 were in receipt of JSA and 32,000 in receipt of Employment Support Allowance. This represented a significant shift in people claiming JSA, which a few years ago was around 40,000, to those with health related issues now claiming ESA. Approximately 38,000 people were long term claimants (2 years or more). Unlike those claiming JSA, recipients of ESA did not have to attend the job centre to apply for work. The perception amongst some people on ESA was that approaching the job centre for work or claiming JSA and not managing to secure a job could result in the loss of their benefits.

With regard to the figures for Broadland, it was noted that these were in keeping with the Norfolk figures. The key issue was the change in demographics with the 18-24 year age group now only making up 10% of the total on work related benefits and those above 24 years making up 90% of the total.

The project to develop an integrated employment and health service aimed to put measures in place to help support people back into work. Feedback from GPs was that a significant number of patients were presenting to their GPs with social issues and not medical issues and support for these clients was not available. It was believed that 40% of those claiming ESA wanted and were able to work but the longer they remained out of work the harder it was to secure employment; national provision to move people into work was not able to address health related barriers to the work place and, despite a growing momentum to tackle the issues, there was little new provision in Norfolk.

A stage 1 bid for money from the European Social Fund had been successful with a stage 2 application currently in progress. Matched funding had been secured from a number of sources including the County Council, pooled business rates and housing associations and discussions were ongoing with others including the LEP, the NHS and the CCGs. Other groups in the area were potentially bidding for funding and, whilst there appeared to be sufficient funding available for all, discussions were ongoing to seek a co-ordinated approach to maximise potential funding for the county.

Mr Hetherington went on to explain the “model” for the proposed service which aimed to put the individual at the centre of the process and provide the necessary support to get them to where they wanted to be. The vital role of the voluntary sector was acknowledged but this was not funded. There was a need to recognise this, with appropriate funding if applicable, as a vital route to support. Access to sport and activity was also a key area as a means of engaging people back into society and improving wellbeing. Training was also a key area to be addressed with a need to understand the needs of the employer and the potential employee. There was also seen to be a need to move away from group support (such as skills development, team building etc) to individual support offered by individual personal advisors. The emphasis was on helping to find the right job and not just any job.

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Mr Hetherington stated that the project needed to be integrated across the whole county and work undertaken with partners, including district councils, to examine how the project would look for each district. The time frame would hopefully see the start of delivery of the service in September this year for a 3 year period.

It was noted that the assessment carried out for eligibility for support would be separate from any benefits eligibility assessments. The proposal was to engage two personal advisors in each district who would focus on working with individuals in that district within the location, maybe hosted by the district councils or local voluntary groups.

In response to a question about the potential impact of universal credit on the proposals, Mr Hetherington commented that the advisors would work closely with the DWP to mitigate any issues and it was hoped the new universal credit regime would actually support the aims of the project and benefits would not be affected in the same way by changes in the number of hours worked or income earnt as was currently the case.

Members welcomed the aims of the project and were keen to see the exploration of ways in which the service could be integrated with those of the district council, for example in relation to the work the Council was already developing on social prescribing, the early help hub and Community at Heart.

The Chairman thanked Mr Hetherington for attending the meeting.

37 BROADLAND RESILIENCE – UPDATE

The Council's Emergency Planning Manager gave Members a brief outline of resilience work in Broadland. The area was fortunate to not have witnessed any major incidents but business continuity plans and emergency plans were in place to deal with any incidents. Work continued in conjunction with partners of the Norfolk Resilience Forum to ensure a multi-agency response to any major incidents.

With the aim of supporting the wellbeing of communities, and encouraging community resilience, work continued to encourage local communities to develop their own plans. Standard templates for plans were available, but it was acknowledged that resilience could exist in a variety of different ways and by any number of different local groups or organisations. The aim was to increase awareness of what resources were available in local communities in the event of an incident. To this end the Emergency Planning Manager undertook to visit any parishes who wanted to explore this area further and invited Members to let him know what existed in their parishes to help him establish connections and build a picture of how local communities responded in the event of an issue.

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In response to questions, the Emergency Planning Manager stated that approximately 8-10 parishes currently had formal plans in place or were developing plans but he would like to increase this number. It was suggested that an article be included in Broadland News.

It was agreed to include a periodic update on Broadland Resilience in the Committee's work programme.

38 SOCIAL PRESCRIBING

The Housing, Health and Partnerships Officer reminded Members of work ongoing on the development of the social prescribing model across the county. A total of £950,000 was available per year for two years funded by Adult Social Care improved Better Care Fund and Public Health. Of this £100,000 was likely to be needed for a programme/service manager and training. The remaining £850,000 would be split along 5 CCG locality boundaries for which Broadland was covered by two: Norwich would get £204,000 and North Norfolk – £144,500. A bid had been put forward by Community Action Norfolk to NHS England for £384,000 over 4 years, topped up by notional match funding. This would be used to pay for training, oversight, data management, governance and quality assurance but the project could still proceed without this funding.

As far as the North Norfolk CCG was concerned, funding would be split on patient population lines which equated to a 40% split for Broadland. North Norfolk District Council would be using funds to directly employ living well workers located in a hub. Broadland would be utilising its £57,800 to face the Norwich service to ensure parity of service across the district. The suggestion was for the money to be used to fund 1.5 fte living well workers who would be employed within the Broadland element of the NNCCG area, through the Voluntary Community and Social Enterprise Sector (VCSE), leaving £8,000 for Community Capacity building. As a general principle, it had been agreed to broadly maintain financial and geographic boundaries and not merge either living well worker resource or VCSS capacity pots, however there needed to be a degree of flexibility across the area to meet supply, need and demand.

With regard to the Norwich CCG, a VCSE organisaion would hold the living well worker funding which would pay for one team manager and 2.5 fte living well workers. These would be employed by voluntary sector partners. The living well workers would be trained to the required level, have 4-5 contacts per client, take a motivational interviewing approach and be flexible in their approach dependent on clients' needs. A small scale support fund of around £20,000 would be available and managed by the team manager for allocation across the 3 areas in the Norwich CCG. The remainder of the £240,000 (approximately £65,000) would be held for capacity building funding (potentially by Norfolk Community Foundation), based on three identified priorities, and signed off by an oversight group.

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With regard to the next steps, a workshop was being held on 12 March to work through and agree the detail, such as where the living well workers would be located. It was envisaged they would be located within GP surgeries but there were also links to the Early Help Hubs. A loneliness and social isolation funding evaluation would be taking place on 2 March (North Norfolk) and 6 March (Norwich). These activities would link to the Social Prescribing funding. With regard to timescales, agreement had not yet been reached as to when the service would commence, however it was hoped that the loneliness and social isolation services would start as close to April as possible.

In response to questions, the Housing, Health and Partnerships Officer confirmed that Norfolk County Council were the commissioners of the service and, in Norwich and Broadland, Norfolk Community Advice Network would hold the funding.

The Deputy Chief Executive highlighted the role of the District Council in looking to provide an environment for all agencies to come together when dealing with clients to deliver a more coherent service.

39 COMMUNITY AT HEART - UPDATE

Members received the report of the Community Projects Officer giving an update on work undertaken to date. Much of her role was to coordinate all engagement activity and establish connections with communities

The big challenge would be in bringing together all elements of community engagement and integrating the range of initiatives being developed including community resilience, social prescribing, the emerging integrated employment and health service and community at heart.

40 FUTURE WORK PROGRAMME

- Community at Heart
- Broadland Resilience – future meeting
- Active Norfolk – Broadland Locality Plan – Update
- Public Health – Update
- Integrated Employment and Health Service
- Social Prescribing

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41 ANY OTHER BUSINESS

None raised.

42 DATE OF NEXT MEETING

18 June 2018

The meeting closed at 6:45pm

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BROADLAND HANDYPERSON+ SERVICE UPDATE

1 SUMMARY

1.1 The purpose of this report is to review how the Handyperson+ service is being used by Broadland residents and how it is meeting Broadland's objectives.

2 INTRODUCTION

2.1 Cabinet agreed to include Handyperson+ in the base budget from 2017-18. The remit of Handyperson+ was extended to include residents of any age if registered blind, in receipt of Incapacity Benefit and those with a health condition that means they are on Personal Independence Payment and Disability Living Allowance. Labour is free of charge for people who fulfil the qualifying criteria: in receipt of one of Attendance Allowance, Council Tax Reduction (not single person discount), Housing Benefit or Pension Credit (guaranteed or savings) payments. A modest hourly rate of £15 is charged to those not meeting the qualifying free criteria. The householder pays for or provides the materials needed for the job.

2.2 The cost of the Handyperson Service is approximately £40,000 per annum. This includes on costs of 29 percent. Demand for the Handyperson+ service continues to remain good. Self-funding income in 2017/18 was £4,653. This is an increase from £3,288 in 2016/17, which rose from £2,932 the previous year.

3 THE ISSUES REVIEWED

3.1 Preventative services such as those delivered by Handyperson+ are known to be cost effective by:

- Postponing entry into residential care by one year saves on average £29,000 per person
- Preventing a fall leading to a hip fracture saves £28,665 on average
- Housing adaptations reduce the costs of home care (saving £1,200 to £29,000 a year).

3.2 Although many of the financial benefits are savings to social care and health, there can be benefits to housing authorities including: improvements in living conditions, improved energy efficiency and the avoidance of major repairs through early intervention. Poor or unsuitable housing costs the NHS £1.4

billion per annum.[1] The Handyperson+ service is one of the services that is working towards Broadland's objective of ensuring older people can continue to live independently and supports our ambition to keep people safe and secure.

4 PERFORMANCE REVIEW

4.1 Basic jobs undertaken by the Handyperson+ service include:

- Small repairs
- Minor adaptations
- Home security improvements
- Personal safety checks
- Fire safety checks and improvements
- Energy efficiency checks
- Signposting and referrals.

4.2 From when Handyperson+ began in November 2014 until March 2018, the following services have been delivered:

- 345 falls prevention jobs to reduce risk of falls.
- 96 general repairs carried out between November 2014 and March 2015.
- 1,349 jobs to assist with living independently and help keep people in their own homes.
- The Handyperson+ service made direct referrals to the following services on behalf of residents: British Legion (8), Care & Repair / Warm & Well (33) and Age UK Norfolk (64).
- Age UK Norfolk and Care & Repair have supported 40+ Handyperson+ referrals to access Attendance Allowance.
- 382 'security works' jobs aimed at reducing risk of burglary. This makes a significant contribution to Broadland's key ambition to 'keep people safe and secure'.
- 349 'fire precaution' jobs aimed at reducing injury or death from a fire.

1 Nicol S. et al (2015) Briefing paper: *The cost of poor housing to the NHS* BRE Bracknell, HIS BRE Press.

- In 2016 the Handyperson+ Service supported an externally funded project specifically addressing fuel poverty to 80 households (funded from Community Action Norfolk to conduct energy efficiency checks). Reducing fuel poverty and reducing risk of excess winter deaths is a significant issue for Broadland with excess winter deaths for females ranking second worst in the Eastern region.

- Improved quality of life and wellbeing.

4.3 Broadland's service looks holistically at all aspects of the older person's life, which are affecting their wellbeing using a comprehensive form to assist in the assessment. This part of the service is highly valued by recipients, where needs are often highlighted which would not have otherwise come to the fore until a crisis point had been reached. The aim is to meet Broadland's long-term outcome of residents enjoying happy and fulfilled lives.

Data: 1.4.15 – 31.3.18	**1.4.15 – 31.3.16**	**1.4.16 – 31.3.17**	**1.4.17 – 31.3.18**
Number of households visited by handyperson	525	491	537
Number of Handyperson+ tasks completed	**873**	**685**	**668**
Advice / assessment / leaflets given	All households	All households	All households
Most common task carried out			
Falls Prevention	144	58	71
Security works	135	100	81
Assistance for living independently	403	373	395
Fire precautions	122	45	91
Direct Referral to British Legion	6	–	–
Direct Referral to Care and Repair / Warm & Well	31	6	2
Energy check sheet completed (new from June 16)		67	
Number of people referred to Age UK Norfolk	19	19	23
Number of households within the Norwich CCG Area	302	293	315
Number of households within the North Norfolk CCG Area	223	198	222

4.4 The majority of jobs were for assistance to live independently, prevent falls and security and fire prevention. The majority of customers are owner-occupiers, with a large number returning to use the service again. This repeat custom is another sign of the success of the Handyperson+ service.

4.5 Population estimates using ONS 2016 data predict the number of residents in Broadland aged 75+ will increase from 14,644 in 2016 to 25,105 by 2036. Within Broadland the prevalence of falls is expected to be high in areas such as Thorpe St Andrew, Sprowston, Wroxham, Rackheath, Acle, and parts of Blofield, Lingwood and Attlebridge.[2] Using these statistics, it may be expected that demand for falls prevention and assistance for living independently may rise within the increasingly ageing population of Broadland.

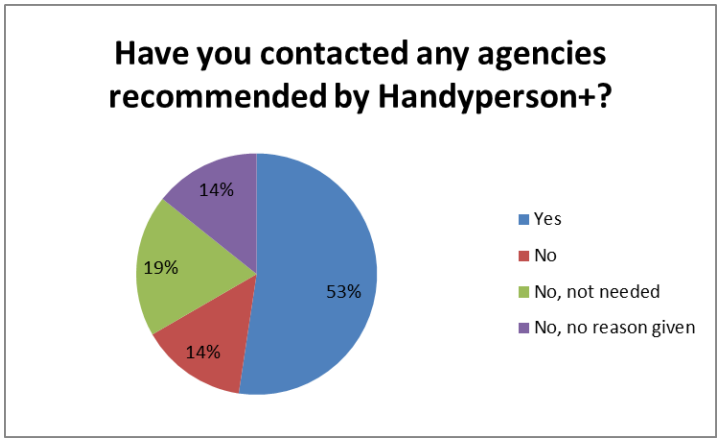
5 LOW LEVEL GRANTS

5.1 Since July 2017 49 Low Level Grants have been completed at a cost of £9,220 funded from the Ministry of Housing Communities and Local Government via the Better Care Fund. This was for work including installation of steps, ramps, rails and key safes by the Handyperson.

6 OUTCOME OF CUSTOMER SATISFACTION SAMPLING: 2017

6.1 In November 2017, three years into delivery of the service, a third round of dip sampling was carried out. This involved telephone calling 10 percent of householders who had used the Handyperson+ service within the past year. They were selected from 200 households most recently visited and the response rate was 100 percent.

6.2 **Question 1: Have you contacted any agencies recommended by the Handyperson+ service?**



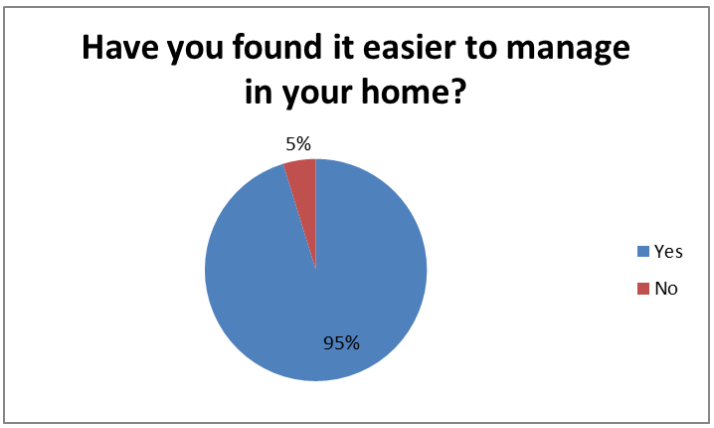
53 percent had contacted a service, which was recommended by Handyperson+. This is comparable to previous dip sampling in 2016 and 2015, which showed 55 percent contacted agencies recommended by the Handyperson. Of those who had not contacted anyone, 19 percent did not feel that they needed any additional support.

2 Public Health Information Team 'Accommodation for older people – current supply, current need and future need (DRAFT), Norfolk County Council, 2016

Of those contacted – what was the outcome?

- British Legion, Careline & Broadland District Council
- Independent Age - Tax advice, also Trusted Trader information
- Age UK about attendance allowance
- British Legion, Age UK attendance allowance
- Blofield Court House
- British Legion – Careline & Broadland District Council
- Looks at books for advice. Broadland District Council fitted wet room from original visit. Care alarm fitted.
- Broadland for advice from HIA Team
- Age UK about attendance allowance – on going
- Trusted Trader. I have used this service twice. Good to know about these services available
- Age UK has been in touch after your visit. Now in receipt of higher rate attendance allowance
- British Legion to change her existing Careline to theirs as it is much cheaper and does the same thing.
- Going to use their Poppy breaks service. Also uses Broadly Active.

6.3 **Question 2: Since the Handyperson+ visited have you found it easier to manage in your home?**



If a 'yes' response – what is easier?

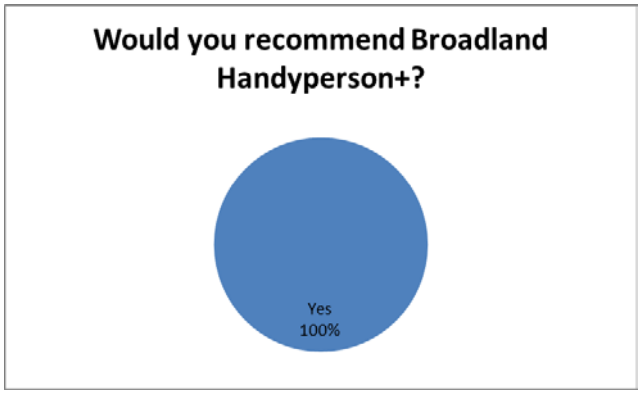
- 'I have smoke alarms, now feel safer'
- 'Grab rails, also wet room now fitted by Broadland on a DFG. From first visit signposted to this service.
- 'Knowledge – knowing that there is someone I can ring if I have a problem is a comfort.'
- 'Definitely – smoke alarms. Got everything I need.'
- 'Adjusted Computer desk.'
- 'New ramp fitted for scooter. Also back door collection arranged for bin – excellent.'
- 'Now don't have to climb ladders.'
- 'Grab rail. Plus the thought of having someone trusted I can call on.'
- 'Getting around, handrail up the stairs, plus sliding door for bathroom.'
- 'Wonderful thing to think of a back up available.'
- 'Always better. Don't need to get ladders. Chain on front door in use daily now.'
- 'Satisfied. Smoke alarm and chain helps me feel safer.'
- 'Shower room fitted, grab rails, plus I don't go up ladders.'
- 'Handrail and grab rails help a lot.'
- 'Stopping me going up ladders. Chain on front door.'
- 'I stopped going up ladders for gutters. Trusted and reliable service.'
- 'Stair Rail and grab rail is an aid because my cane gave way.'
- 'Really nice to know. Also I was happy with the trip advice indoors, removing rugs and leads.'
- 'Grab rail, handrail in sun lounge makes life easier. Could I have another one fitted?'
- 'Grab rails helpful.'

95 percent reported it was easier to manage in their homes following the Handyperson visit. A significant number of visits were to install grab rails and mobility aids. A recent survey by the Centre for Ageing Better identified 'good evidence that people can be put off installing adaptions until they reach a

point of crisis, in part because they do not wish to change or 'medicalise' their home.'[3] However, this does not appear to be the case in Broadland. The Handyperson+ service is installing mobility aids that should reduce falls before the point of crisis without any possible stigma associated with medical aids.

Whilst financial benefits can be difficult to quantify, the positive Return on Investment (ROI) of home interventions in preventing falls on stairs is 62p for every £1 and a payback period of less than eight months.[4] The Centre for Ageing Better highlighted that 'low-cost modifications can lead to a 26 percent reduction in falls that need medical treatment, saving £500 million each year to the NHS and social care services in UK.'

6.4 **Question 3: Would you recommend Broadland Handyperson+?**



100 percent of those using the service would recommend it to others. This repeats the results of previous dip sampling carried out in 2015 and 2016 and is evidence of the continuing value residents place on the service.

Comments received included:

- 'I have done already.'
- 'Of course definitely.'
- 'Already recommended to sister who has used service.'
- 'Definitely would.'
- 'Yes – absolutely.'

3 Centre for Ageing Better (November 2017), '*Room to improve. The role of home adaptions in improving later life.*
4 Centre for Ageing Better (November 2017), '*Room to improve. The role of home adaptions in improving later life.'*

- ‘Of course definitely.’
- ‘I have done twice. Both people have used service.’
- ‘Definitely, most helpful.’
- ‘Certainly.’
- ‘Definitely and have done.’
- ‘Already recommended.’
- ‘I have recommended to a neighbour.’
- ‘Yes I would.’
- ‘Yes we would.’
- ‘Yes definitely.’
- ‘I have done many times.’
- ‘Yes of course - spoken to several people as normally companies don't want to do small jobs.’
- ‘Definitely. I wish to commend Broadland for this really, really good service. I have one issue with street light now being switched off, find this unnerving now living on my own after my husband passed away.’
- ‘Well yes – probably.’
- ‘Yes and I have done.’
- ‘I do all the time.’

In addition to meeting Broadland District Council objectives, the value of a Handyperson+ service was also highlighted in a recent Government report, ‘Most older people do not plan to move and wish to stay in their current home as long as possible. Home Improvement Agencies (HIA) and handyperson services, undertaking small repairs, maintenance and adaptations, have a significant role to play in ensuring that the homes of those who ‘stay put’ are comfortable, healthy and safe.’ [5]

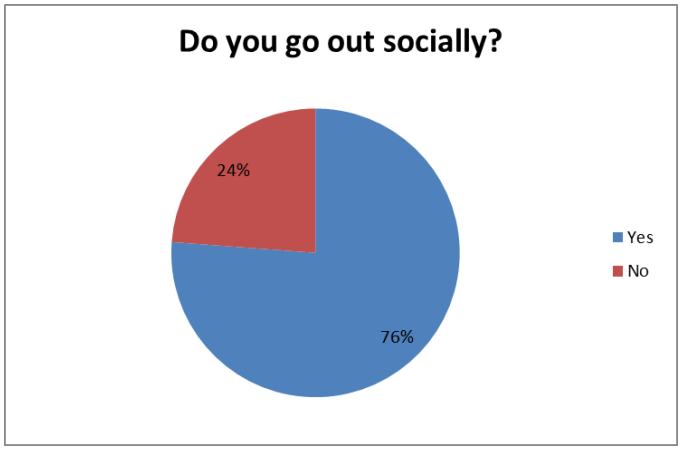
Adaptions and repairs work best when those affected are fully involved and the adaptations do not detract from the use of their home and help them to remain in their home for longer.

5 House of Commons Select Committee Paper ‘Housing for Older People’, Second Report of Session, 2017-19 HC370. 9 February 2018

Examining the potential for Handyperson+ to link with forthcoming Social Prescription/loneliness & social isolation initiatives:

As part of the dip sampling, a new question about social interaction was asked.

6.5 **Question 4: Do you go out socially?**



Feedback was that 76 percent of respondents went out socially, (not grocery shopping or visits to healthcare professionals)

Social activities included:

- Shopping, friends, dinner, outings
- Going out with friends
- Luncheon Club run by church, plus shopping
- Seeing family
- Keep fit classes, indoor & outdoor bowls, gardening
- Going to quilted mat classes
- Still going to work in my 80's
- Going to craft fairs
- Lounge lunch, Broadly Active, Diamond Centre, Taverham Day Centre, Deaf Café in Castle Meadow were just some of the places visited by one respondent

6.6 The respondents who did not go out were also asked 'What stops you going out?' The responses were recorded as follows:

- 'Never – only some shopping.'

- ‘Can't walk very far, I have visitors.’
- ‘Just out shopping with daughters – quite happy.’
- ‘Just go out for shopping.’
- ‘I’m a self-contained person. Happy on my own.’
- ‘Don't go out at all socially. Just library, surgery and shop.’

The responses demonstrate a wide variety of activities are being undertaken by those using the Handyperson+ service. The majority are active within their community.

7 WORKING WITH PARTNER AGENCIES

District Direct

7.1 District Direct was a six month pilot from September 2017 to March 2018, based at Norfolk & Norwich University Hospital (NNUH) aimed at reducing Delayed Transfers of Care (DTOC), by having District Council Housing Officers within the discharge hub to identify housing related barriers and reduce delays, help to prevent re-admission and support sustainable independent living at home.

7.2 Within the Broadland area, the Handyperson+ service has been used by District Direct on 10 occasions. Work carried out included installing key safes using Low Level Grant procedures and moving furniture to enable residents to move back into their homes safely.

GP Receptionist – Signposting Service

7.3 OneNorwich is an alliance of GP Practices in Norwich, including practices within Broadland who are training their Receptionists in ‘active signposting’. This is about helping patients to get the right help they need from the right person, the first time. Details of the Handyperson+ service has been sent to OneNorwich and there may be an increase in demand for its services from Sprowston, Thorpe St Andrew, Taverham, Hellesdon and Old Catton.

8 CONCLUSION

8.1 Research has shown that ageing well at home will be key to future health, housing and care. 80 percent of older people say that they want to stay living

in their current home[6]. Minor home adaptions are an effective and cost efficient way to prevent falls and injuries, whilst helping with every day activities and improving mental health.

8.2 Adaptations and repairs work best when those affected are fully involved and the adaptations do not detract from the use of their home, helping them to remain in their home for longer.

8.3 The Handyperson+ service is meeting the needs Broadland residents and enabling people to remain in their own homes for longer. The focus is on reducing the risk of falls and injuries, improving household security and helping to improve resident's health and wellbeing. The popularity and excellent feedback from users of the Handyperson+ service supports this. The dip sampling shows users also have a high-level social interaction and support.

8.4 Referral volume has been maintained and the service criteria has been extended. Additional need for Handyperson+ services may come from new services such as District Direct, GP active signposting and an increasingly ageing population within Broadland.

9 RECOMMENDATIONS

9.1 Encourage residents to come forward to use Handyperson+ services when they are most likely to benefit from them, i.e. before they have a fall. This could be linked to promotion of Energy Checks in autumn 2018 or via Broadland News.

9.2 Given the expected increase in ageing population across Broadland together with residents wish to stay in their own homes for as long as possible, demand for Handyperson+ services is likely to increase in the long term.

9.3 Future promotion may include extending links with new services, such as Social Prescribing, Loneliness and Social Isolation, frailty initiatives and GP signposting services, to identify patients at risk of falls in Broadland and who would benefit from a visit / assessment.

9.4 Currently the resource available, meets the demand on the Handyperson+. However if demand increases following the introduction of new services, further resources may have to be considered.

6 Lloyd.J. (2015), Older Owners Research on the lives, aspirations and housing outcomes of older homeowners in the UK.

10 RESOURCE IMPLICATIONS

10.1 The service is resourced from the base budget.

11 LEGAL IMPLICATIONS

11.1 There are no legal implications.

12 RISK IMPLICATIONS

12.1 This is a proven, popular service and there may be some risk to the Council's reputation if it were to cease.

Matthew Cross
Deputy Chief Executive

Background Papers

Centre for Ageing Better (November 2017), 'Room to improve. 'The role of home adaptions in improving later life.'

Public Health Information Team 'Accommodation for older people – current supply, current need and future need (DRAFT)', Norfolk County Council, 2016.

Nicol, S *et al* (2015) Briefing paper: 'The cost of poor housing to the NHS'. BRE Bracknell, HIS BRE Press.

House of Commons Select Committee Paper 'Housing for Older People', Second Report of Session, 2017-19 HC370. 9 February 2018

Lloyd, J (2015), 'Older Owners Research on the lives, aspirations and housing outcomes of older homeowners in the UK'.

For further information on this report call Sarah Oldfield on 01603 430121 or e-mail sarah.oldfield@broadland.gov.uk

HEALTH AND WELLBEING UPDATE

Portfolio Holders: Policy, Environmental Excellence, Communities & Housing and Economic Development
Wards Affected: All

1 SUMMARY

1.1 This report provides an update on activity over the last six months relating to increasing the levels of health and wellbeing of Broadland residents in line with the Council's stated ambition.

2 INTRODUCTION

2.1 In April 2018 Public Health England updated their Health Profile Deprivation Maps to include data for Indices of Multiple Deprivation (IMD) from 2015 (previously it was from 2010) and 2016 electoral ward boundaries. The update is available on page 2 at: http://fingertipsreports.phe.org.uk/health-profiles/2017/e07000144.pdf.

2.2 This showed no change to Broadland's overall position as above the England average for deprivation with 35 percent of our population in the least deprived category and no areas in the most deprived quartile. However there was a slight increase in deprivation in Foulsham, Guestwick and Wood Dalling parishes, together with a small area around Aylsham town centre. On a positive note, deprivation reduced in Halvergate parish. The 2018 Profile is due to be published in June 2018 and will be fully evaluated in the next Public Health Update.

2.3 The Social Mobility Commission published their 'State of the Nation' report on 28 November 2017. Their Social Mobility Index, used a range of 16 indicators for every major life stage, from early years through to working lives, to map England's social mobility hotspots and coldspots. This ranked all 324 local authorities in England in terms of the social mobility prospects for someone from a disadvantaged background.

2.4 The report found the worst performing areas for social mobility were not city areas, but remote rural and coastal areas. Broadland was ranked 93rd from the top, the highest scoring local authority in Norfolk. Five local authorities in Norfolk were in the bottom 65 local authorities. Details of the full report are available at https://www.gov.uk/government/news/social-mobility-in-great-britain-fifth-state-of-the-nation-report

2.5 Data from the 'State of the Nation' report will be used to inform future improvement projects.

2.6 Indicators where Broadland performed above average nationally were

	Indicator	**Score**
Schools	% of children eligible for FSM* achieving at least the expected level in reading, writing and maths at the end of Key Stage 2. (*FSM: Free School Meals)	Best 10%
Youth	% of young people eligible for FSM that are not in education, employment or training (positive destination) after completing KS4	Best 20%
	Average points score per entry for young people eligible for FSM at age 15 taking A-level or equivalent qualifications	Best 10%
	% of young people eligible for FSM at age 15 entering higher education at a selective university (most selective third by UCAS tariff scores) by the age of 19	Best 25%
Adult	% of families with children who own their home	Best 10%

2.7 However not all indicators gave a positive result and some of the worst performing areas in Broadland were:

	Indicator	**Score**
Schools	Average attainment 8 score for pupils eligible for Free School Meals (FSM)	Worst 10%
Youth	% of young people eligible for FSM at age 15 entering higher education by the age of 19	Worst 20%
Adult	Median weekly salary (£) of employees who live in the local area, all employees (FT and PT)	Worst 20%

2.8 The Housing Affordability ratio supplied by ONS (2014 average house prices / total household weekly income) is high across many Broadland parishes, particularly in the north of the District. This reflects the lower wages and higher property prices.

2.9 Across Broadland it is estimated there are 251 households in the most financially vulnerable decile. These households might benefit from access to advice, learning and jobs, which may prevent further deterioration in finances and potential need for services. Whilst this is the lowest number across Norfolk, these households are most concentrated in Thorpe St. Andrew, Acle and Aylsham areas. Norwich had the highest number (12,603).

3 THE NORFOLK CONTEXT

Health and Wellbeing Board (HWB)

3.1 The Health & Wellbeing Board (HWB) is developing its joint Health & Wellbeing Strategy for 2018-22. A workshop in December 2017 focused on three areas:

- The links with Sustainability & Transformation Plan (STP) and HWB
- District Councils and a Place Based approach
- Wider issues around building healthy, resilient communities.

3.2 Some key workshops outcomes were:

- Creating a single integrated, sustainable system to improve the health and wellbeing of Norfolk and Waveney. Integrating ways of working, collaborating on delivering person centred care.
- Taking a collective view as a system – working as system leaders to engage workforce, elected members and the public.
- Sustainability of the health, care and wellbeing system – focus on prevention, early intervention and wider determinants of health and wellbeing.
- Place based approach – build health and wellbeing systems around people and communities.

3.3 To take this forward, there needs to be strategic alignment between the HWB, the Joint Health & Wellbeing Strategy and the STP. A draft strategic framework has been drawn from development work to date.

3.4 The framework will be a core element of the Board's new Strategy and is a shared commitment by all partners.

3.5 An early draft of the Joint Health & Wellbeing Strategy has received comments from Broadland District Council and we will continue to contribute to the Strategy over forthcoming months.

Better Care Fund (BCF)

3.6 A report on Integration of Norfolk Adult Social Services and a review of the Better Care Fund 2017/18 was presented to the May Health & Wellbeing Board.

3.7 This set out the high level position of Adult Social Services on future integration and reported on the Better Care Fund for 2017/18, including work on social prescribing. Full details of the report are available at: http://norfolkcc.cmis.uk.com/norfolkcc/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/1483/Committee/39/Default.aspx

3.8 Broadland has received an allocation from the improved Better Care Fund (iBCF) of £766,000 to deliver Disabled Facilities grants and adjacent services as detailed in the IHAT (Integrated Housing Adaption Team) Locality plan submitted to the BCF.

Sustainability and Transformation Plan

3.9 In February an Expression of Interest was submitted by Norfolk & Waveney STP to become an Integrated Care System (ICS).

3.10 NHS England will work with the STP over the next six to twelve months so they can be fully prepared to become an ICS. The STP will work closely with local health and wellbeing boards to develop plans for closer working around the ICS in coming months.

Social Prescribing Update

3.11 Funding of £950,000 per year for two years from the Adult Social Care improved Better Care Fund and Public Health has been allocated to support county-wide Social Prescription initiatives.

3.12 £100,000 has been allocated for a programme/service manager and training. There are no further details of this as yet.

3.13 £850,000 is to be divided across the five CCG locality boundaries to develop local Social Prescription models. Norwich CCG will receive £240,000 and North Norfolk CCG will receive £144,500 annually for two years.

3.14 Norwich CCG funds will be held by Norwich Community Advice Network to provide 2.5FTE Living Well Workers and a FTE Team Manager who will be employed by voluntary sector partners.

3.15 The Living Well Workers will be trained to NCAN Level 1 or Level 2 Advice Qualification standard and have around 4-5 contacts per client, with a motivational interviewing approach. A degree of flexibility will be required as some clients may respond to advice; some may need further support and help to access other organisations.

3.16 A small scale support fund of around £20,000, managed by the Team Manager will be allocated across the three areas in Norwich CCG (East, Central and West). £10,000 of this will be allocated to Central Norwich as

this is larger area. The remainder of the £240,000 (approximately £65,000) will be held for capacity building funding

3.17 North Norfolk CCG agreed that funding should be split along patient population, which would give a 40 percent allocation (£57,800) to Broadland area. This will be used to provide the Living Well Workers, same as Norwich CCG area to ensure parity of service across the District.

3.18 It is expected there will be 1.5 FTE Living Well Workers employed within the Broadland area of the North Norfolk CCG boundaries, with a small amount remaining to support Voluntary Community Sector (VCS) capacity.

3.19 It has been agreed to broadly maintain financial and geographical boundaries and not merge either Living Well Workers or VCS capacity pots. However a degree of flexibility across the areas to meet supply, need and demand will be required, particularly around the borders of the two CCG areas.

3.20 It is expected to have Living Well Workers in place by July.

3.21 North Norfolk District Council will use the remaining North Norfolk CCG funds to directly employ Living Well Workers in their hub.

District Direct

3.22 District Direct was a six-month pilot from September 2017 to March 2018, based at Norfolk & Norwich University Hospital (NNUH) aimed at reducing Delayed Transfers of Care, by having District Council Housing Officers within the discharge hub to identify housing related barriers and reduce delays, help to prevent re-admission and support sustainable independent living at home.

3.23 One member of staff from the Housing Options Team was based in the Discharge Hub with officers from four other districts providing resource for the remaining four days. One hundred and eighty four patients were managed via District Direct and the review identified a 36 percent reduction in average length of stay from 11 days to 7 days. Based on NNUH performance management information this saved 725 bed days over the 29 week pilot (a saving of £181,250 based on £250 cost per bed day

3.24 Over the course of a year, this could lead to a saving of £325,000 for a five day service or £465,250 for a seven day service. The most significant savings were made in Geriatric Medicine, and General Surgery.

3.25 The current pilot ended on 31 March 2018 and an interim generic email address has been provided by South Norfolk District Council to co-ordinate any subsequent enquiries the Discharge Hub staff may have. Options for future funding have been proposed and are being considered by Adult Social Care, Clinical Commissioning Groups and the District Councils.

Community FICS

3.26 The Integrated Case Management has been rebranded as “Community FICS” (Fully Integrated Care and Support) across Norwich CCG. This new model is being piloted in the City 2 area, covering GP surgeries in Old Catton, Sprowston and Thorpe St. Andrew.

3.27 A key aim is to free up capacity within general practice. This new model includes a standard weekly Multi-Disciplinary Team (MDT) meeting involving a wider group of organisations from across all sectors, including representation from Broadland District Council. The expectation is that most referrals will be managed at this level and will include people who have historically been difficult to engage and or hard to help.

3.28 There will be a monthly Enhanced MDT to review the small number of complex cases who require GP input and a more in-depth multi-agency discussion to support robust and effective care and prevention planning

3.29 The new Community FICS began on 26 April 2018. The pilot will run in City 2 for several months and will be evaluated before being rolled out across the remaining Norwich CCG neighbourhoods.

Healthy Norwich

3.30 Broadland District Council continues to work in partnership with Norwich City Council, Norfolk Public Health and Norwich CCG through Healthy Norwich to improve health outcomes particularly in relation to four priorities for 2017/18:

- Smoking cessation and prevention
- Promoting healthy weight and lifestyles – including diabetes prevention
- Affordable warmth
- Cancer – prevention and early detection

3.31 A 2018/19 project plan has been submitted to the Norwich CCG programme board for approval and will then be shared with Broadland District Council.

Smoking cessation and prevention

3.32 **Smoke-free side-lines:** This Norfolk wide project involves Healthy Norwich, District Councils, Smokefree Norfolk and the Norfolk Football Association to encourage adults to refrain from smoking at youth football games. Norfolk now has 28 football clubs signed up to the scheme. The UEA are undertaking a formal evaluation of the project to assess the impact on

behaviour change. Taverham and Hungate Rovers have joined South Walsham, Old Catton Juniors, Horsford Juniors and Aylsham Juniors taking part. There has been significant positive engagement on twitter, at: #smokefreesidelines. Aylsham Juniors Youth Football club was part of a feature on Radio Norfolk https://www.bbc.co.uk/programmes/p062ml2p.

3.33 Promoting Healthy Weight and Lifestyles – including diabetes prevention has a number of work streams within this area.

3.34 **The Daily Mile:** Engagement with primary schools continues to prove a challenge across Norfolk. Research from Stirling University into the link between the Daily Mile and a child's cognitive function and their academic performance is still awaiting publication. The Daily Mile is gaining national momentum, with an advert on ITV. Healthy Norwich has engaged GP practices to ask them to write to their local primary schools to support engagement in this initiative.

3.35 **Breastfeeding Friendly (BFF) GP Surgeries:** This project is still proving successful with 85 percent of Norwich CCG practices engaged in the scheme. Practice level outcome data on the impact on feeding rates has begun to be collated.

3.36 **Sugarsmart**: Healthy Norwich initially developed a Sugarsmart campaign with Dieticians from NNUH. The Mancroft Advice Project (MAP) was commissioned to develop the Sugarsmart project to secondary schools during 2018/19. Learning from this will inform a 'sugarsmart offer' to all Norwich secondary schools including Thorpe St Andrew High School, Sprowston, Taverham and Hellesdon High Schools.

3.37 **National Diabetes Prevention Programme:** This has been successfully rolled out across Norwich CCG, with practices carrying out retrospective database trawls to invite their patients to attend the programme. 1350 Norwich CCG patients have been referred into the scheme since its launch in January 2017.

3.38 **Cancer Prevention and Early Detection.** A significant amount of work has taken place since this project began in October 2017. The activities include launching a C the Signs cancer diagnosis app with GP Practices in Norwich CCG area, working closely with Cancer Research UK and Macmillan to develop a variety of training courses for nursing and medical staff and development of practice level data packs.

Public Health

3.39 The Local Public Health Offer (LPHO) has provided £17,142 annually for three years from 2016/17 until 2018/19.

3.40 Local Public Health Offer monies in 2016/17 and 2017/18 funded a six-month pilot of the Home Improvement Agency (HIA) intervention at Drayton Surgery. This pilot is currently being evaluated by Norfolk Public Health using an independent assessor, together with data from North Norfolk CCG Integrated Care Coordinators (ICC). Results from the evaluation will be shared once available.

3.41 The HIA intervention was extended to a Norwich CCG Practice, East Norwich Medical Partnership who have practices in Sprowston and Thorpe St Andrew. However there was limited response due to the different nature of their ICC criteria and the HIA Officer was relocated to accept an additional 10 referrals from Aylsham ICC. These referrals will also be included in the evaluation being carried out by Public Health.

3.42 Options for Local Public Health Offer funds for 2018/19 are currently being considered. These include looking at improving resilience in young people. Suitable models are currently being examined; including using the PATHs (Promoting Alternative Thinking Strategies) in young people aged 5-11.

3.43 Along with the Health Profiles, data from the 'State of the Nation' report will be used to inform future Public Health initiatives.

Joint Working with Partner Agencies

3.44 A joint Broadland, North Norfolk District Council, North Norfolk CCG and Public Health workshop took place on 8th December 2017. This aimed to raise awareness of the different work of the organisations and identify gaps in services and looked at partnership working opportunities.

3.45 Outcomes from the workshop included a discussion between Broadland District Council and North Norfolk CCG about the benefits of taking Broadly Active to their CCG Executive Board. A workshop was arranged as part of Social Prescribing planning for practitioners.

3.46 A Public Health Workshop for Members was held on 1 February 2018. This was attended by 11 members and facilitated by the Director of Public Health and Public Health Officers.

3.47 The Workshop aimed to enable members to champion health improvements in their communities. It covered many aspects of Public Health policy, including the national context, with a focus on prevention and health improvement, including measures to improve health and reduce inequalities.

3.48 The role of District Councils and Public Health in tackling inequalities and preventing ill health was also covered. Members gave a very positive response to the workshop with feedback scores of 8/10 and above.

4 BROADLAND DISTRICT COUNCIL SPECIFIC ACTIVITY

4.1 There is a range of activity delivered by Broadland District Council meeting the ambition to increase levels of health and wellbeing. Updates on some key pieces of work are summarised below.

Handyperson+

4.2 A review of Handyperson+ activity for years 2015 to 2018 is being undertaken in May 2018. This will include dip sampling from November 2017 and the results will be presented to the Wellbeing Panel on 18 June 2018.

Broadly Active

4.3 Broadly Active has received 462 referrals across Broadland and Norwich in 2017/18. Final figures are not yet available due to active clients referred before the end of the financial year not yet completing the scheme, but indications are completion rates will remain above 30 percent. A full evaluation of 2017/18 will be presented in the next update. In November 2017, an evaluation sample of Broadly Active clients who had completed the scheme one year ago or more produced the following results:

- Those referred for being overweight had lost an average of 11.5% of their starting bodyweight after a minimum of one year (suggesting weight loss is being sustained)
- After a minimum of one year's completion, patients reported an average of 85 minutes more physical activity per week than when they began.
- 73 percent reported being more physically active than when they completed the scheme (9 percent remained the same). On average the clients were partaking in 53 more minute's physical activity than when they completed the scheme.
- 61 percent felt healthier than when they completed (23 percent the same).
- 58 percent visited their GP less than when they completed (37 percent the same).
- 89% were doing activities in independent, community based provision.

4.4 Most of the clients sampled referred to the social support that Broadly Active (and then their follow-on activity groups) provided as being a key element of their adherence. These statistics clearly demonstrate the long term benefit (and cost effectiveness) of the scheme.

4.5 Norwich CCG have agreed to continue to fund Broadly Active for 2018/19 with South and North Norfolk CCGs currently considering an option to provide funding at their executive committees.

4.6 Active Norfolk's Physical Activity Pathway pilot project has operated in two surgeries in Broadland this year. It has seen a limited number of patients but has shown early indications that direct referral is the best method for engaging patients in health change behaviours therefore recommending Broadly Active. The scheme has continued to deliver with Weight Intervention Norwich (WIN), a Tier three weight management scheme commissioned by Norwich CCG. Early analysis has suggested patients engaging with both Win and Broadly Active/Why Weight are losing a greater percentage of bodyweight than by attending WIN alone.

Why Weight

4.7 Three full Why Weight courses have been delivered in the second half of the year along with two four week Christmas focused groups. 36 residents attended with a 78 percent completion rate and average weight loss of 2.75 percent of their starting bodyweight. Two further follow up sessions have been held with 35 percent of completed members surveyed continuing to lose weight. 83 percent of those measured remain below their original bodyweight.

4.8 Two Why Weight sessions have been delivered for Broadland staff.

Parkrun

4.9 Despite the poor winter weather, the average attendance at Broadland's three parkruns rose to 740 per week in the early stages of 2018 and there has been a noticeable increase in 'new' runners. Blickling parkrun saw a huge new record turnout on New Year's Day, from 277 to 508. The increase in popularity has also seen a knock on effect to running clubs, races and events. In February 2018, The Stroke Association held a 'Resolution Run' that was supported and promoted by Catton parkrun participants and volunteers. Over £20,000 was raised at this event.

4.10 There are several stories of regular users crediting their local parkrun with getting them exercising for the first time or providing support through a period of poor mental health. Case studies are being prepared to illustrate this.

Community Activity

4.11 Various community groups continue to flourish throughout Broadland with support from the Council. The Acle Cardiac Support group has continued to meet, although the numbers are still quite low it does have a small core group of regular attendees. Recently, a Cardio Pharmacologist attended as a guest

speaker and gave an excellent presentation about the various heart related medications, which all members of the group found extremely useful.

4.12 The Co-ordinator has continued to provide activity sessions to Dementia Café groups including one at Roxley Hall, Thorpe St Andrew. In addition to the Dementia Cafes the Co-ordinator has continued attending sessions at the Stroke Survivors group at Thorpe St Andrew and has introduced other activities which have been provided and organised by community representatives from one of the other established Community Groups (from Frettenham Village Hall). In effect, this has provided an opportunity for an existing active community group organiser to support other groups with activities which they provide independently – a good example of one community group supporting another one.

Marriott's Way 10k

4.13 The 2018 Marriott's Way 10k will take place on 7 October 2018. This year will be the 10th anniversary of the event with the number of places increased to 500 and a range of celebratory ideas are being considered. The successful juniors fun run will accompany the race and a 'Couch to 10k' Beginners Course will take place in the Reepham/Aylsham area of the district in the approach to the race.

5 SAFEGUARDING

5.1 Broadland continues to be an active partner in the District Council Safeguarding Group which looks at both adults and children. The Chair is now held by Norwich City Council.

Safeguarding Workshop

5.2 An internal training workshop for Broadland District Council Managers has been arranged for Wednesday 13 June 2018. This will include updates on Safeguarding and dealing with immediate risks.

Harmful Sexual Behaviour (HSB)

5.3 The HSB audit report is currently with the Norfolk Safeguarding Children's Board for final approval before being published. A copy will be sent to Broadland District Council and will also be available on the Norfolk Safeguarding Children Board website: www.norfolklscb.org

6 RESOURCE IMPLICATIONS

6.1 There are no resource implications arising from this report.

7 LEGAL IMPLICATIONS

7.1 There are no legal implications arising from this report. The statutory responsibilities within the Health and Social Care Act 2012 lie with the upper tier authority.

8 CONCLUSION

8.1 Broadland residents continue to enjoy relatively good levels of health and wellbeing but the Council has an ambition to increase these further and will continue to support key areas of concern, which include obesity, dementia and mental health, particularly for young people.

8.2 Broadland District Council continues to work closely with partner organisations such as Public Health and the Clinical Commissioning Groups to build on existing strong relationships, particularly around new developments in healthcare. We continue to engage with Members and an update will be presented to the next Wellbeing Panel in June. Council officers are continuously briefing the relevant Portfolio Holders on current proposals.

9 RECOMMENDATION

9.1 The Wellbeing Panel is asked to note the content of this Health and Wellbeing Update and feedback any further questions to the Deputy Chief Executive.

Matthew Cross
Deputy Chief Executive

Background Papers

None

For further information on this report call Sarah Oldfield on 01603 430121 or e-mail sarah.oldfield@broadland.gov.uk