

## **CABINET MEMBERS REPORT TO COUNCIL**

**July 2025**

### **COUNCILLOR LIZ WITHINGTON - CABINET MEMBER FOR COMMUNITY, LEISURE AND OUTREACH SERVICES**

For the period up to 31<sup>st</sup> July 2025

#### **1 Progress on Portfolio Matters.**

##### **Community Outreach Portfolio Holder report: activity and achievements in July 2025**



##### **Homelessness Prevention**

During July, the team received **49** referrals to support residents threatened by, at risk of, or experiencing homelessness.

These came from several sources, including the NNDC Housing Options team, the North Norfolk Foodbank, DWP, Community groups and settings and self-referrals.

##### **Homelessness Prevention Case Studies**

Mr D was referred to the Outreach Officers by the Housing Team. He had been living in the annexe of his now deceased parents' property for 13 years, but this property is now due to be sold. Mr D has neurological issues and needs support and encouragement to start packing his possessions and to locate and secure a private tenancy. The Outreach officer has supported Mr D with accompanying him to estate agents and flat viewings. A tenancy has now been agreed, which has given relief to Mr D and his family who are selling the property.

The Outreach Officer will continue to support Mr D to ensure the final stages of his move are successful.

Mr and Mrs E have rented their property for over 40 years, however the landlord has taken the decision to sell up. Community Outreach officers have been supporting the couple by completing benefit checks and ensuring their income is maximised and have assisted them with signing up with local estate agents to support finding and securing a new tenancy. Support will continue until a tenancy is secured.

Miss F has been served a section 21 notice by her landlord and is due to be

evicted in August. After reaching out on social media, Community Outreach Officers have been working with Miss F to find an alternative tenancy by reviewing private rentals with her, referring her to debt management via Citizens Advice, and provided support with Universal Credit for income maximisation.

Miss F has a diagnosis of PTSD and Bi-Polar disorder and thus finds managing the situation very stressful. The Outreach Officers have been able to offer gentle encouragement and support to move Miss F through the process, connecting her to a support network and improving her ability to manage moving forward with any future tenancy, thus reducing further homelessness risk.

### **New Connections**

This month, Outreach Officers visited supported housing settings in the Cromer area to learn more about what they offer, and to explain what the Outreach officers can do to support. On these occasions, the officer informed the settings of the food voucher grant, and as a result, £100 worth of vouchers across the tenants was received at each setting.

Visits to supported housing settings in Sheringham are planned for the coming weeks.

Officers also contacted Leeway, Domestic Violence and Abuse services. Officers explained the service available and provided signposting to several grants. Leeway officers were pleased to understand how the Outreach service could be used to support vulnerable families after fleeing Domestic Abuse.

A 'help yourself' library has been set up in one of the local temporary accommodation locations to support residents with daily needs.

### **Falls and Frailty**

Data from the NNUH continues to be received on a weekly basis.

In July, we processed **47** referrals for North Norfolk residents. **2** were duplicates and **10** referrals went on to decline the service. **85** calls were made during July.

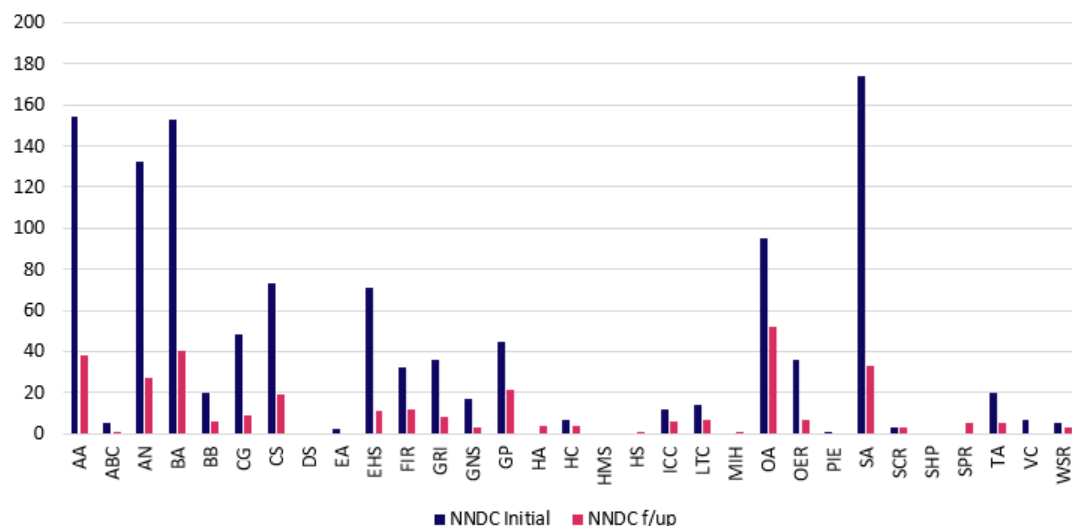
This support empowers residents to:

- Stay safer in their homes for longer
- Become stronger and more active
- Connect with others
- Improve their income
- Improve their wellbeing

The strategic development group for this stream, which is made up of

colleagues from the Norfolk and Waveney Integrated Care Board, North Norfolk and Broadland District Councils, Norfolk Community Health and Care, NHS, Norwich County Council and Active Norfolk, is meeting regularly to discuss development and future proofing, as well as alignment with the upcoming Promoting Independence stream, which is led by Norfolk County Council, and will commence work within the Community Outreach team at NNDC during the coming weeks.

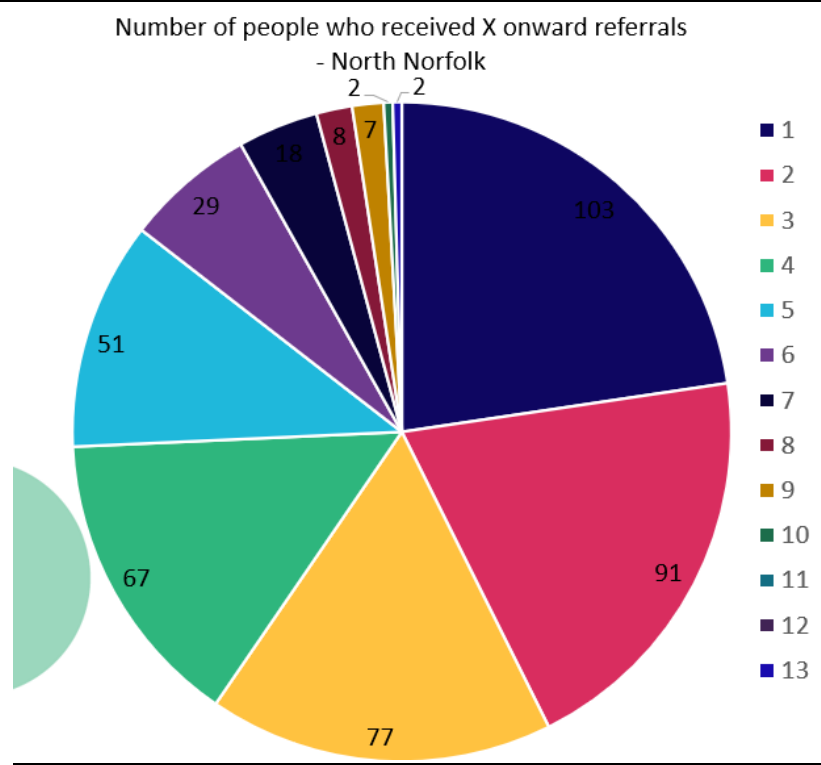
*The following bar graphs show the range of referrals and actions made during the initial and follow up contacts with the Frailty pathway officer. These vary from over the phone advice, the sending of leaflets and information by letter, signposting, and completion of referrals into the service, as some examples.*



AA – Aids and Adaptations  
 ABC – Assisted Bin Collection  
 AN – Active Now Falls and Frailty Pathway Referral  
 BA – Benefit Advice  
 BB – Blue Badge Application  
 CG – Community Group Signposting  
 CS – Carer Support  
 DS – Debt Support  
 EA – Everyone Active Referral  
 EHS – Energy and Heating Support  
 FIR – Financial Inclusion Referral (North Norfolk Only)  
 GRI – Grant Funding Identified  
 GNS – Good Neighbour Scheme or Community Support Referral  
 GP – Signposted back to GP  
 HA – Housing Application (Or Suitability Assessment Referral)

HC – Hearing Concerns Referral/Signposting  
 HMS – Handyman Service (Broadland and South Norfolk Only)  
 HS – Hoarding Support  
 ICC – Escalated to ICC for MDT review or intervention  
 LTC – Long Term Condition Support  
 MIH – Make it Happen Funding Used  
 OA – Other Action  
 OER – Other Exercise Referral  
 PIE – Purchase of Items or Equipment  
 SA – Safety Advice  
 SCR – Social Care Referral  
 SHP – Referred back to Social Housing Provider  
 SPR – Social Prescribing Referral  
 TA – Transport Advice  
 VC – Visual Concerns Referral/Signposting  
 WSR – Wellbeing Service Referral

*The following chart shows the number of people who have received one or more referrals from their contact with the pathway. For example, 77 customers have received 3 referrals or actions, 51 customers have received 5 referrals or actions, and 2 customers have received 13 referrals or actions, because of their contact with the pathway.*



### **Falls & Frailty Case Study**

Mr C was referred to the service following a fall in his bathroom, which resulted in a wrist injury. He had experienced three strokes in the past, resulting in decreased mobility and some cognitive delays. His home already had some adaptations in place that had been installed for his late wife, and he had walking-aids and an in-the-home care alarm in place (although he did not always wear this).

Following the initial call, the officer referred Mr C to Active Now for three sessions of 1-2-1 exercise in his home. She also provided Mr C with information on Community Transport, Singing for Breathing, Emergency plans, A mobile care alarm system for use outside and guidance on how to apply for Attendance Allowance and a Blue Badge. Mr C's daughter was able to support these applications.

At the follow up appointment, Mr C and his daughter reported real positive progress. He had completed his initial sessions with Active Now and continued his exercises between sessions. He had found these sessions so beneficial he had gone on to privately book further sessions. An emergency plan is now in place, and Mr C is now wearing his care alarm more, which provides peace of mind to both Mr C and his daughter. An application has been made for Attendance Allowance, and we await the outcome.

Mr C and his daughter were very complimentary of the service and very happy with the progress Mr C has made, both physically and in his confidence and quality of life.

## **Healthier Towns**

### **Progress and new connections**

#### **Sheringham:**

Successful connections have been made between Healthier Sheringham and the local GP surgery, creating a positive relationship for collaborative work.

A wellbeing project, "Roots to Rise" is in development, and has received encouraging interest from several key agencies, including Mind and MensCraft.

Talking Therapies are working with Everyone Active to provide regular drop-in sessions at the Reef Leisure Centre, both during daytime hours and in the early evening, which have received positive feedback.

Sheringham Golf Club are due to launch their Dementia Golf Project in September 2025.

#### **North Walsham:**

Agreement has now been met with Birchwood Surgery to continue to develop the Healthier model for North Walsham. The surgery will continue to host and manage the website and social media, whilst the new Town Council will facilitate the physical meetings. The first meeting is due to take place in October.

Talking Therapies are now offering drop-in sessions at North Walsham Library and at Victory Leisure Centre.

#### **Other developments:**

The Healthier Minds group's next meeting is scheduled for September 2025 and has 20+ groups due to attend.

Meetings are scheduled for discussion around the development of Healthier Fakenham and Stalham, in the coming weeks.

## **PositiviTea**

### ***Safe Summer PositiviTea***

*Fakenham Market on 24<sup>th</sup> July 2025*

Stand holders included: Barclays Bank, Trading Standards, the local Beat Manager, Norfolk & Suffolk Victim Care, Change Grow Live, Together for Mental Wellbeing and Papyrus.

### **Conversations on the day (examples)**

- Person A spoke to us after becoming homeless the previous night, seeking guidance.
- Person B had an enquiry about Council Tax – it turns out they had received a letter purporting to be from another council where their son/daughter used to live saying they owed money. They didn't feel it could be true as their son/daughter no longer lives there, but they weren't too sure.
- Person C talked about two bereavements they have been through in quick succession and were offered support and signposting.
- Person D was already known to the service and was actively working with an Outreach Officer. They suffered with phone anxiety but was able to have a conversation with a Housing Officer in person, with the support from their Outreach Officer.
- The local Beat Manager was also able to share her local knowledge with CGL and Together for Mental Wellbeing. They will use this new information to target their support and offer involvement in their survey to shape the future of drug and alcohol support services in Norfolk.
- Barclays chatted with person E, who had shared with them that they have met someone online. This person they had been chatting to was who had asked them to buy them some vouchers. Barclays talked to the person about this and were able to sensitively say that this person may not be who they appear to be.

**“There's huge value in just being here. Even if people don't come over to talk to us, they look, see our banners, read 'Norfolk & Suffolk Victim Care' and you never know when they might need that information.”**

*Norfolk and Suffolk Victim Care on attending PositiviTea events*

### **Poppyland Radio**

1. Recorded 7 July: [Together for Mental Wellbeing](#) – Hear about the long history of this service user led charity and hear from Jamie about a peer research project which will shape the future of Norfolk's drug and alcohol support services
2. Recorded 14 July: [Gro Health](#) – Will Lawson-Brown explains about

the healthy lifestyle service offered for free to children aged 4-18yrs with a BMI in the 91% centile or above in Norfolk

3. Recorded 21 July: [Exploitation Awareness Campaign](#) – Suzannah Armstrong Cobb discusses what exploitation is, how to recognize the signs and what to do if you think you or someone you know is being exploited

### **North Norfolk Health and Wellbeing Partnership**

#### **2<sup>nd</sup> July 2025: meeting of the Health Inequalities Working Group**

The group met to discuss the partnership priorities as suggested by the Health and Inequalities Toolkit. It was agreed that:

- *Digital exclusion shouldn't just be about the NHS app, but also wider determinants of health such as work, social connections, etc.*
- *Platforms must be accessible as well as supporting people with digital access*
- *Mental health must be the golden thread which is present across all of the work we do*
- *Incorporate infant feeding, physical activity and smoking cessation into a "healthy lifestyle/living" priority*
- *Propose adoption of the Healthier Model approach for actioning the priorities*

#### **16<sup>th</sup> July 2025: Meeting of the North Norfolk Health & Wellbeing Partnership**

It was agreed to adopt the priorities highlighted by the Health Inequalities Toolkit and recommended by the Health Inequalities Working Group at their meeting on 2 July.

Community Action Norfolk presented the results from their survey and workshops regarding the state of the voluntary sector.

Partners were encouraged to get involved in North Norfolk District Council's Homelessness Review.

It was agreed that the existing working groups would close with a view to starting new working groups and/or task and finish groups aligned with the Health Inequalities Toolkit priorities.

## **2      Forthcoming Activities and Developments.**

Healthier North Norfolk development and linking this with local communities and the North Norfolk Health and Wellbeing Partnership (NNHWP)

<b>3      Meetings attended</b>
Dementia Information Pack Working Group x2 North Norfolk Dementia Working Group Healthy Minds – Focus Group NNHWP x3 NNHWP- Health inequalities Working Group Creative Foundations Fund Mind Connecting with Nature Members briefing on housing Volunteers wellbeing programme