Norfolk Health & Wellbeing Board

Date: **Wednesday 06 March 2024**
Time: **09:30 - 12:30**
Venue: **Council Chamber, County Hall, Martineau Lane, Norwich**

Representing	Membership	Substitute
Borough Council of King's Lynn & West Norfolk	Cllr Jo Rust	Cllr Bal Anota
Breckland District Council	Cllr Tristan Ashby	Cllr Sam Chapman-Allen
Broadland District Council	Cllr Natasha Harpley	Cllr Eleanor Laming
Cambridgeshire Community Services NHS Trust	Anna Gill	Steve Bush
East Coast Community Healthcare CIC	Ian Hutchison	John Niland
East of England Ambulance Trust	David Allen	Nicolas Smith
East Suffolk Council	Cllr David Beavan	Cllr Jan Candy
Great Yarmouth Borough Council	Cllr Emma Flaxman-Taylor	Cllr Donna Hammond
Healthwatch Norfolk	Patrick Peal	Alex Stewart
James Paget University Hospital NHS Trust	Mark Friend	Joanne Segasby
Norfolk Care Association	Angela Steggles	Jack White
Norfolk Community Health & Care NHS Trust	Lynda Thomas	Stephen Collman
Norfolk Constabulary	ACC Nick Davison	Supt Chris Balmer
Norfolk County Council, Cabinet member for Adult Social Services	Cllr Alison Thomas	Cllr Shelagh Gurney
Norfolk County Council, Cabinet member for Childrens Services and Education	Cllr Penny Carpenter	Cllr Karen Vincent
Norfolk County Council, Cabinet member for Public Health and Wellbeing, Leader (nominee)	Cllr Bill Borrett	
Norfolk County Council, Interim Executive Director Adult Social Services	Debbie Bartlett	Nicholas Clinch
Norfolk County Council, Executive Director Children's Services	Sara Tough	Sarah Jones
Norfolk County Council, Director of Public Health	Stuart Lines	Suzanne Meredith
Norfolk & Norwich University Hospital NHS Trust	Tom Spink	Nicholas Hulme
Norfolk & Suffolk NHS Foundation Trust	Zoe Billingham	Tricia Fuller
NHS Norfolk and Waveney Integrated Care Board (Chair)	Rt Hon Patricia Hewitt	
NHS Norfolk and Waveney Integrated Care Board (Chief Executive)	Tracey Bleakley	Andrew Palmer
North Norfolk District Council	Cllr Liz Withington	
Norwich City Council	Cllr Claire Kidman	
Place Board Chair Great Yarmouth & Waveney	Jonathan Barber	
Place Board Chair Norwich	Tracy Williams	
Place Board Chair North Norfolk	Dr James Gair	
Place Board Chair West	Carly West-Burnham	Oliver Judges
Place Board Chair South Norfolk	Dr Ge Yu	
Police and Crime Commissioner	Giles Orpen-Smellie	Dr Gavin Thompson
Queen Elizabeth Hospital NHS Trust	Chris Lawrence	Alice Webster
South Norfolk District Council	Cllr Kim Carsok	Cllr Andy Evans
Voluntary Sector Representative	Emma Ratzer	Pete Boczko
Voluntary Sector Representative	Dan Mobbs	
Voluntary Sector Representative	Alan Hopley	Daniel Childerhouse
Additional members (non-voting)		
Norfolk Health Overview and Scrutiny Committee (Chair)	Cllr Fran Whymark	
Suffolk County Council, Cabinet Member for Adult Care	Cllr Beccy Hopensperger	
Suffolk County Council Representative	Bernadette Lawrence	
University of East Anglia Representative	Prof Nicole Horwood	

For further details and general enquiries about this Agenda please contact the Committee Officer: Maisie Coldman on 01603 638001 or email: committees@norfolk.gov.uk

Norfolk and Waveney Integrated Care Partnership

Date: **Wednesday 06 March 2024**
Time: **on rise of the Health and Wellbeing Board**
Venue: **Council Chamber, County Hall, Martineau Lane, Norwich**

Representing
Borough Council of King's Lynn & West Norfolk
Breckland District Council
Broadland District Council
Cambridgeshire Community Services NHS Trust
Chair of Voluntary Sector Assembly
East Coast Community Healthcare CIC
East of England Ambulance Trust
East Suffolk Council
Great Yarmouth Borough Council
Healthwatch
James Paget University Hospital NHS Trust
Norfolk Care Association
Norfolk Community Health & Care NHS Trust
Norfolk Constabulary
Norfolk County Council, Cabinet member for Adult Social Care, Public Health and Prevention
Norfolk County Council, Cabinet member for Childrens Services and Education
Norfolk County Council, Director of Public Health
Norfolk County Council, Executive Director Adult Social Services
Norfolk County Council, Executive Director Children's Services
Norfolk County Council, Leader (nominee)
Norfolk & Norwich University Hospital NHS Trust
Norfolk & Suffolk NHS Foundation Trust
Norfolk & Waveney Integrated Care Board (Chair)
Norfolk & Waveney Integrated Care Board (Chief Executive)
North Norfolk District Council
Norwich City Council
Police and Crime Commissioner
Place Board Chair Great Yarmouth & Waveney
Place Board Chair Norwich
Place Board Chair North Norfolk
Place Board Chair South Norfolk
Place Board Chair West
Primary Care Representatives TBC
Queen Elizabeth Hospital NHS Trust
South Norfolk District Council
Suffolk County Council, Cabinet Member for Adult Care
Suffolk County Council, Executive Director of People Services
Voluntary Sector Representative (1)
Voluntary Sector Representative (2)

For further details and general enquiries about this Agenda please contact the Committee Officer:
Maisie Coldman on 01603 638001 or email: committees@norfolk.gov.uk

Norfolk Health & Wellbeing Board and Integrated Care Partnership

Wednesday 06 March 2024
Agenda
Time: 09:30 - 12:30

08:45 - 09:25: *There will be a networking opportunity available prior to the start of the meeting in the Edwards Room next to the Council Chamber at County Hall, Norfolk County Council.*

1.	Apologies	Committee Officer	
2.	Chair's opening remarks	Chair	
	Norfolk Health and Wellbeing Board		
3.	HWB Minutes	Chair	(Page 5)
4.	Actions arising	Chair	
5.	Declarations of interests	Chair	
6.	Public Questions (How to submit a question: HWB) Deadline for questions: **9am, Friday 01 March 2024**	Chair	
7.	Urgent arising matters	Chair	
8.	Director of Public Health Annual Report (HWB)	Stuart Lines / Diane Steiner / Ciceley Scarborough	(Page 13)
9.	Better Care Fund Quarterly reports (HWB)	Debbie Bartlett / Edward Frazer / Karin Byrant	(Page 73)
10.	NHS, Norfolk and Waveney Integrated Care Board Annual Report (HWB)	Tracey Bleakley / Andrew Palmer	(Page 92)
	Norfolk and Waveney Integrated Care Partnership		
1.	ICP Minutes	Chair	(Page 5)
2.	Actions arising	Chair	
3.	Declarations of Interest	Chair	
4.	Public Questions (How to submit a question: ICP) Deadline for questions: **9am, Friday 01 March 2024**	Chair	
5.	Learning Disabilities Plan (ICP) [Presentation]	Debbie Bartlett / Lorna Bright / Tracey Bleakley	(Page 97)
6.	Norfolk and Waveney Health Inequalities Strategic Framework for Action (ICP) [Presentation]	Tracey Bleakley / Mark Burgis / Tracy Williams	(Page 202)
7.	Committing to the Hewitt Review recommendations (ICP) [Presentation]	Cllr Kim Carsok / Jamie Sutterby	(Page 239)
8.	Cancer, Public Health key indicator for Norfolk and Waveney (ICP) [Presentation]	Stuart Lines / Suzanne Meredith	(Page 254)
9.	Driving Integration through system wide training opportunities (ICP) [Presentation]	Debbie Bartlett / Paul Wardle Tracey Bleakley / Sharon Crowle	(Page 268)
10.	Norfolk & Waveney NHS System Capital Distribution for 2024/2025 (ICP)	Debbie Bartlett / Tracey Bleakley	(Page 279)
11.	Norfolk and Waveney Integrated Care System Suicide Prevention Strategy 2023-2028 (ICP)	Stuart Lines	(Page 284)

Reports to Note

12. Driving Integration through Digital, Data and Technology (ICP). (Page 295)
13. UEA Health Data interpretation reports on impact of Covid-19 on healthcare services and health outcomes in Norfolk (ICP). (Page 313)

Further information about the Health and Wellbeing Board can be found on Norfolk County Councils website at: About the Health and Wellbeing Board

Information regarding the Integrated Care Partnership can be found on the Integrated Care System website at: About the Integrated Care Partnership

Health and Wellbeing Board and Integrated Care Partnership
Minutes of the meeting held on 09 November 2023 at
in the Council Chamber, County Hall.

Present:	**Representing:**
Cllr Jo Rust	Borough Council of King's Lynn & West Norfolk
Anna Gill	Cambridgeshire Community Services NHS Trust
Mark Little	East of England Ambulance Trust
Cllr David Beavan	East Suffolk Council
Cllr Emma Flaxman-Taylor	Great Yarmouth Borough Council
Patrick Peal	Healthwatch Norfolk
Carolyn Fowler	Norfolk Community Health & Care NHS Trust
ACC Nick Davison	Norfolk Constabulary
Cllr Bill Borrett	Norfolk County Council, Cabinet member for Public Health and Wellbeing, Leader (nominee)
Cllr Fran Whymark	Norfolk County Council, Cabinet member for Childrens Services and Education
Suzanne Meredith	Norfolk County Council, Director of Public Health
Debbie Bartlett	Norfolk County Council, Interim Executive Director Adult Social Services
Sara Tough **(arrived 09:53)**	Norfolk County Council, Executive Director Children's Services
Professor Nancy Fontaine	Norfolk & Norwich University Hospital NHS Trust
Caroline Donovan	Norfolk & Suffolk NHS Foundation Trust
Rt Hon Patricia Hewitt	Norfolk and Waveney Health and Care Partnership (Chair) and NHS Norfolk and Waveney Integrated Care Board (Chair)
Mark Burgis	NHS Norfolk and Waveney Integrated Care Board (Chief Executive)
Cllr Cate Oliver **(arrived 09:51)**	Norwich City Council
Jonathan Barber	Place Board Chair (Great Yarmouth)
Tracy Williams	Norfolk and Waveney Integrated Care Board NHS
Cllr Kim Carsok **(arrived 10:01)**	South Norfolk District Council
Alan Hopley	Voluntary Sector Representative

Officers Present:	
Stephanie Butcher	Policy Manager Health and Wellbeing Board
Rachael Grant	Policy Manager Public Health
Stephanie Guy	Advanced Public Health Officer
Maisie Coldman	Committee Officer

Speakers:	
Diane Steiner	Deputy Director of Public Health, Norfolk County Council
Emma Willey	Associate Director of Mental Health, Adult Mental Health Strateg Commissioning team
Geoff Connell	Director of Digital Services, Norfolk County Council
Ian Riley	Director of Digital and Data, NHS Norfolk and Waveney Integrated Care Board
Andrew O'Connell	Senior LeDeR Nurse, Quality in Care Team Norfolk and Waveney Integrate Care board
Christopher Butwright	Assistant Director Prevention and Policy, Public Health, Norfolk County Counci

Norfolk Health and Wellbeing Board (HWB)

1. Apologies

1.1 Apologies were received from Carly West Burnham, Cllr Alison Thomas, Cllr Penny Carpenter (substituted by Cllr Fran Whymark), Dan Mobbs, Joanne Segasby, Cllr Hopfensperger, Angela Steggles, Nick Hulme (substituted by Professor Nancy Fontaine), Tracey Bleakly (substituted by Mark Burgis), Stuart Lines (substituted by Suzanne Meredith), Lynda Thomas (substituted by Carolyn Fowler) and David Allen (substituted by Mark Little).

2. Chair's Opening Remarks

2.1 The Chair welcomed Caroline Donovan, CEO of Norfolk and Suffolk Foundation Trust and Cllr David Beavan from East Suffolk council to their first meeting since becoming members.

3. Minutes

3.1 The HWB minutes of the meeting held on 27 September 2023 were agreed as an accurate record and signed by the Chair.

4. Actions arising

4.1 None.

5. Declarations of Interests

5.1 None.

6. Public Questions

6.1 None.

7. Urgent Matters Arising

7.1 None.

8. Combating Drugs and Alcohol Partnerships Annual Report

8.1 The Combating Drugs and Alcohol Partnerships Annual Report was introduced to the HWB by Diane Steiner, Deputy Director of Public Health, Norfolk County Council who provided the board with an update of the progress on the Drug and Alcohol Strategy. The Norfolk Drugs and Alcohol Partnership (NDAP) was up and running, this strategic group was chaired by the Director of Public Health. The partnership's four priorities were noted in item 8, appendix 1. Additionally, an action plan, with support from the Office of Health Improvement and Disparities (OHID) was being developed to increase numbers in treatment and improve prison continuity of care.

8.2 Emma Wiley, Associate Director of Mental Health, Adult Mental Health Strategic Commissioning team spoke to the report. They highlighted that one of the priorities was Dual Diagnosis (DD) and the development of pathways that support engagement, treatment, and recovery for people experiencing both mental health and substance misuse issues. The HWB heard that discussions with service users had been happening and that there was agreement between stakeholders that action relating to this priority needed to occur to ensure that patients have a joined-up approach to treatment and recovery.

8.3 Further work on this was expected to take place at a workshop in January 2024.

The following points and comments were discussed:

- Members noted the importance of the work around, and inclusion of, dual diagnosis. The development of joint and integrated pathways was felt to be a positive step to begin improving the disconnection between mental health and substance misuse support and treatment.

- Data was being collected to enrich understanding of the issues, what support was already available, and what was needed. This information would be used to inform the development of services and pathways.

- Caroline Donovan (CEO of Norfolk and Suffolk Foundation Trust) asked what the current operating hours were for drug and alcohol support services. This information would be shared with the member once the information had been confirmed.

- Work was being completed on the alcohol pathways and once it had been reviewed and

refreshed, it would be fed back into the pathway.

- Rt Hon Patricia Hewitt highlighted that the work on substance misuse and abuse was an example of effective cross-government joined-up working that was facilitating integration across the ICS to tackle these issues.

The HWB **agreed** to:

a) **Endorse** the workplan of NDAP and acknowledge the work of the Suffolk Combating Drugs Partnership in relation to the Waveney part of our ICS.

b) **Encourage** partner organisations to ensure relevant staff take part in the NDAP joint training programme once this has been agreed. This will be staff that may be working with individuals or families that are experiencing substance misuse issues in the course of their day-to-day work.

c) **Ensure** partner organisations participate in the Local Drug Information System (LDIS) by sharing intelligence relating to drugs in circulation with CGL and disseminating patient safety alerts relating to drugs within their organisations. For those organisations not already signed up, take advantage of distribution and training on the administration of Naloxone by CGL. *Naloxone is a medicine which can reverse opiate overdose.

d) **Support** their organisations to identify drug and alcohol users in their care and support them to engage with drug and alcohol treatment to reduce risk.

e) **Endorse** their organisations and contracted providers finding ways to collect and share appropriate pseudonymised data on non-fatal overdoses and administrations of Naloxone in order to track the impact of opioids, alert the system to emerging trends and target potential supply lines.

Meeting concluded 09:54.

Norfolk and Waveney Integrated Care Partnership (ICP)

1. Minutes

1.1 The minutes of the Norfolk and Waveney Integrated Care Partnership (ICP) meeting held on 27 September 2023 were agreed as an accurate record and signed by the Chair.

2. Actions arising

2.1 None.

3. Declarations of Interest

3.1 None.

4. Public Questions

4.1 None.

5. Driving Integration Through Digital, Data and Technology

5.1 Debbie Bartlett, Executive Director of Adult Social Care, introduced the Driving Integration Through Digital, Data and Technology report. The report provided information on the digital roadmap for further integration and highlighted the opportunities available.

5.2 Geoff Connell, Director of Digital Services, Norfolk County Council, and Ian Riley, Director of Digital

and Data, NHS Norfolk and Waveney Integrated Care Board, presented the annexed presentation (Item 5, Appendix A). They highlighted that there were differences in digital maturity across the system and that work was being undertaken to bring the system to the same standard. The Strategic Roadmap of ICS level Digital Initiatives was outlined to the partnership and the projects that were due to be implemented over the next few years were explained. This included the Shared Care Record (SCR) where the beginning phases were now live and multiple partners had access to real-time information from across the system. The Population Health Management programme was explained and the benefits of drawing on data to aid new proactive models of care were highlighted. The work being completed in West Norfolk around Digital Inclusion had exceeded its initial goal of supporting 1000 residents. Additionally, there had been a pilot within Adult Social Care where AI was used to support proactive intervention by extracting information from case notes to identify people who may be at risk of a fall. Those identified as being at risk can then receive preventative action. Tests show that the model was correct up to 70% of the time.

5.2 The following points and comments were discussed:

- Alan Hopley (Voluntary Sector Representative) shared the difficulties encountered due to the lack of data sharing with the voluntary sector; highlighting that the service user often has to share their story twice, once to the voluntary sector and then again to statutory bodies. In response, the partnership heard that the work around Shared Care Records (SCR) was being completed in phases and that the next phase would include the voluntary sector having some level of access. The details of what this might look like need to be explored and co-designed with partners, in particular those voluntary organisations that have contracts with statutory bodies. Ian Riley, Director of Digital and Data, NHS Norfolk and Waveney Integrated Care Board, to link in with Alan Hopley to further this discussion.

- The Digital Inclusion Programme included tech skills and upskilling for staff, this was felt to be important in ensuring that staff felt confident navigating new technology and models of working. Training and learning were being implemented in a targeted way that sought to enrich staff knowledge in areas identified as having gaps. This learning would be shared with others.

- It was generally felt that the SCR would transform the way that the system works together and would be able to offer more directed and personalised intervention. There would be more confidence that people who require support are not falling through the gaps.

- The partnership heard of the work being carried out in Hunstanton and Kings Lynn. The Tech Skills for Life project supports the population with digital skills and inclusion. Some of this support would be helping the population to access the NHS app and attend virtual appointments. The trial had yielded positive results and it was felt that there was a business case to potentially expand this work across other areas of the county.

- The ICB carries out a programme of works to help local practices modernise their space and processes and to encourage uptake of the NHS app.

- Rt Hon Patricia Hewitt shared that up to 10,000 careers in Norfolk and Waveney were using a mobile and desktop software called Birdie to record care notes and wondered if there was an opportunity to learn from this software.

- Legislation has not caught up to the advancements of technology and thus, it was felt the additional steps and workarounds that have to be taken, needed to be acknowledged.

- Regarding the ambulance service, it was confirmed that each part of the East of England has a separate SCR system. Work was happening nationally to collect data from all the systems because currently, data was not able to be collected from each of the systems.

- There was an overarching framework for this work and an Integrated Care System (ICS) wide group. There was national guidance on what was required for health-related data sharing. This would be shared.

- The Chair of the ICP suggested that this item come to all future meetings as a standing item so that the partnership can be aware of the developments and dialogue on the SCR can begin ahead of integration.

5.3 The ICP **agreed** to:

a) The principle that all System Leaders commit to the idea of data sharing.

b) Support the use of new joined up systems such as the Shared Care Record System and the Data Hub, as they become available in partnership organisations, to deliver the maximum value from these enabling technologies.

c) Direct the ICS Digital leadership to report back to the board in 2024/25 with a progress update on the ICS Digital Roadmap delivery.

d) Direct the ICS Digital leadership to return to the ICP board with more detailed analysis of the benefits expected and / or achieved from individual projects on the roadmap as required.

6. Taking action to address Health Inequalities in Norfolk and Waveney

6.1 Mark Burgis, Executive Director Patient and Communities and Senior Responsible Officer for Health Inequalities, Norfolk and Waveney ICB, introduced the report that sets out the ambition to develop a Strategic Framework for Action that outlines steps to address health inequalities. It was highlighted that the development of a Strategic Framework for Action would be building on existing work that was happening and was not looking to start from scratch. It was felt that the system had a good understanding of health inequalities but was less sure about what the system was doing to address them. The partnership received the annexed presentation (item 6, Appendix A) which outlined the four themes that engagement would focus on and also the strategy design principles.

6.2 The following points and comments were discussed:

- The partnership supported the work that was being carried out and highlighted that it needed to be sustained and focused.

- It was questioned how the current resources could be better utilised and orientated towards addressing health inequalities and that a dedicated work stream to explore this could be beneficial.

- Caroline Donovan (CEO of Norfolk and Suffolk Foundation Trust) noted the gap in life expectancy for people with mental health illnesses and people with learning disabilities and asked if the strategy would look to address this. In response, it was confirmed that this was core to the strategy and that engagement with all partners across the community was important to highlight gaps. There is knowledge of the areas and specific groups of the population where focus work needs to be applied.

- Anna Gill (Cambridgeshire Community Services NHS Trust) raised the point that a long-term strategy would need to accommodate emerging plus groups and challenges.

- The Executive Director for Children Services wondered whether the work being done to tackle inequalities could work alongside the existing frameworks as part of Flourish.

- The Chair summarised the conversation, highlighting that a lot of the answers were known and that the struggle was how the system could turn pilots' initiatives into sustained projects

6.3 The ICP **agreed** to:

a) **Endorse** the proposed design principles for developing the Strategic Framework for Action.

b) **Support** the programme of 'Health Inequalities Conversations' with stakeholders.

c) **Agree** to receive and consider a draft of the Strategic Framework for Action in March2024, with a view to endorsing the framework and agreeing to support its implementation.

7. Mental Health: Public Health outcomes in the Integrated Care System

7.1 Suzanne Meredith, Deputy Director of Public Health, Norfolk County Council, introduced the report and presented the annexed presentation (item 7, Appendix A) to the partnership that provided a summary of Mental Health and Wellbeing outcomes.

7.2 The following points and comments were discussed:

- ACC Nick Davison asked if the evidence of the mental health outcomes in Norfolk and Waveney was being shared and highlighted to the politicians who decide the budget. In response, the partnership heard that this was a challenge to the system and that a key reason for the public health reports was to make the system aware of the challenges. It was not the direct responsibility of the system to decide the budget. The member for the Borough Council of Kings Lynn and West Norfolk added that the Health and Wellbeing partnerships have no wider influence on how resources are used within mental health services and that they are only able to facilitate projects for specific demographics.

- The mental health challenges, and their scale, that careers face was raised and the need to support these individuals was highlighted.

- It was confirmed that there was a similar exploration to the slide on Autism on learning disabilities and that was published on the Joint Strategic Needs Assessment. The data on mental health outcomes for people with learning disabilities was not held by Public Health and this could be accessed through the trust and ICB.

- Suicide rates are monitored, and a group has been established to understand and work towards addressing the rates.

- Rt Hon Patricia Hewitt highlighted that deaths recorded as suicides were a small subset of deaths that are related to mental health and questioned if the data on suicides could be potentially misleading.

- It was raised that the way that numbers are spoken about was important and that using percentages to translate numbers may not be the most effective way of sharing information. It was suggested that using numbers when communicating rather than percentages could be more effective in ensuring that the information was interpreted accurately.

- Cllr Kim Carsok (South Norfolk District Council) asked if there was / could be data that indicated whether prevention projects were working.

- Debbie Bartlett (Interim Executive Director of Adult Social Services) raised the value that could be added through having a conversation about what it would look like to prioritise mental health prevention.

- One of the priorities for the system was Children and Young People. The Executive Director for Children Services shared that there were a significant amount of Children and Young People who were experiencing challenges, diagnosable or not. There had been a significant increase in SEN assessments, between 2020 and the present day this had increased by 136% with Social and Emotional mental health being a rising category. They shared that collaborative work was being carried out across the system and that funding had been received from the ICB to invest in support for Children and Young People.

Cllr David Beavan left the meeting at 11:34

7.3 The ICP **agreed** to:

Note the data and information relating to Mental Health for people living in Norfolk and Waveney for use in their strategic and operational planning and note there is additional information contained within the Norfolk Joint Strategic Needs Assessment (JSNA).

8. LeDeR Annual Report 2022/2023

8.1 Mark Burgis, Executive Director Patient and Communities and Senior Responsible Officer for Health Inequalities, Norfolk and Waveney ICB, introduced the LeDeR annual report (item 8, appendix A). Andrew O'Connell, Senior LeDeR Nurse, Quality in Care Team Norfolk and Waveney Integrated Care Board, provided the partnership with an overview of the report, the reasons for it, and key highlights.

Caroline Donovan left the meeting at 11:40

8.2 The following points and comments were discussed:

- The need for a service to support the long term and palliative care of adults with learning disabilities was acknowledged. The services provided through EACH to support children and young people with learning disabilities were referenced to suggest the type of support that adults also required. The workforce issues to support this was mentioned.

- Carolyn Fowler (Norfolk Community Health & Care NHS Trust) highlighted that there was a limited workforce that was suitably trained to support and provide specific treatment for people with learning disabilities. They shared that there was no course to upskill staff knowledge. In response, the committee heard that there was a plan to improve workforce planning to improve skill and confidence.

8.3 The ICP **agreed to:**

- **Approve** the recommendations from the LeDeR annual report and system learning.

9. Public Health Strategic Plan

9.1 Suzanne Meredith, Deputy Director of Public Health, Norfolk County Council, introduced the report on the Public Health Strategic Plan.

9.2 Chris Butwright, Assistant Director Prevention and Policy, Public Health, Norfolk County Council provided the partnership with the annexed presentation (item 9, appendix A) that offered an overview of the plan, its vision, mission and ambition. The intention was to focus on prevention, particularly in the context of children & young people, adults, and older people.

Professor Nancy Fontaine left the meeting at 12:01

9.3 The following points and comments were discussed:

- The Chair highlighted that public health should provide the foundation for the creation of tools to manage challenges across different areas of Norfolk and Waveney. It was important the population was influenced to help themselves, and also the people that they care about.

9.4 The ICP **agreed** to:

a) **Endorse** the Public Health Strategic Plan.

b) **Promote** the Public Health Strategic Plan within organisations and consider what resources can be provided to support prevention interventions.

10. Department for Education Families First for Children Pathfinder Update

10.1 Sara Tough, Executive Director of Children Services, Norfolk County Council, provided the partnership

with an update on the Education Families First for Children pathfinder work as part of the children's reform agenda. Norfolk was hoping to be successful in bidding to be a Pathfinder area and would be taking the lead on two regional Pathfinders.

10.2 The following points and comments were discussed:

- The Chair noted that this was an exciting opportunity if the bid was successful. He also took the opportunity to congratulate Sara Tough who was recently presented with an honorary doctorate from the University of East Anglia and City College Norwich.

- It was confirmed that the East Region has made two submissions, fostering, recruitment, and retention and regional care co-operatives, and Norfolk would be the lead authority if the bid was successful.

- The work of the children service's team, and leadership, was praised.

10.3 The ICP **agreed** to:

Endorse the submission by NCC on behalf of the local Safeguarding Partners to become a FFC Pathfinder area.

Meeting concluded at 12:11.

Bill Borrett, Chairman,
Health and Wellbeing Board

Norfolk Health and Wellbeing Board

Item No: 8

Report title: Director of Public Health Annual Report for Norfolk 2023: Smoking, tobacco control and vaping

Date of meeting: 06 March 2024

Sponsor (HWB member): Stuart Lines, Director of Public Health, Norfolk County Council

Reason for the Report

Norfolk's vision is for our residents and communities to no longer be affected by the harm caused by tobacco. The Director of Public Health's Annual Report for 2023 highlights why we must refocus our efforts towards reducing the number of people smoking in Norfolk and our ambition to achieve a smokefree county. The report also serves as a reminder on the use of e-cigarettes which can be a useful tool for quitting smoking but are not recommended for those who do not smoke already.

Report summary

The Director of Public Health's Annual Report for 2023 (see Appendix A) explores the key figures and trends related to smoking and vaping in Norfolk, highlighting that smoking remains the single largest cause of preventable deaths and one of the leading contributors of health inequalities. Case studies highlight work that is already underway to protect Norfolk residents from the harms caused by tobacco and to make Norfolk smokefree.

The report shows how national policy on smoking and vaping has developed over the past 60 years and the local plans and strategies in place to reduce rates of smoking, to ensure effective tobacco control, and to control long term use and take up of vaping in Norfolk. It demonstrated the wider impacts of smoking on Norfolk, including the cost of smoking to individuals, communities and services, are described in the report, and opportunities for improvement and the benefits that reduced smoking rates would generate for Norfolk are discussed. The report draws attention to the plans and intentions from system partners in 2024 to intensify their efforts to tackle smoking and vaping and includes actions that can be taken by Norfolk organisations and residents to enable Norfolk to become smokefree.

Recommendations

The HWB is asked to:

a) Approve the publication of the Director of Public Health's Annual Report 2023 on the Joint Strategic Needs Assessment (JSNA) website.
b) Support the recommended actions for individuals and organisations as set out in the Director of Public Health's Annual Report 2023.
c) Share the Director of Public Health's Annual Report 2023 with relevant partners.

1. Background

1.1 The Director of Public Health has a statutory duty to produce an independent annual report on the health of the local population and the Council has a duty to publish the report. Previous reports have included the impacts of Covid-19 in Norfolk (2020-2021) and how health varies in Norfolk (2022). These reports are accessible on the JNSA website.

1.2 This year's Director of Public Health's Annual Report 2023 focuses on smoking, vaping and tobacco control in Norfolk, and the work already underway to help protect our residents from the harms caused by smoking tobacco.

2. Director of Public Health Annual Report for Norfolk 2023: Smoking, tobacco control and vaping

2.1 The Director of Public Health's Annual Report for 2023 (see Appendix 1) explores the key figures and trends related to smoking and vaping in Norfolk, below demonstrates some of the Key findings of the report.

2.2 Smoking, while decreasing over time, still causes too much harm and is a key cause of health inequalities in Norfolk. The good news is that there are steps we can all take to reduce the harm that smoking causes.

2.3 Smoking is addictive and can be difficult to stop, but quitting smoking is one of the best things smokers can do to improve their health. Quitting is easier and more effective with support – free help to quit is available and increasing.

2.4 Vaping is significantly less harmful than smoking and can be a useful tool to help smokers to quit. However, the advice is: if you don't smoke, don't vape.

2.5 Organisations across Norfolk have prioritised smoking reduction and tobacco control and are working together to reduce smoking related harm to local residents. There are great opportunities for further action.

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

Name: Diane Steiner Tel: 01603 638417 Email: diane.steiner@norfolk.gov.uk

Director of Public Health annual report 2023

Smoking, tobacco control and vaping

Norfolk County Council
Public Health

Contents

Contents

Foreword

Bill Borrett
Cabinet Member for
Public Health and Wellbeing

I am delighted to introduce the Director of Public Health's Annual Report. This year the report focuses on smoking and vaping in Norfolk.

Smoking remains one of the biggest contributors to preventable ill health and health inequalities. It kills an estimated 1,240 people in Norfolk every year and accounts for nearly 6,000 years of life lost annually.

Three in four smokers wish they had never started, and more than half would like to quit.[1] Quitting smoking is quite simply one of the best and simplest things anyone can do to improve their health. The benefits start almost immediately and last a lifetime. We know just how hard it can be to quit, which is why we offer as much support as possible.

E-cigarettes can be a useful tool for those trying to quit smoking – experts advise that vaping is less harmful than smoking.[2] However, it's important to stress that vaping is not recommended for people who don't already smoke and should not be promoted to children and young people.

This report highlights many positive examples of local initiatives, and I would like to thank everyone who is working hard to help reduce the harm caused by tobacco and nicotine in Norfolk.

[1] **Public Health England Better Health – Stoptober 2021: Opinium online survey summary**

[2] Nicotine vaping in England: 2022 evidence update summary – **GOV.UK (www.gov.uk)**

Introduction

Stuart Lines
Director of Public Health

I am very pleased to present my first independent annual report as the Director of Public Health for Norfolk. This year's report is focussed on smoking, vaping and tobacco control. Smoking remains the single largest cause of preventable deaths and one of the largest contributors to health inequalities.

Smoking impacts on many facets of an individual's life. As well as dying earlier than non-smokers, smokers also suffer from poorer health. Many of the conditions caused by smoking are long term illnesses such as heart disease, stroke, lung cancer and respiratory disease. Breathing in second-hand smoke also has harmful impacts on health for babies, children and adults.

In Norfolk around 44,900 children live in households with adults who smoke. As well as affecting the child's health, this increases their chances of becoming smokers themselves – two thirds of adult smokers will have started smoking before they have reached the age of 18. The costs associated with smoking are substantial and estimated in Norfolk to be in the region of £872 million each year, including costs of health care, social care, lost productivity, and house fires.

It can take 30 or more attempts before a smoker successfully quits, although getting support can help significantly. This indicates the addictive nature of smoking and the grip that tobacco has on people.

For all these reasons, tobacco remains a key public health priority, and some excellent case studies from across Norfolk highlight some of the ways we're working together on this issue. These include not only helping people to quit smoking, but also what's called 'tobacco control' – protecting people from harm such as clamping down on underage or illegal sales to help prevent take up in the first place.

Over the past decades a great deal has already been done to reduce the rates and acceptability of smoking. In 1974, nearly half the country's population were smokers – this is down to less than 1 in 7 people today.

So why focus on smoking when so much has already been achieved?

Smoking rates are still too high in Norfolk if we are to achieve a smokefree generation by 2030. In addition, smoking rates vary within our local population. Some communities and groups which are already more deprived or marginalised have higher smoking levels. This increases inequalities in health and leads to poorer health for some.

This report therefore aims to refocus our efforts on reducing the number of people smoking in Norfolk and on our ambition for a smokefree county where our residents and communities are no longer affected by the harm caused by tobacco. It also serves as a reminder on the use of e-cigarettes: these can be a useful tool for quitting smoking but are not recommended for anyone who doesn't already smoke, including children. In this report, we look at the data on vaping and some of the key messages on the use of e-cigarettes.

Finally, if you'd like to delve further into the detail, you can find more information in our tobacco needs assessment – you'll find the link at the end of the report.

Some definitions

The NHS explains e-cigarettes and vaping as follows:[3]

An e-cigarette is a device that allows you to inhale nicotine in a vapour rather than smoke. E-cigarettes do not burn tobacco and do not produce tar or carbon monoxide, two of the most damaging elements in tobacco smoke.

They work by heating a liquid (called an e-liquid) that typically contains nicotine, propylene glycol, vegetable glycerine, and flavourings.

Using an e-cigarette is known as vaping.

E-cigarettes can also be referred to as vapes. Smoking refers to using tobacco cigarettes, pipes, cigars etc.

Prevalence means the proportion of a group or population that has a particular condition or engages in a specific behaviour – for example, the number of people who smoke or vape at a particular time.

Deprivation is where people don't have the conditions that are usually considered necessary for a pleasant life, for example sufficient income, employment, education, health, living environments, and low levels of crime and few barriers to housing and services.

The black line with a bar at each end in some of the charts in this report shows what's called a **95% confidence interval**. It often looks like a shorter or longer **I** or **H**. This is a statistical measure that shows how 'confident' we are that the figure used is accurate, for example when a survey of a certain number of people is used to estimate figures for the whole population. The confidence interval shows the range in which the real value is likely to lie.

[3] Using e-cigarettes to stop smoking – **NHS (www.nhs.uk)**

Section 1
Key figures and trends

Norfolk has higher life expectancy than the national average for both males and females, and Norfolk has lower death rates than the national average. However, there are some ways in which health and wellbeing in Norfolk could be improved, such as reducing smoking rates.

This section shows some of the key figures and trends related to smoking and vaping in Norfolk.

Key messages

- Smoking poses the single greatest risk for early deaths in Norfolk
- Smoking in pregnancy can have significant effects on the baby – and the rates of smoking in pregnancy in Norfolk are above average
- Tobacco is the third biggest risk factor for ill health
- Around 13% of adults in Norfolk smoke – around 99,300 people
- Stop smoking services and Ready to Change can help people to quit
- Some groups smoke more than others and there are strong links with socioeconomic status
- Quitting smoking can reduce negative health impacts – sometimes quite quickly
- Around 44,900 children in Norfolk live in smoking households
- Vaping is much less harmful than smoking and can help people quit
- E-cigarette use is increasing, especially in the 16-24 year olds. It is also increasing in children and young people.

How does smoking affect health?

Deaths

Smoking poses the single greatest risk for early deaths in Norfolk – more than other issues like high blood pressure, obesity, alcohol or air pollution. Tobacco contributes to early deaths from diseases like cancer, cardiovascular disease, and respiratory disease.

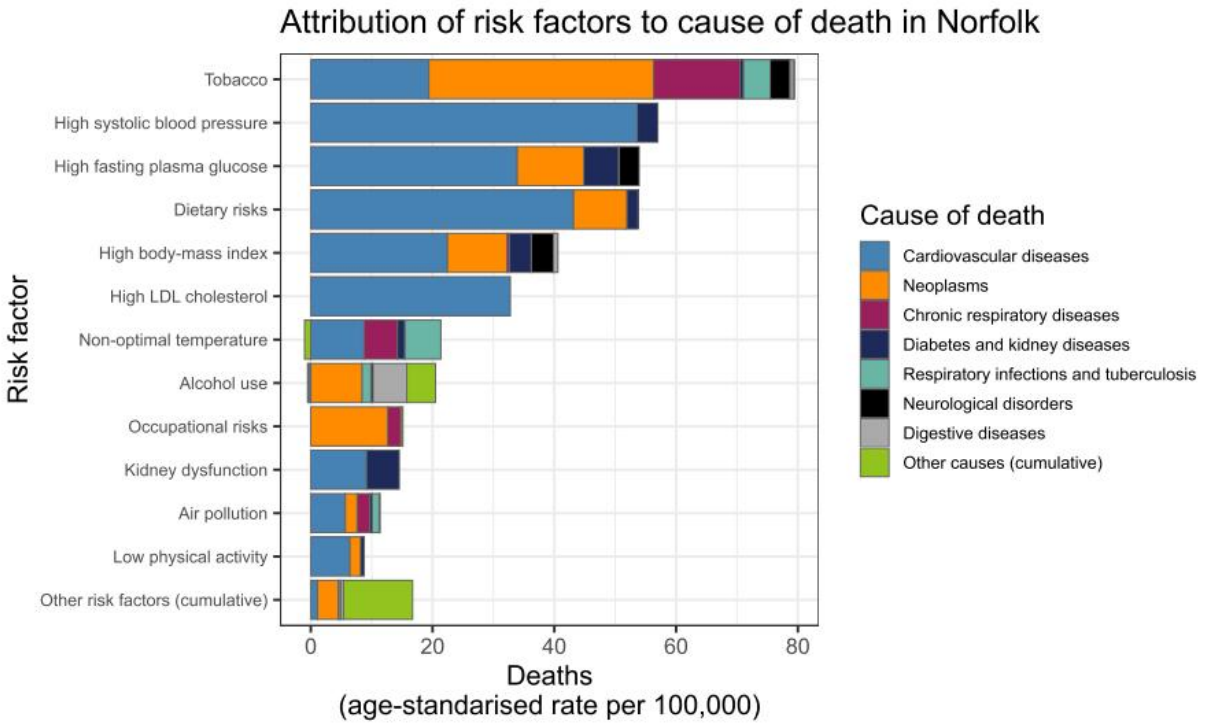

Figure 1: Attribution of risk factors to causes of death in Norfolk, 2019. Source: Institute for Health Metrics and Evaluation. Used with permission. All rights reserved. For more information visit: **Health Data**

Fortunately, deaths due to smoking in Norfolk have decreased over recent years and are below the England average.

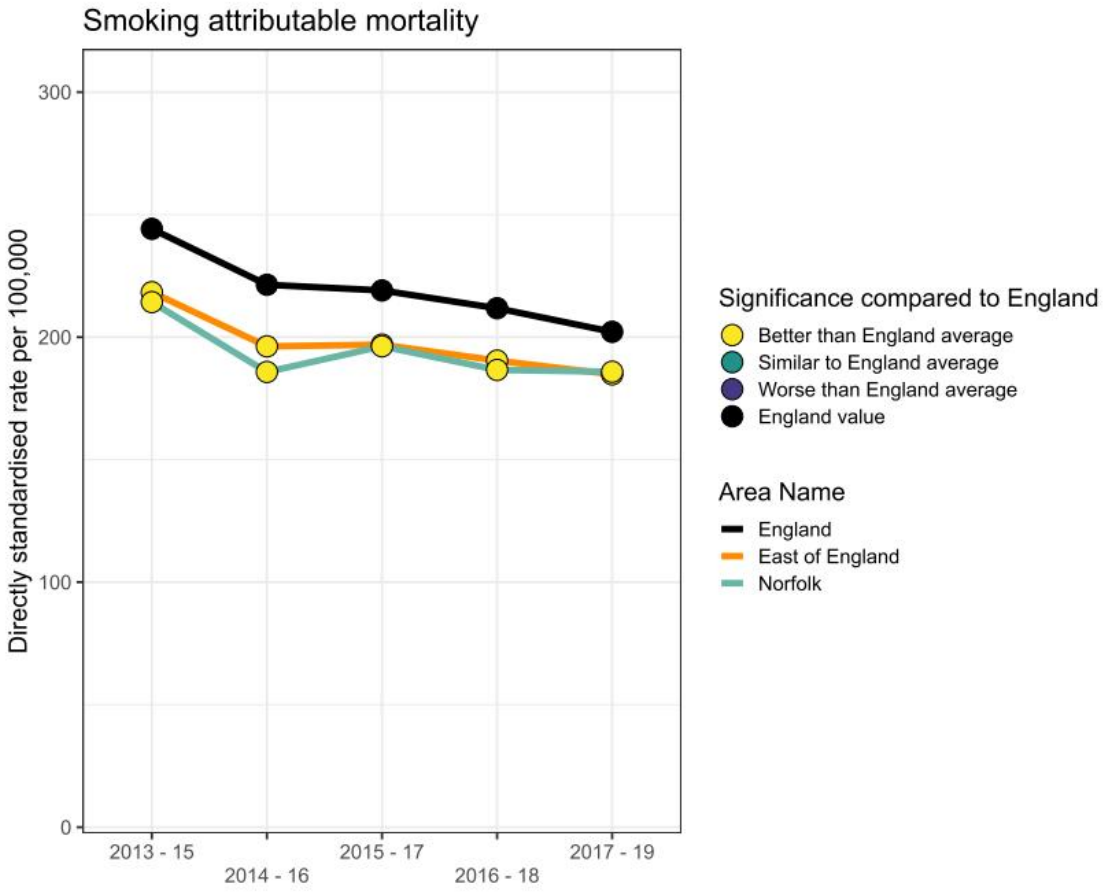

Figure 2: Smoking attributable mortality over time. Source: Office of Health Improvement and Disparities using mortality data from the Office of National Statistics mortality data; Office for National Statistics (ONS) – mid-year population estimates; Smoking prevalence data from Annual Population Survey; and relative risks from the Royal College of Physician's Report 'Hiding in Plain Sight'.

Lung cancer

Smoking is a leading cause or contributor of many cancers, including lung cancer. Lung cancer is one of the most common cancers and has a low survival rate compared to other types of cancer like colon, breast, and prostate cancers. The number of lung cancer cases in Norfolk has remained consistent and has been lower than the England average over the last decade.[4]

[4] Office for Health Improvement & Disparities. Public Health Profiles: Lung cancer registrations 2017-19 directly standardised rate – per 100,000. [Accessed 05/02/2024] fingertips.phe.org.uk

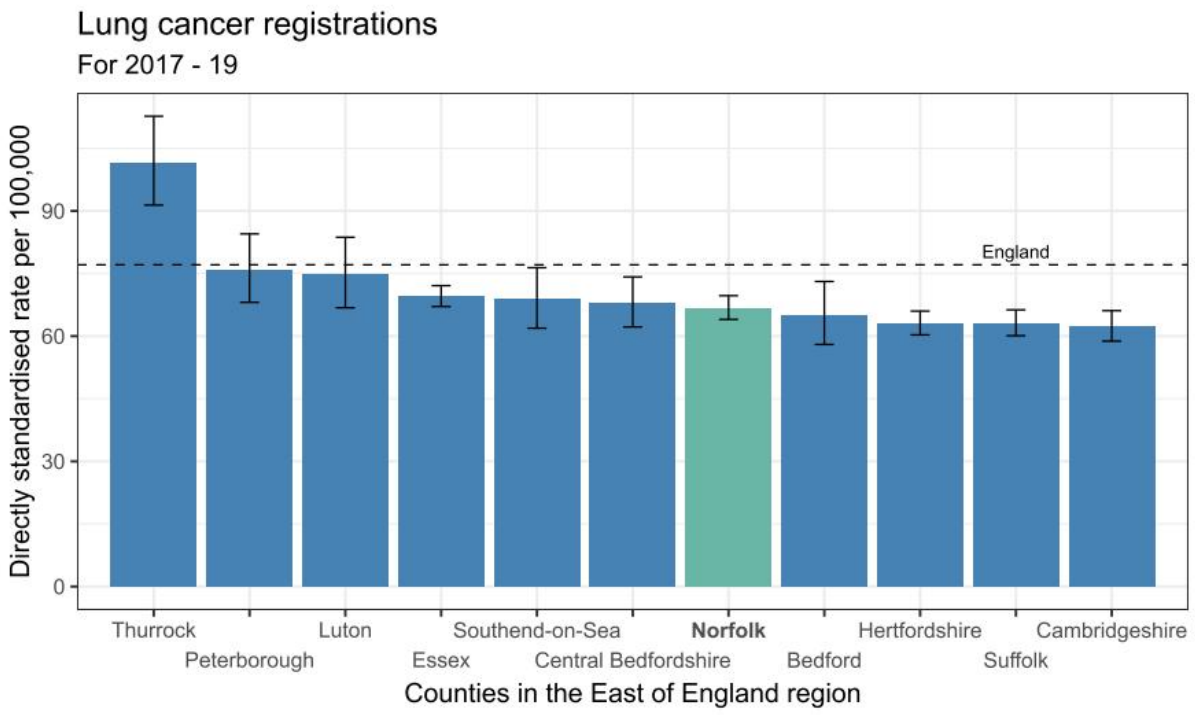

Figure 3: Lung cancer registrations for East of England counties, 2017 to 2019. Source: Office for Health Improvement and Disparities.

Impact of smoking in pregnancy – on both the mother and the child

Smoking during pregnancy can have an impact on both mothers and their babies. It can increase the risk of problems in pregnancy, stillbirth, premature birth, and low birth weight.[5] In 2021, 492 babies in Norfolk were born at a low birth weight. It has been estimated that between 10% and 27% of cases of low birth weight are due to mothers smoking,[6] suggesting that between 50 and 130 babies in Norfolk were born with low birth weight due to smoking.

Norfolk has consistently had higher rates of smoking during pregnancy than the England average. In 2022/23, there were around 850 mothers in Norfolk who were recorded as smoking at the time of delivery, around 1 in 9. Fortunately, that figure has been declining, following the overall national trend – but Norfolk's rates are still higher than both the England and regional averages.

[5] Stop smoking in pregnancy – **NHS (www.nhs.uk)**

[6] **Public Health Wales technical report, 2014: Low Birth Weight – technical paper v1.pdf** (wales.nhs.uk)

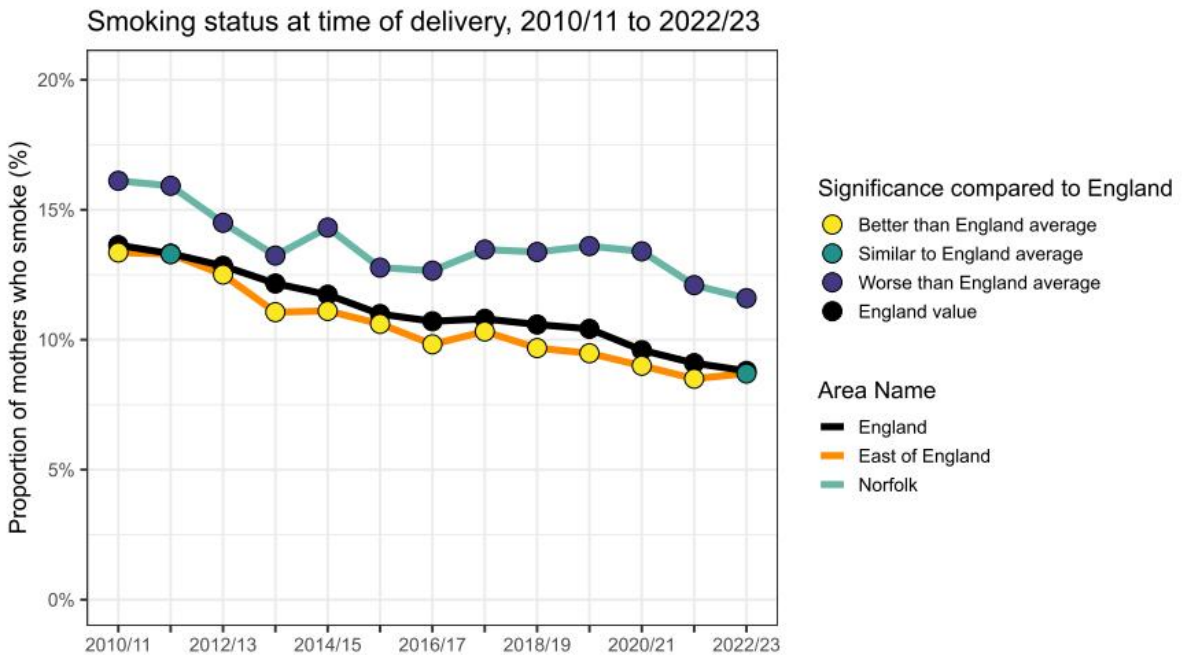

Figure 4: Smoking Status at Time of Delivery (SATOD) over time. Source: Office for Health Improvement and Disparities using NHS digital data.

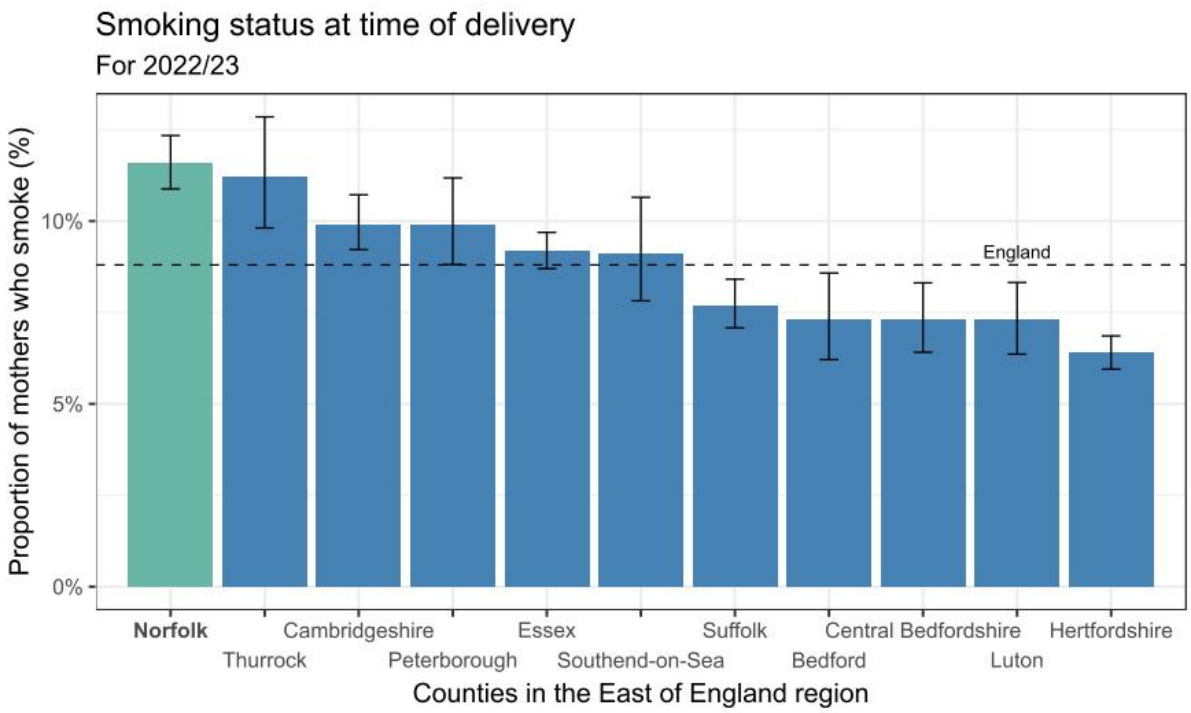

Figure 5: Smoking Status at Time of Delivery (SATOD) across the East of England counties, 2022/23. Source: Office for Health Improvement and Disparities using NHS digital data.

Case Study

Incentives to stop smoking during pregnancy

In an effort to tackle the relatively high rates of smoking in pregnant women in Norfolk, a 12-month incentive programme was launched in May 2023. This involves collaboration between the Local Maternity and Neonatal System, the James Paget University Hospital and Smokefree Norfolk (the stop smoking service that Norfolk County Council funds).

As part of the programme, verified pregnant smokers who actively participate receive 'Love2Shop' vouchers worth a total of £250. The vouchers are given to the women when they set a quit date and at various points during their pregnancy, through to two weeks after they have given birth. Members of the programme can also nominate a support buddy who is given a £50 voucher for helping the pregnant woman to quit.

The National Institute for Health and Care Excellence (NICE) recommends supporting pregnant women to quit smoking by offering incentives at different stages of pregnancy. There is strong evidence to support this, as women who receive incentives are more than twice as likely to quit successfully. Early results from the programme have shown an increase in the number of quit dates set and a higher level of engagement with Smokefree Norfolk.

The insights gained from this initial scheme will inform the implementation of a countywide programme in summer 2024.

Long term conditions

Tobacco use is the third largest risk factor for illness.[7] It can be a contributing cause of diabetes, kidney disease, chronic respiratory conditions, cardiovascular conditions such as heart disease and stroke, and musculoskeletal conditions. It is also a risk factor for dementia.

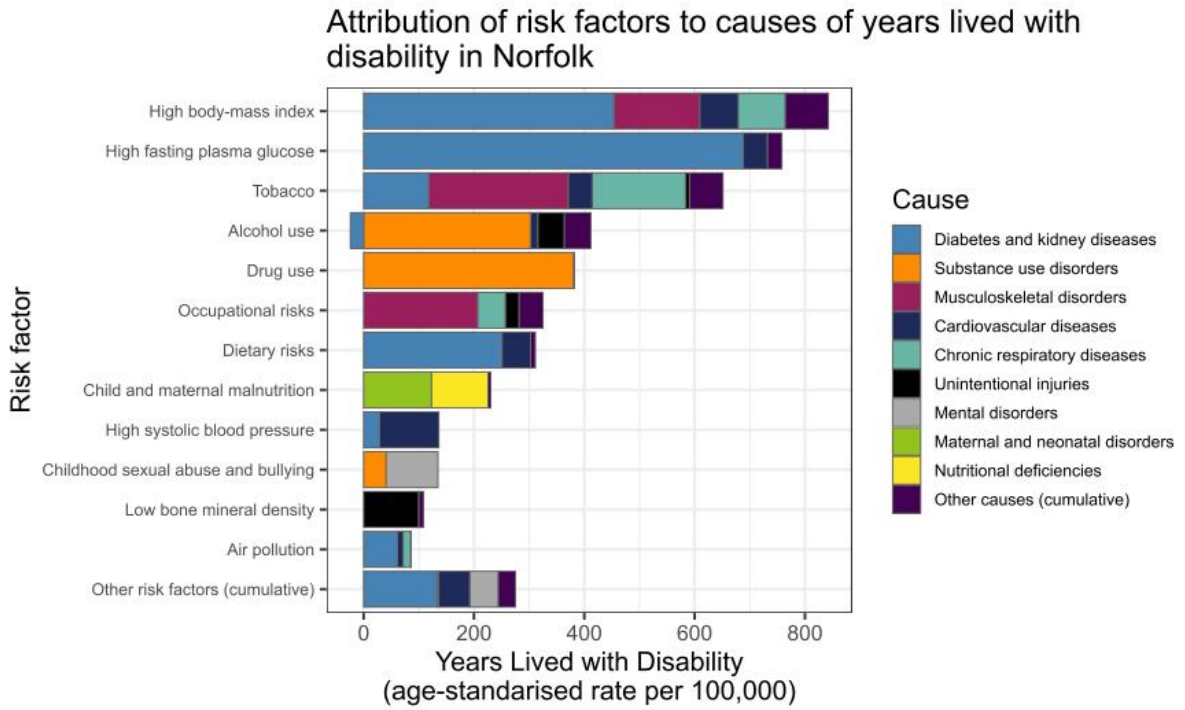

Figure 6: Attribution of risk factors to causes of years lived with disability in Norfolk, 2019. Source: Institute for Health Metrics and Evaluation. Used with permission. All rights reserved. For more information visit: **Health Data**

Long term conditions are illnesses that can be controlled and managed but not cured. People who smoke are at greater risk of developing a long term condition and spending more years in later life in poorer health.

For example, smoking is the biggest preventable risk factor of Chronic Obstructive Pulmonary Disease (COPD). In 2019/20, Norfolk had 2,240 emergency hospital admissions for COPD,[8] many of which could have been avoided if smoking rates had been lower over recent decades. While Norfolk has had lower than average rates of emergency admissions for COPD, this has been increasing over the last decade in contrast to the national trend.

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[7] Institute for Health Metrics and Evaluation. Used with permission. All rights reserved. For more information visit: **Health Data**

[8] Office for Health Improvement & Disparities. Local Tobacco Control Profiles: Emergency hospital admissions for COPD (35+) 2019/20 directly standardised rate - per 100,000. [Accessed 05/02/2024] **fingertips.phe.org.uk** © Crown copyright 2024

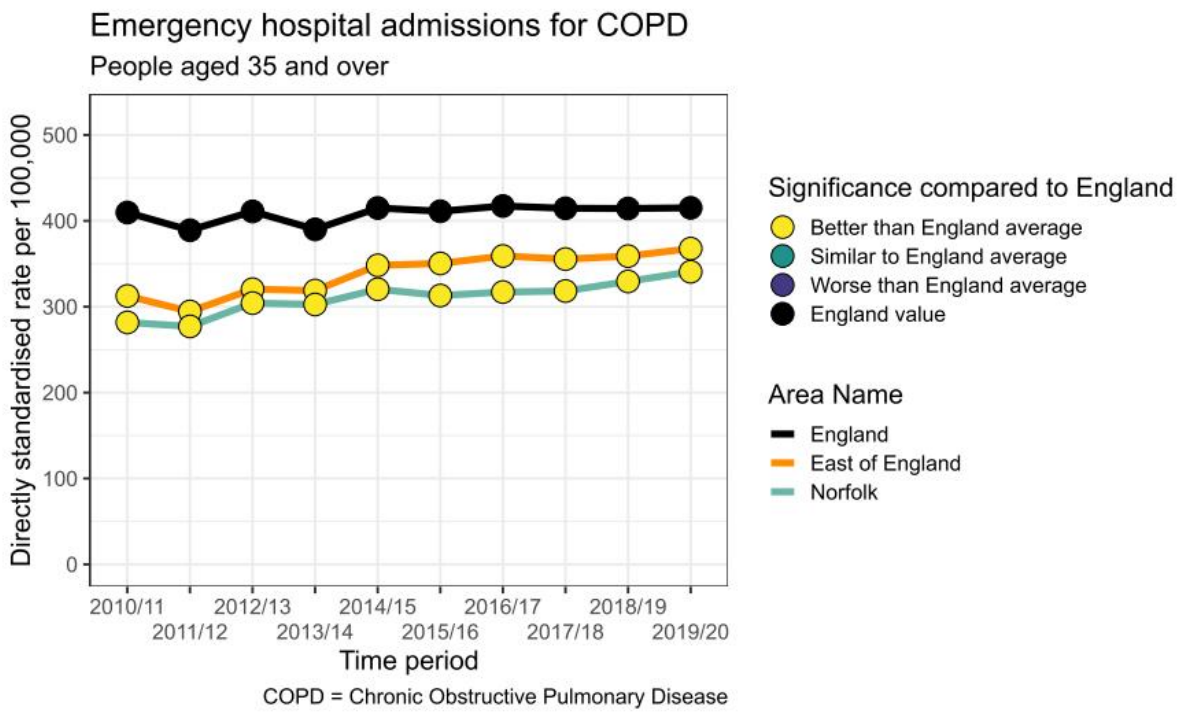


Figure 7: Emergency hospital admissions for Chronic Obstructive Pulmonary Disease (COPD) in people aged 35 and over. Source: Office for Health Improvement and Disparities, using Hospital Episode Statistics.

Case Study

Cessation of Smoking Trial in the Emergency Department (COSTED) UEA

Researchers from the University of East Anglia (UEA) conducted the Cessation of Smoking Trial in the Emergency Department (COSTED) at six UK hospitals, including the Norfolk and Norwich University Hospital. Participants were randomly assigned to receive either brief advice, an e-cigarette starter kit, and stop-smoking service referral, or no intervention (control group). Participants were generally from deprived neighbourhoods, with a higher than average number unemployed or unable to work due to sickness or disability.

Out of 972 participants, 1 in 4 in the intervention group reported quitting smoking at 6 months, compared to 1 in 8 in the control group. Carbon monoxide tests confirmed that those in the intervention group were twice as likely to quit. They were also more likely to reduce how many cigarettes they smoked and to make more attempts to quit than the control group.

The trial demonstrated the potential of emergency departments to reach smokers opportunistically, especially in disadvantaged communities. Economic evaluation suggested the intervention is cost-effective and implementing it across the three Accident and Emergency departments in Norfolk could lead to 1,636 additional quits annually at a lower cost than traditional methods.

Smoking patterns and inequalities

Norfolk position

Around 13% of adults in Norfolk smoke – around 99,300 people. This is similar to the national average. This is similar to the national average and is in line with other parts of the region.

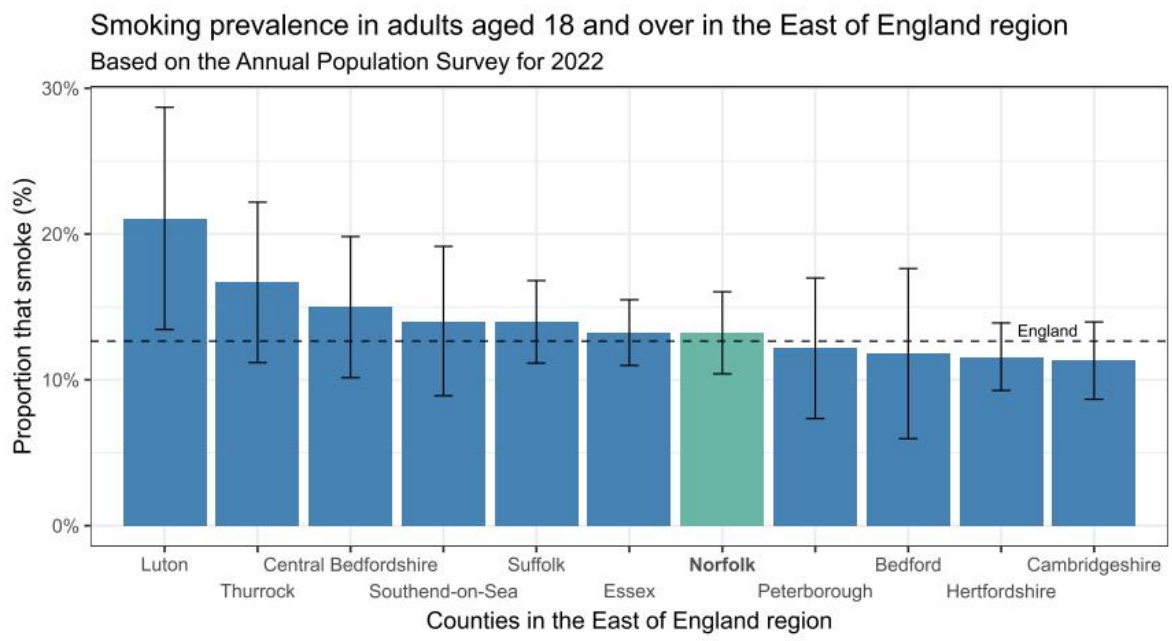


Figure 8: Smoking prevalence in adults by county in the East of England region, 2022. Source: Office for Health Improvement and Disparities using Annual Population Survey data.

However, there is variation within Norfolk: Great Yarmouth has the highest adult smoking rate (around 18%), which equates to around 14,200 smokers and Broadland has the lowest rate (8%) or around 8,900 smokers.

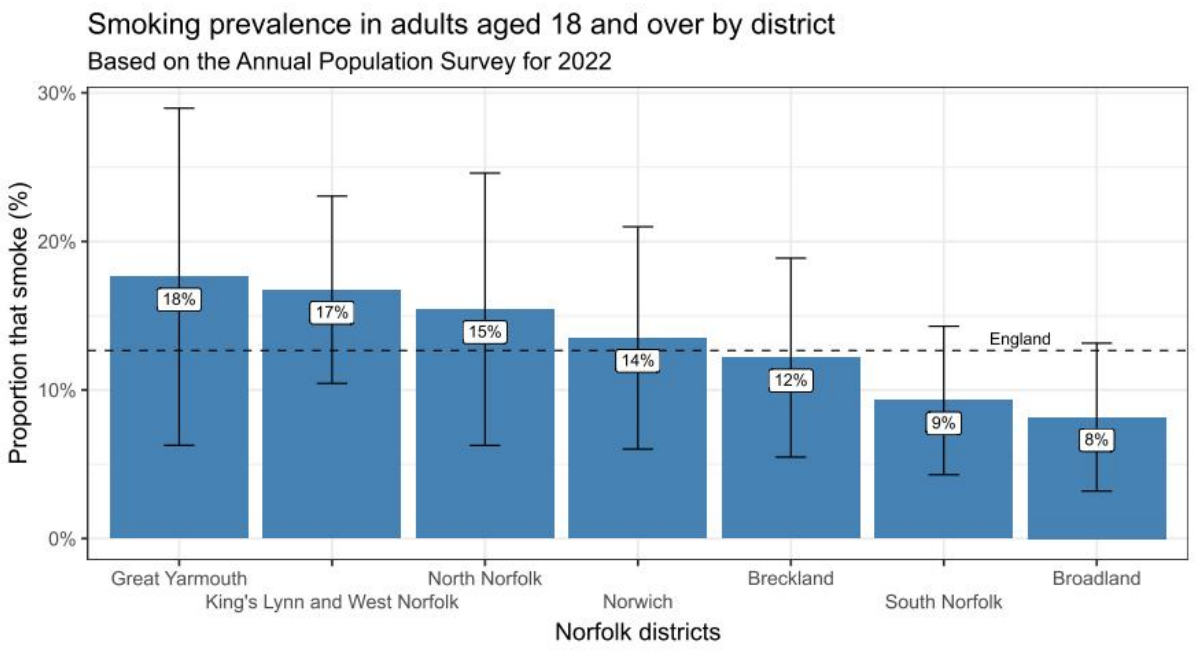


Figure 9: Smoking prevalence in adults by Norfolk districts, 2022. Source: Office for Health Improvement and Disparities using Annual Population Survey data.

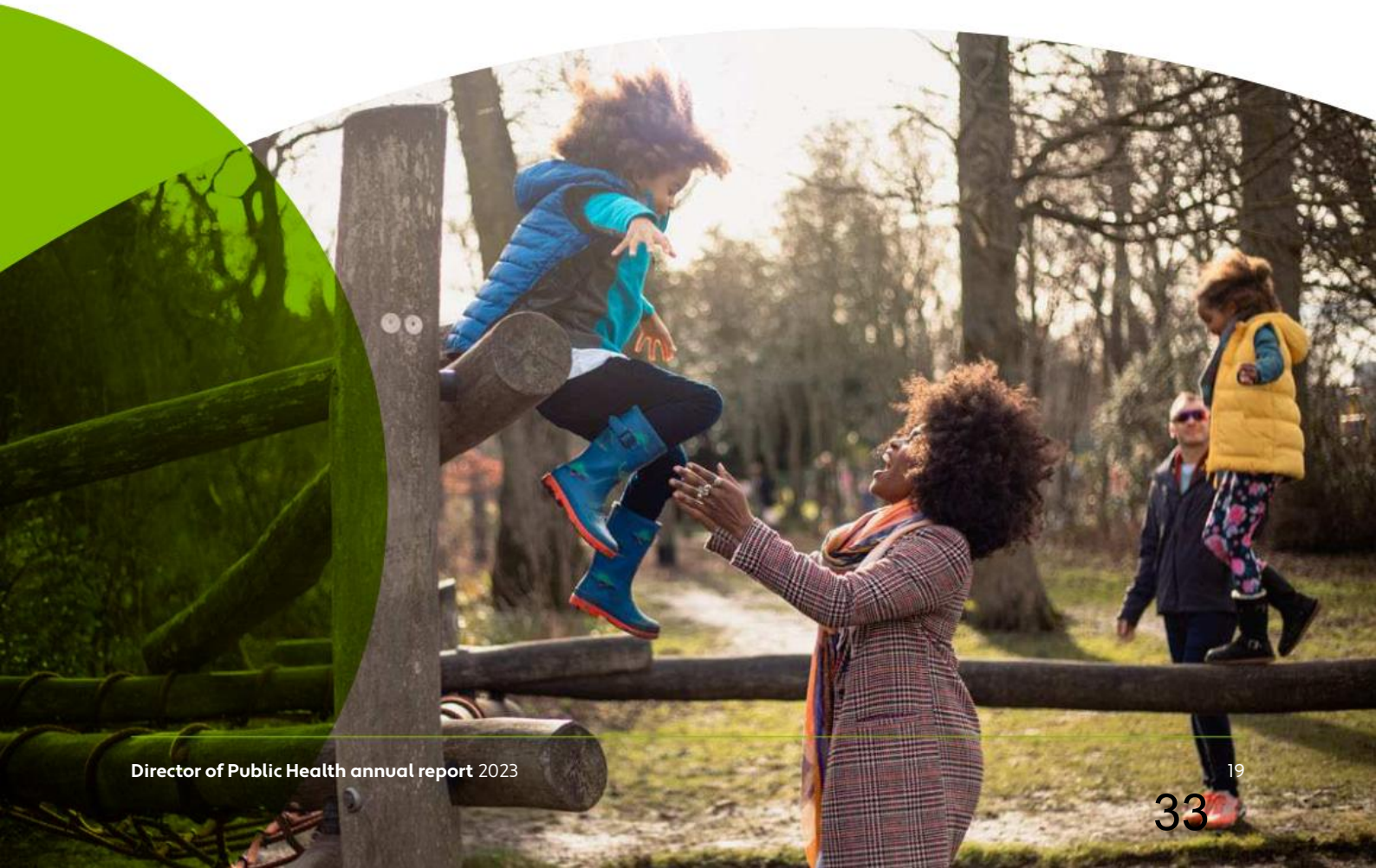
District	Smoking rate (%)	Estimated number of adult smokers	How many fewer needed to reach 5%
Breckland	12	14,200	8,400
Broadland	8	8,900	3,500
Great Yarmouth	18	14,200	10,200
King's Lynn and West Norfolk	17	21,300	14,900
North Norfolk	15	13,500	9,100
Norwich	14	16,100	10,100
South Norfolk	9	10,800	5,000
Norfolk	**13**	**99,300**	**61,800**

Table 1: Estimated adult smokers in Norfolk in 2022, based on Annual Population Survey prevalence rates and 2021 Census population estimates. Numbers rounded to nearest 100, district totals may not sum to make Norfolk total.

A national ambition aims for every area in England to be smokefree by the year 2030.[9] 'Smokefree' is defined as having no more than 5% of adults smoking. For Norfolk to reach that ambition, we would need to have fewer than 37,500 smokers in the county – that is 61,800 fewer smokers than currently. Taking into account our growing population, we would need at least 6,500 people to quit smoking each year until 2030 to reach the national ambition – and more if people continue to take up smoking in the meantime. Some districts are closer to the 5% ambition than others, e.g. Broadland and South Norfolk.

People can and do attempt to quit smoking by themselves. Some people find it harder to quit than others, and Norfolk County Council funds services to help them. The stop smoking services reach around 8,600 smokers per year and offer support to help quit. Of those, 1,850 per year go on to successfully quit. This has significant impacts in helping improve the health of the people of Norfolk. However, not everyone takes advantage of stop smoking services. That's why the County Council developed its Ready to Change website, which helps people to quit smoking:
Help to quit smoking - Norfolk County Council

[9] Stopping the start: our new plan to create a smokefree generation – **GOV.UK (www.gov.uk)**



Case Study

Ready to Change

Quitting smoking can be one of the best lifestyle changes anyone can make, even though this can be challenging due to tobacco's addictive nature. Ready to Change is a free online tool to help Norfolk residents in adopting healthier habits, including giving up cigarettes.

Developed by Norfolk County Council in collaboration with health psychologists and experts at the University of East Anglia, Ready to Change utilises behaviour change science to help individuals modify their habits for a healthier life. It includes quizzes, tips, and guidance for quitting smoking. A **video** explaining the behavioural science approach has been produced, along with campaign materials for print and social media.

Since its launch in 2022, over 8,000 people have used **Ready to Change** to help in their quitting journey – e.g. taking quizzes, reading about the benefits of stopping smoking or setting goals.

ready to change
your way to better health

Smoking by gender

In Norfolk, more men smoke than women (14% compared to 12%) – this is a long running trend. Recently, Norfolk rates of female smokers has risen above the national average.

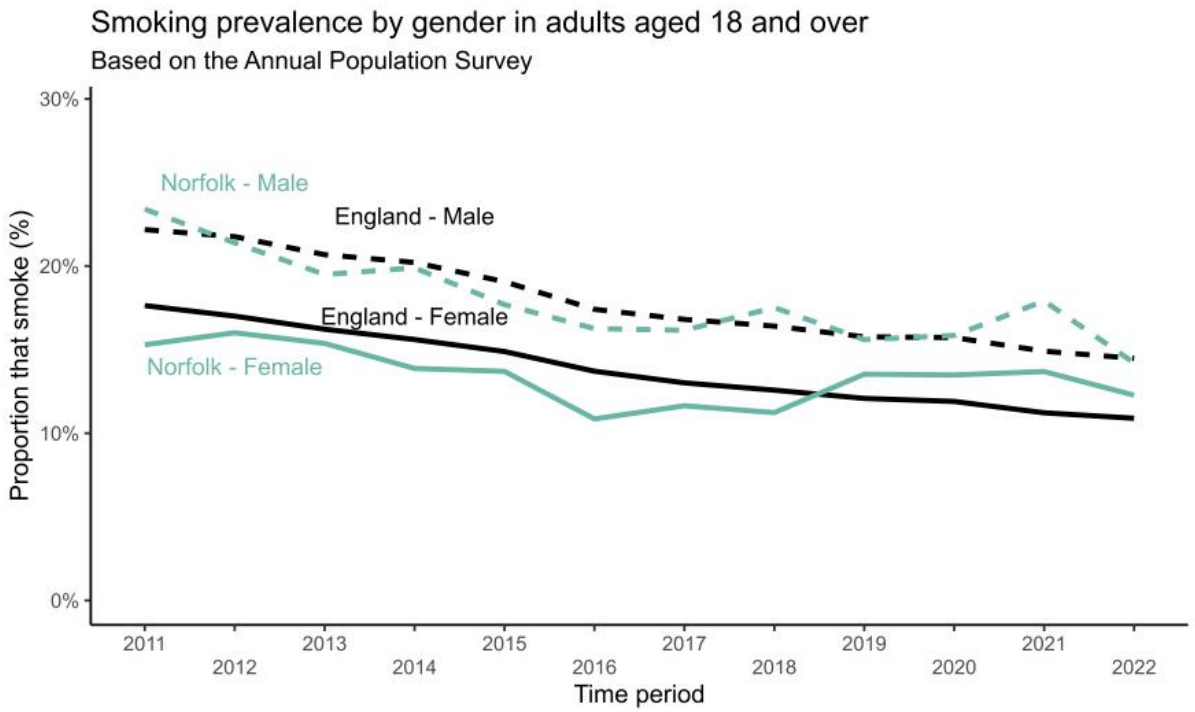


Figure 10: Smoking prevalence by gender over time. Source: Office for Health Improvement and Disparities based on Annual Population Survey data.

Smoking by age

Data on smoking rates for different age groups in Norfolk is not available. National data, however, shows the highest rates in those aged 25-29 (16%), with the numbers decreasing for older age groups. Nationally, those aged 65 and over smoke less than the England average.

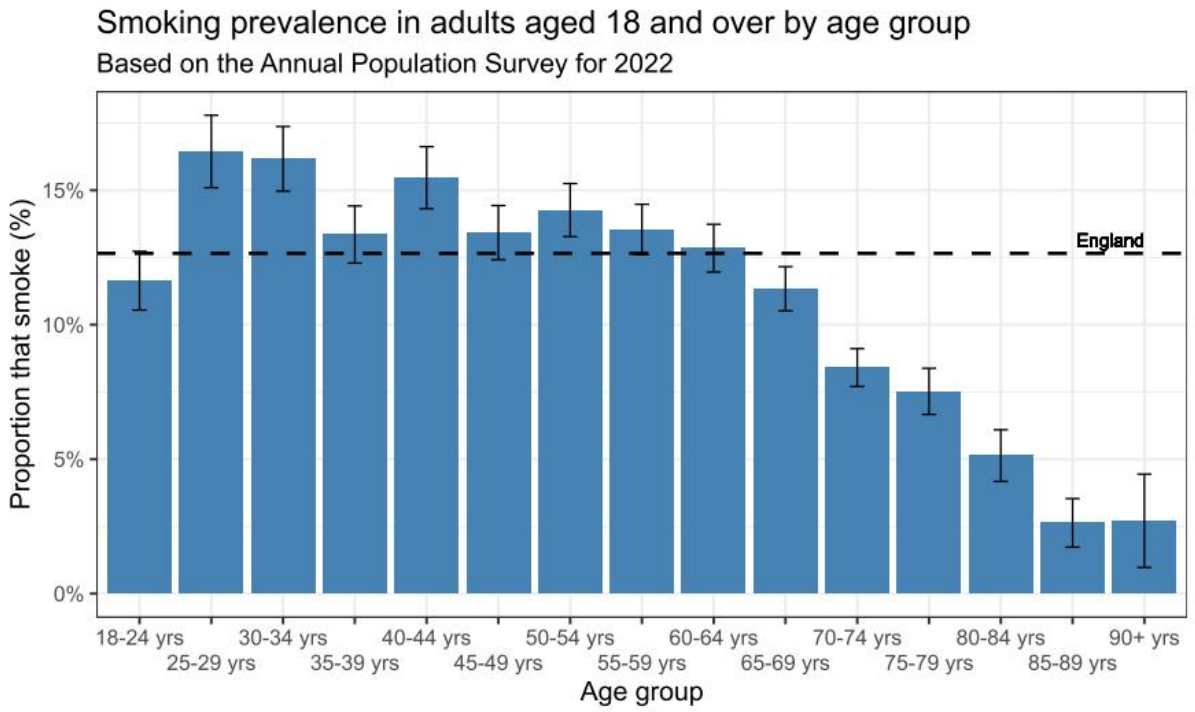


Figure 11: Smoking prevalence by age group in England, 2022. Source: Office for Health Improvement and Disparities based on Annual Population Survey data.

Since 2011, smoking rates have declined most rapidly amongst the 18-24 year olds, however a recent study suggests this trend may have changed with rates in this age group increasing since 2020.[10] The 25-29 year olds have consistently had the highest rates of smoking.

[10] Have there been sustained impacts of the COVID-19 pandemic on trends in smoking prevalence, uptake, quitting, use of treatment, and relapse? A monthly population study in England, 2017–2022 | BMC Medicine | Full Text biomedcentral.com

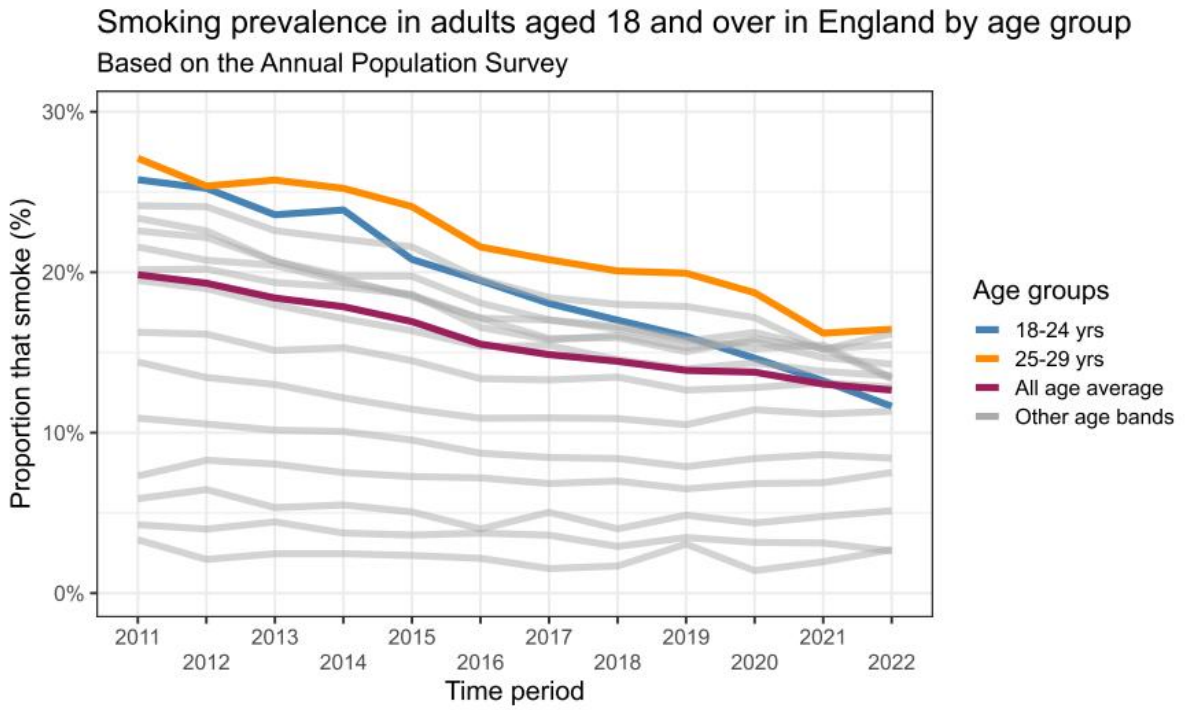


Figure 12: Smoking prevalence by age group over time showing the age group with the highest rates of smoking, the age group with the fastest rate of decrease in smoking, and the all age average smoking rate. Source: Office for Health Improvement and Disparities based on Annual Population Survey data.

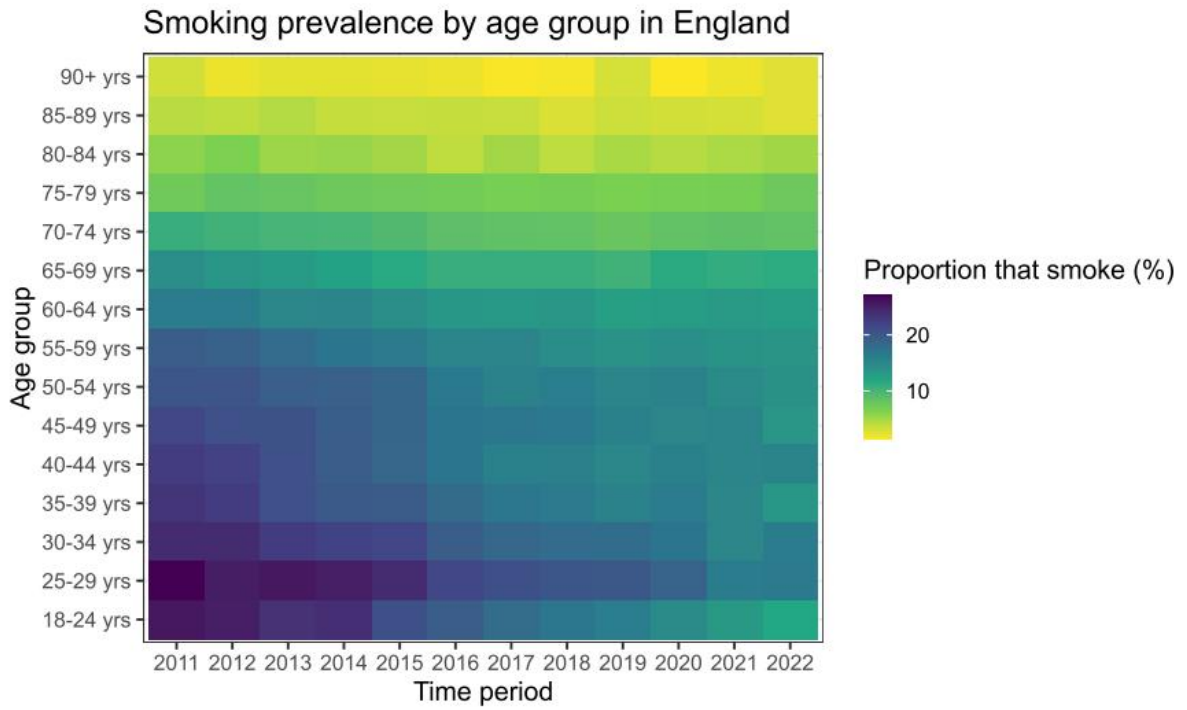


Figure 13: Heat map of smoking prevalence by age group over time. Darker colours show higher rates of smoking compared to other age groups and time periods. Source: Office for Health Improvement and Disparities based on Annual Population Survey data.

Smoking and deprivation

Smoking rates are higher in more deprived areas. Nationally, in the most deprived areas, around 16% of people smoke, compared to 10% in the least deprived areas. Around 1 in 3 of all smokers live in the fifth of the country that is most deprived.[11]

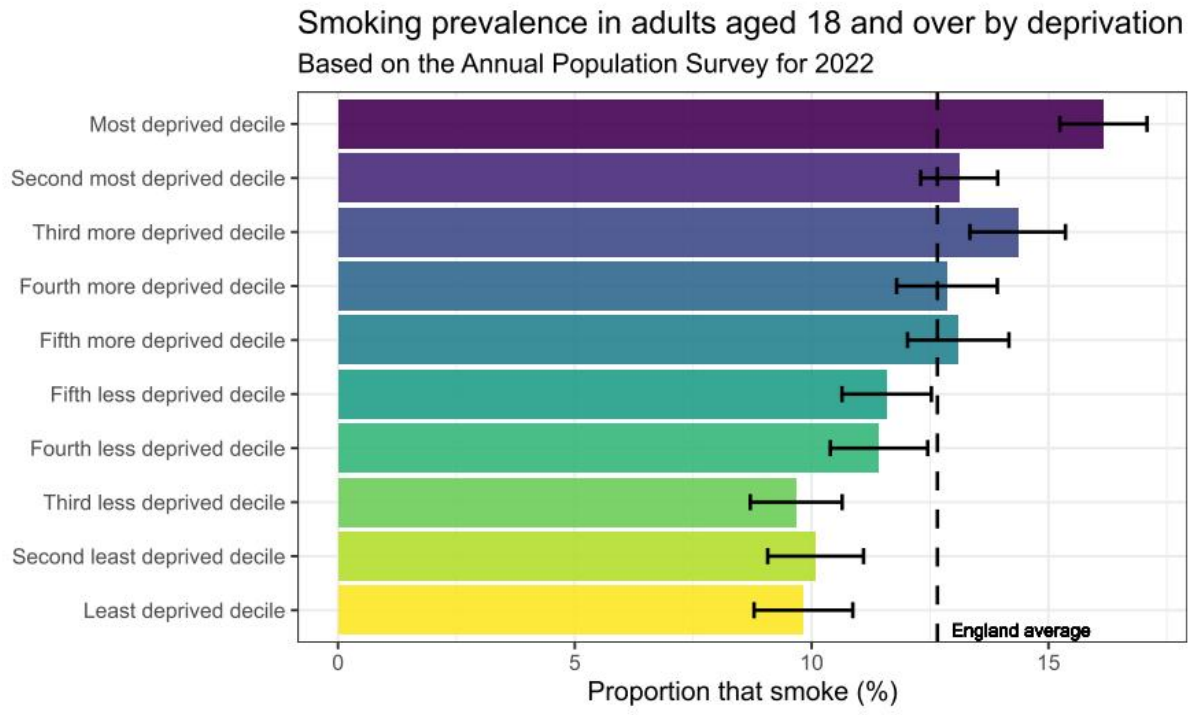


Figure 14: Smoking prevalence by deprivation group (Index of Multiple Deprivation 2019) of residential areas in England, 2022. Source: Office for Health Improvement and Disparities based on Annual Population Survey data.

[11] Office for Health Improvement & Disparities. Public Health Profiles: Lung cancer registrations 2017-19 directly standardised rate - per 100,000. [Accessed 05/02/2024] fingertips.phe.org.uk © Crown copyright 2024.

In Norfolk, around 136,000 people live in areas that are some of the most deprived in the country – and health on average is poorer in deprived areas. Around 4 in 10 people in Great Yarmouth and Norwich live in these more deprived areas, compared to 1-2 in 10 people in Norfolk as a whole. None of the most deprived neighbourhoods are in Broadland and South Norfolk.[12]

Smoking and socioeconomic status

'Socioeconomic status' is a way of looking at the resources groups of people can draw upon. It often reflects education, income, work conditions, employment relations and job roles. The Office of National Statistics uses a set of groups linked to occupations to show socioeconomic status.

In Norfolk:

- around 1 in 4 people in routine and manual occupations smoke
- around 1 in 5 of those in 'intermediate' occupations (e.g. sales, administration, services and some technical jobs) smoke
- around 1 in 12 people in 'management and professional occupations' smoke.

This continues a long-running trend of smoking rates varying by socioeconomic status.

[12] Based on 2019 Index of Multiple Deprivation: www.gov.uk/government/statistics/english-indices-of-deprivation-2019

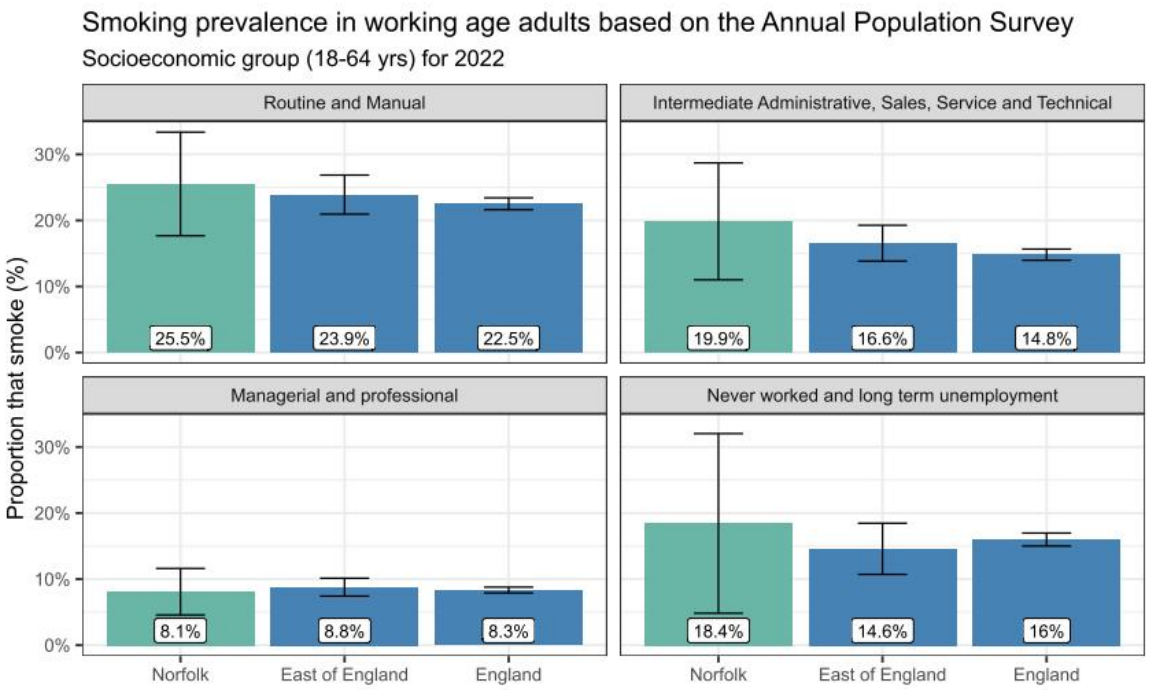


Figure 15: Smoking prevalence by socio-economic category in working age adults, 2022. Source: Office for Health Improvement and Disparities based on Annual Population Survey data.

Case Study

Community Voices smoking conversations

In summer 2023, as part of the Integrated Care System's Community Voices Programme, Community Champions engaged in conversations with people in communities facing health inequality to discuss factors that either supported or hindered their efforts to quit smoking. The insights from these discussions were collected in an online 'insight bank,' which now contains over 200 recorded conversations.

These insights were organised according to factors that aid individuals in making positive health changes, namely capability, opportunity, and motivation. Some key themes emerged from these conversations:

- the role of social influences on smoking behaviour and the importance of having strong social support when attempting to quit smoking
- the short term versus long term economic costs of stopping smoking
- the need to maintain motivation and to have action plans and rewards
- the importance for stop smoking providers to tailor services to meet smokers' needs.

The insights tallied with research on this topic. Importantly, these real life Norfolk insights will inform the future design of local stop smoking services and the establishment of NHS pathways.

Smoking and housing tenure

Around 1 in 3 people living in social housing smoke. This is much higher than those who own their homes where around 1 in 11 smokes. Smoking rates for those who rent privately fall between the two.

What underlies these different smoking rates is complex. For example, people in social housing may face greater financial difficulties (see deprivation and socioeconomic status above). People who have paid off their mortgages may tend to be older – and smoking rates decrease with age, particularly for the over 65s.

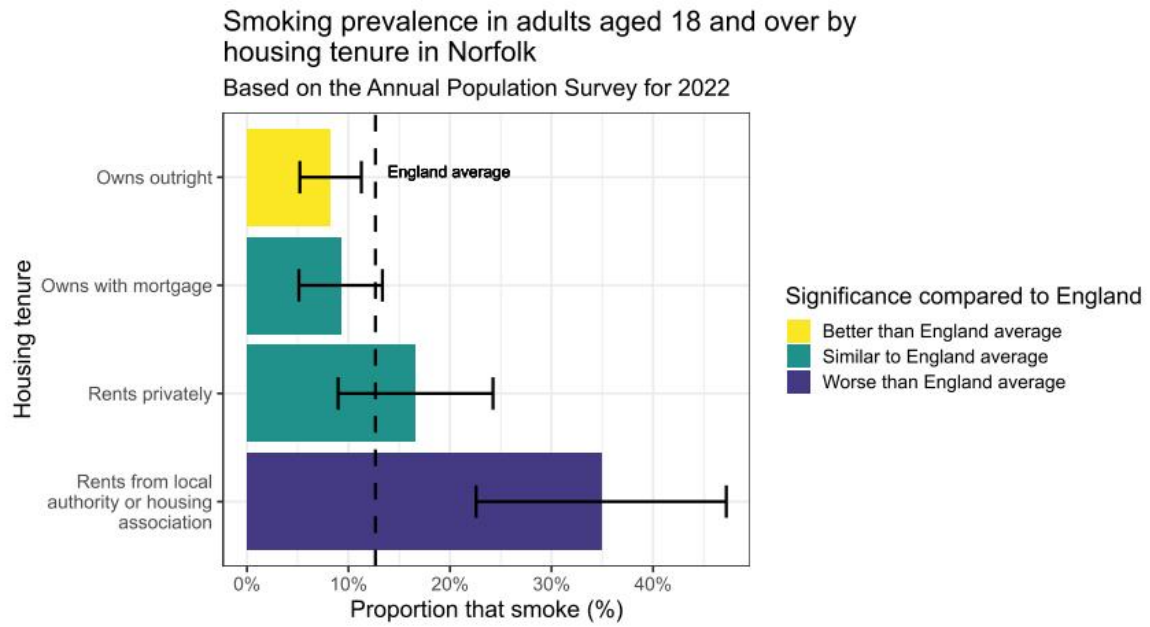


Figure 16: Smoking prevalence by housing type in Norfolk adults, 2022. Source: Office for Health Improvement and Disparities based on Annual Population Survey data.

Smoking and ethnicity

Nationally, smoking rates are highest among the white (13%) and mixed (17%) ethnic groups. Smoking rates are below the England average for the black (8%), Asian (7%) and Chinese (5%) ethnic groups. We do not have this breakdown for Norfolk, so rely on national figures.

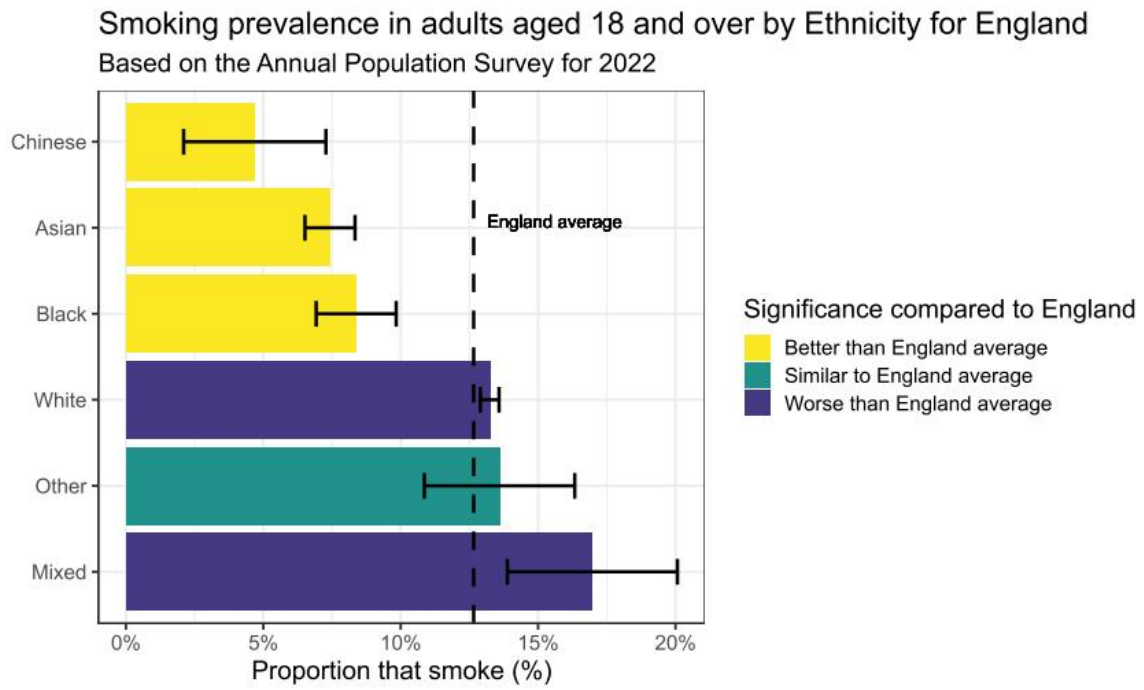


Figure 17: Smoking prevalence by Ethnicity, 2022. Source: Office for Health Improvement and Disparities based on Annual Population Survey data.

Smoking and country of birth

Smoking rates by country of birth have remained largely consistent over time. People living in the UK but born in India have had the lowest smoking rates since 2014 – around 5%. People born in Poland have consistently had the highest smoking rate, though this has decreased from 32% in 2014 to 21% in 2022.

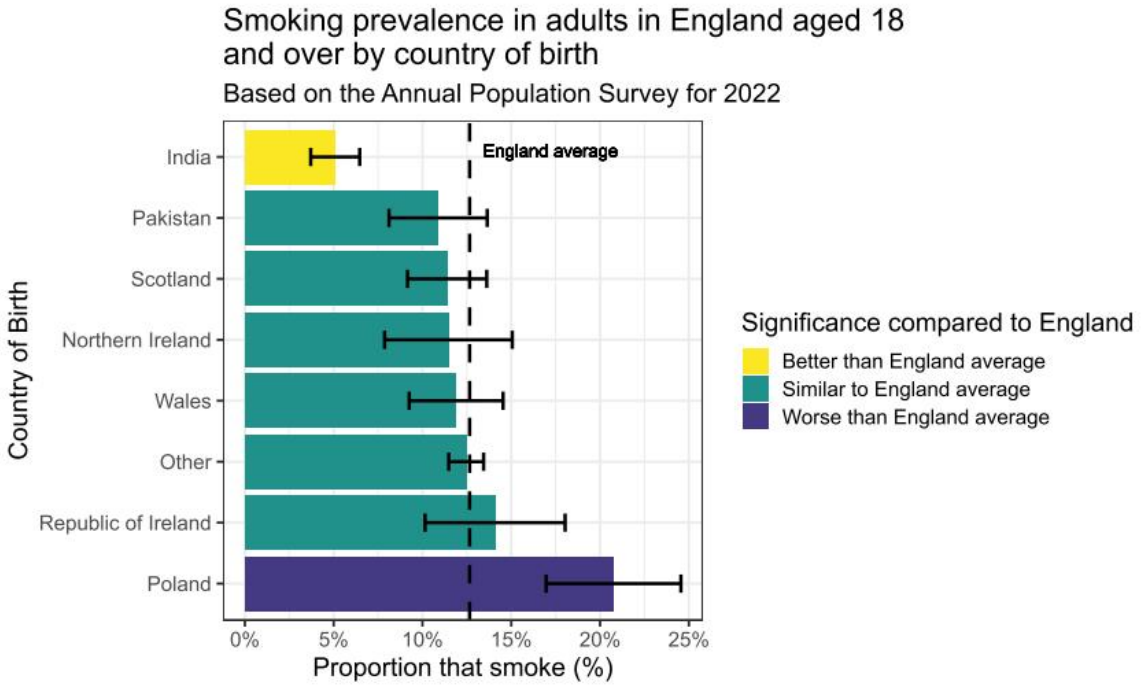


Figure 18: Smoking prevalence by country of birth, 2022. Source: Office for Health Improvement and Disparities based on Annual Population Survey data.

Smoking and overall health

People who report the poorest health consistently have the highest smoking rates. One in four people who rate their health as 'very bad' are smokers. Those that report being in good health have the lowest smoking rates.

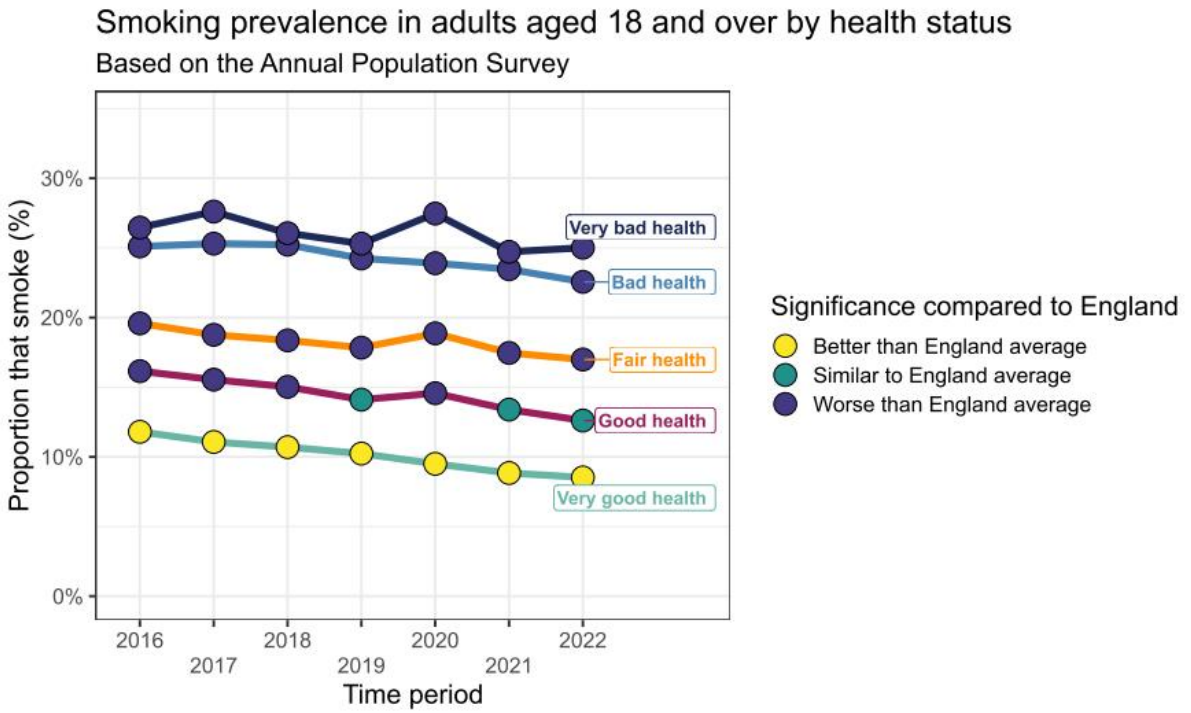


Figure 19: Smoking prevalence over time in England by health status. Source: Office for Health Improvement and Disparities based on Annual Population Survey data.

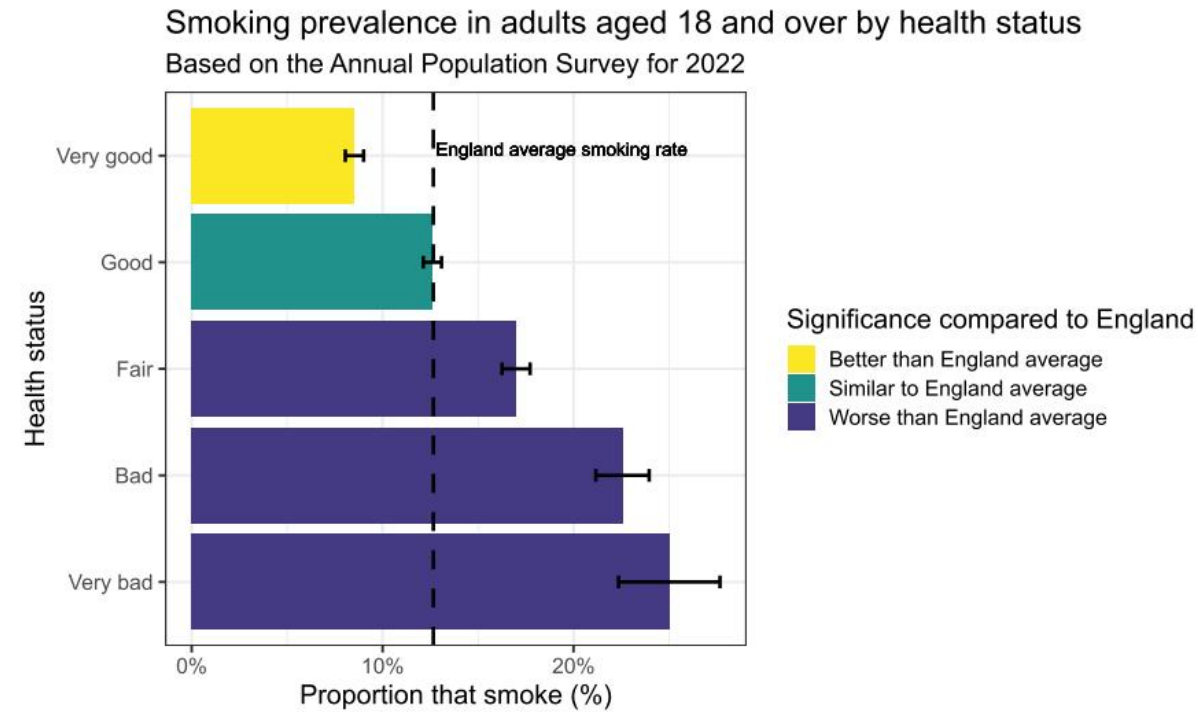


Figure 20: Smoking prevalence in England by health status in 2022. Source: Office for Health Improvement and Disparities based on Annual Population Survey data.

Smoking and mental health

Smoking rates are higher in those who have mental health issues, representing a significant health inequality. A survey conducted among general practice patients found that in Norfolk, nearly one in four people with a long term mental health condition smoked. This is similar to the national average for those with long term mental health conditions, but much higher than for the general population.

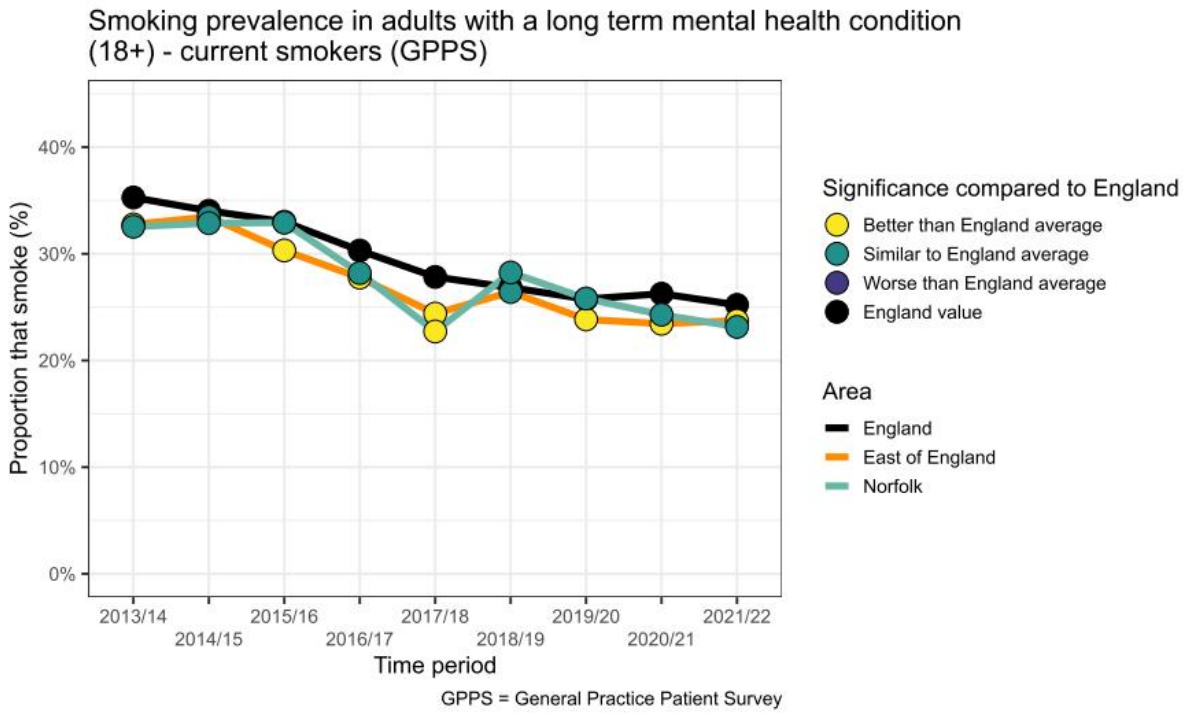


Figure 21: Smoking prevalence in those with a long term mental health condition. Source: Office for Health Improvement and Disparities based on the General Practice Patient Survey.

Case Study

Community serious mental illness service

NHS England committed to offering a new universal smoking cessation programme within specialist mental health services for long term smokers by 2023/24. People with serious mental illness (SMI) face greater challenges quitting smoking due to higher dependency and heavier smoking.

NHS England is testing a pathway and service model before a national rollout, selecting four primary care network areas in Gorleston, Great Yarmouth and Norwich for the trial. These areas were chosen based on data indicating they serve over 30% of the SMI population in Norfolk and Waveney.

Smokefree Norfolk and Together for Mental Wellbeing are collaborating on the pilot service, with promising early results, including an 88% engagement rate, 81% setting a quit date, and 58% quitting within the first nine months. A research team from the UEA is evaluating the pilot, with findings informing the future service.

The benefits of quitting

The National Institute for Health and Care Excellence (NICE) report that:

- On average, stopping smoking at age 60 can add 3 extra years to life. Stopping at 30 can add 10 extra years[13]
- A study of over one million UK women showed that stopping smoking before the age of 40 avoids the vast majority (90%) of the increased risk of dying caused by continuing to smoke[14]
- For people who stop smoking before the age of 50 years, the risk of dying of smoking-related disease is cut in half.[15]

The sooner you quit, the sooner you'll notice changes to your body and health. Look at what happens when you quit for good.

After 20 minutes
Check your pulse rate, it will already be starting to return to normal.

After 8 hours
Your oxygen levels are recovering, and the harmful carbon monoxide level in your blood will have reduced by half.

After 48 hours
All carbon monoxide is flushed out. Your lungs are clearing out mucus and your senses of taste and smell are improving.

After 72 hours
If you notice that breathing feels easier, it's because your bronchial tubes have started to relax. Also your energy will be increasing.

After 2 to 12 weeks
Blood will be pumping through to your heart and muscles much better because your circulation will have improved.

After 3 to 9 months
Any coughs, wheezing or breathing problems will be improving as your lung function increases by up to 10%.

After 1 year
Great news! Your risk of heart attack will have halved compared with a smoker's.

After 10 years
More great news! Your risk of death from lung cancer will have halved compared with a smoker's.

Quitting smoking can also save individuals and their families money – on average around £3,100 per smoker per year.

[13] Doll, 2004 [14] Pirie, 2013 [15] PHE, 2015b

Case Study

What quitting smoking felt like for Dan*

Dan started smoking as a teenager and had attempted to quit smoking multiple times, but without success. On his social media feed, he spotted adverts for Ready to Change, the Council website offering help to stop smoking. Intrigued by the promise of free assistance, Dan decided to click on the link and explore further.

Dan started with the Ready to Change quiz about his smoking habits. He then discovered the many benefits of quitting smoking. As someone facing financial difficulties, he realised that his cigarette expenses were a significant contributing factor. Furthermore, with his partner expecting their first child, Dan was motivated to eliminate the risk of second hand smoke for his family's wellbeing.

Dan recognised that swapping from smoking to vaping could serve as a good first step to quitting smoking because it would address the hand-to-mouth habit and provide a controlled level of nicotine. It would also be significantly less harmful than smoking. Determined to make a change, Dan contacted the local stop smoking service, which offered free vape kits for 12 weeks and the support of a specialist advisor.

Setting a quit date, Dan used the goal-setting and 'if-then' planning tools from Ready to Change to boost his motivation and maintain his progress. Six months later, Dan is still not smoking and only vapes a couple of times per day. He keeps a diary to track when he vapes so he can eventually quit vaping altogether.

*This is a fictional case study taking the reader through an example journey a quitter might follow when giving up smoking

Protect others from secondhand smoke

Second hand smoke (passive smoking) refers to the smoke that smokers exhale or that is given off from the end of a lit cigarette while it is burning – which people nearby can then inhale. Harmful chemicals such as tar, nicotine, and carbon monoxide are contained within second hand smoke making it harmful to those that inhale it.

In the short term, being exposed to second hand smoke can result in headaches, sore eyes, and coughing. In the longer term, people exposed to second hand smoke are at higher risk of heart disease, some types of cancer, and poor lung function. Children and young people are at particular risk due to their more delicate lungs.[16]

An estimated 44,900 children in Norfolk live in smoking households and are therefore likely to be exposed to second hand smoke. Children from smoking households are four times more likely to take up smoking themselves later in life.[17]

As smoking rates decrease, second hand smoke exposure can also decrease, reducing related harms.

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[16] **Secondhand Smoke – ASH**

[17] **ash.org.uk/resources/view/economic-and-health-inequalities-dashboard**

Vaping (e-cigarettes)

Vaping is an effective tool to help people quit smoking. Tobacco cigarette smoke contains thousands of chemicals – many of them poisonous – and dozens of them can cause cancer.[18] Cigarettes also contain nicotine, which is an addictive substance.[19] Once addicted, it can be difficult to quit smoking.

The latest evidence review from the Office for Health Improvement and Disparities (OHID) shows that in the short and medium term, vaping poses only a small fraction of the risks of smoking.[20]

E-cigarettes with nicotine are still addictive, however, and the long-term effects of vaping are not yet known. Vaping is not risk free, particularly for people who have never smoked.[21] The Chief Medical Officer Professor Sir Chris Whitty wrote succinctly for The Times in May 2023:

> 'The key points about vaping (e-cigarettes) can be easily summarised. If you smoke, vaping is much safer; if you don't smoke, don't vape; marketing vapes to children is utterly unacceptable.'[22]

Key messages on vaping

- Vaping is much less harmful than smoking
- Vapes are an effective tool to help smokers quit smoking
- Swapping from smoking to vaping is a positive health move
- If you don't smoke, don't vape
- Vapes should not be marketed to children

[18] What chemicals are in a cigarette? | What does smoking do to your body? cancerresearchuk.org
[19] ash.org.uk/resources/view/whats-in-a-cigarette
[20] Nicotine vaping in England: 2022 evidence update summary – GOV.UK www.gov.uk
[21] Nicotine vaping in England: 2022 evidence update main findings – GOV.UK www.gov.uk
[22] Chief Medical Officer for England on vaping – GOV.UK www.gov.uk

Vaping in adults (aged 16 and over)

Local data on vaping in Norfolk is not available, so we rely on national surveys. Nationally, around 5% of people aged 16 and over use e-cigarettes daily.[23] This would equate to around 40,000 adults in Norfolk. Around 3.5%, or 27,000 people, occasionally use e-cigarettes.

Evidence is mounting that while tobacco cigarette smoking is decreasing, e-cigarette use is increasing.

Current smokers (27%) and ex-smokers (17%) vape more than non-smokers.[24] While at lower levels, e-cigarette use is increasing among those who have never smoked before – currently a little under 2%. This would mean around 13,800 people in Norfolk who have never smoked cigarettes, use e-cigarettes.

Among adults aged 16 and over, occasional or daily vaping is increasing most quickly in the 16-24 year olds – from around 11% in 2021 to over 15% in 2022. At the same time, smoking tobacco cigarettes is decreasing most quickly in the 18-24 year olds.

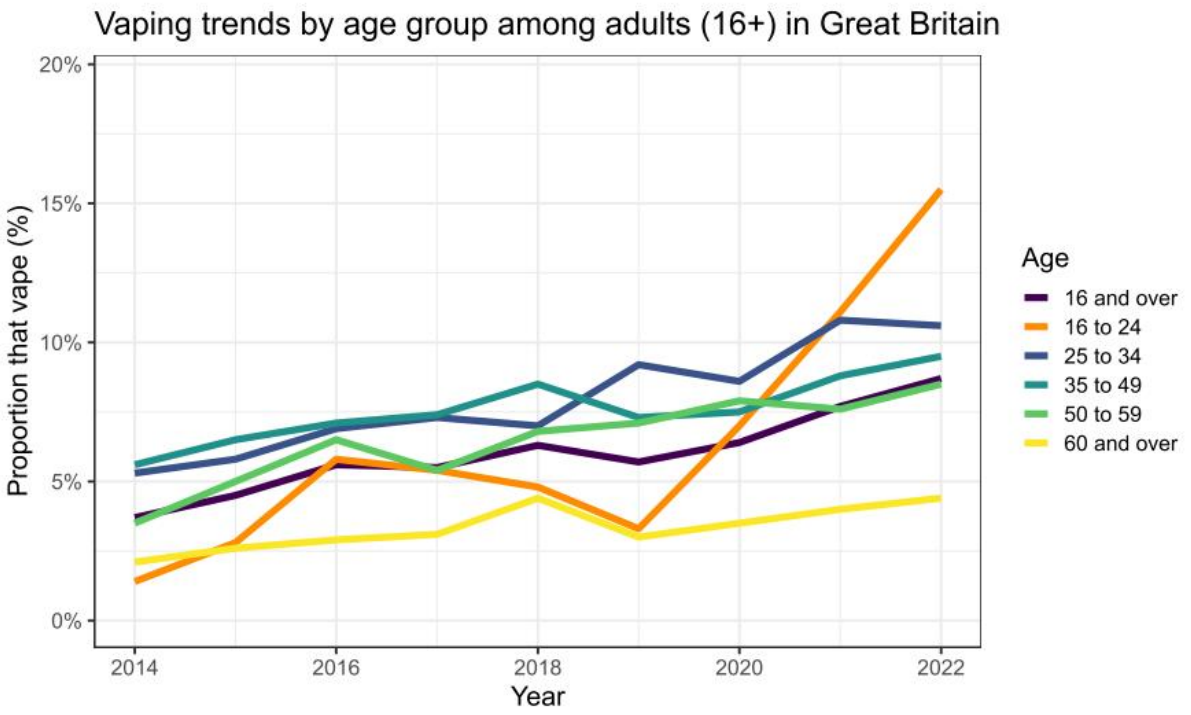


Figure 22: Vaping prevalence by age group in Great Britain. Source: Office for National Statistics based on the Opinions and Lifestyle Survey data.

[23] **Adult smoking habits in the UK** – Office for National Statistics (ons.gov.uk) Office for National Statistics report referencing Opinions and Lifestyle Survey

[24] **E-cigarette use in Great Britain** – Office for National Statistics (ons.gov.uk)

Case Study

E-cigarette pilot and vouchers

In 2020 and early 2021, Norfolk County Council (NCC) Public Health, Smokefree Norfolk and the University of East Anglia conducted a pilot programme offering vouchers for vape starter kits or refills to specific groups in Great Yarmouth, where smoking rates are highest in Norfolk. These groups included individuals who had unsuccessfully tried to quit smoking, those with multiple health conditions, and people with mental health conditions.

During the trial, over 340 participants used their vouchers, and many provided positive feedback. Encouragingly, 42% of those who switched to vaping quit smoking at 4 weeks, with vapes proving effective where other methods had failed. The trial also helped dispel the myth that vaping is as harmful as, or more harmful, than smoking.

Given the success of the vape voucher trial, the service was expanded countywide in 2022, offering free 12-week vape vouchers to everyone in Norfolk as part of the stop smoking service. Recent figures show a 52% smoking quit rate at 4 weeks, surpassing the initial target.

Vaping in children and young people

Vaping is becoming more common among children and young people across England. Based on national data, around 13,600 children aged 11-17 in Norfolk are estimated to have tried vaping. An estimated 5,000 children aged 11-17 (8%) are current users. Nationally, use increased slightly in 2023, after having doubled from 2021 to 2022.

Only one in three children believe that e-cigarettes are less harmful than cigarettes. More than half believe they are as harmful as, or more harmful than, smoking.[25]

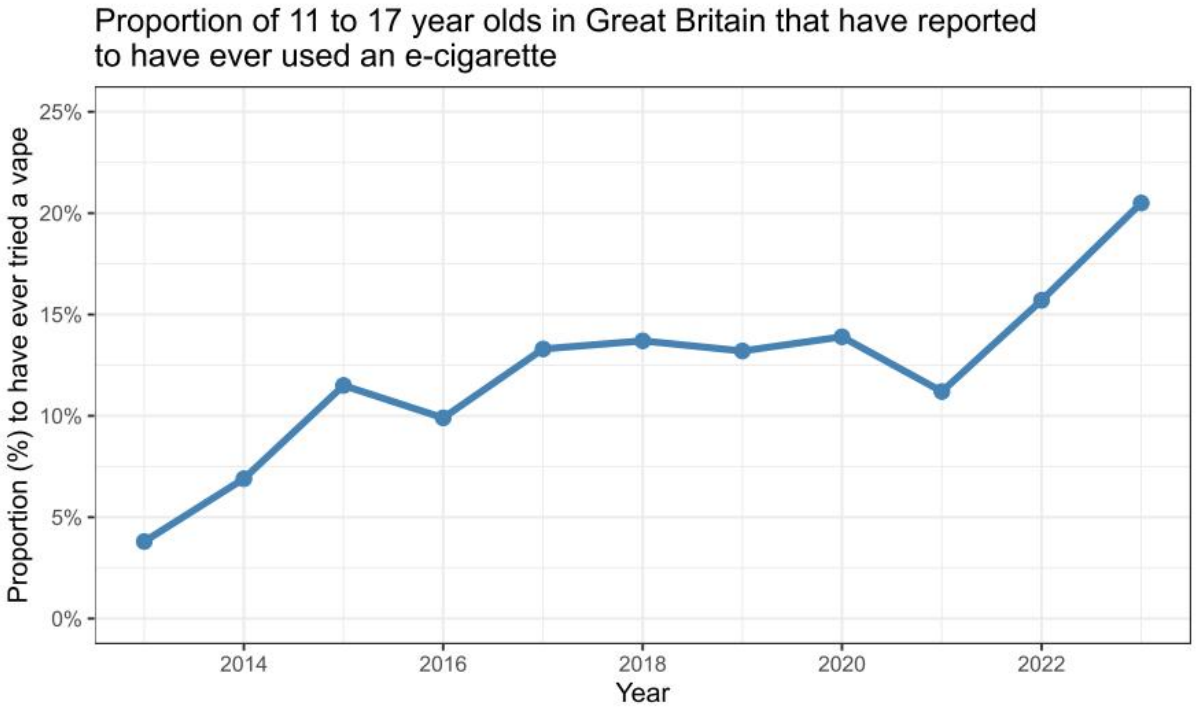


Figure 23: Vaping prevalence by age group in Great Britain. Source: Action on Smoking and Health.

The use of single-use e-cigarettes among children has increased substantially from fewer than one in ten young vapers preferring disposable vapes in 2021 to seven in ten in 2023.[26]

[25] ASH – Use of e-cigarettes among young people in Great Britain

[26] ash.org.uk/resources/view/use-of-e-cigarettes-among-young-people-in-great-britain

Case Study

Schools vaping toolkit

In October 2023, Norfolk County Council's Children's Services developed a vaping toolkit for schools. The goal is to assist schools in tackling increased vaping by offering high quality guidance and resources for a comprehensive approach. The toolkit features an audit tool for schools to assess their current approaches and areas for improvement, along with an action plan to support further development. It emphasises preventative measures and strategies to address vaping concerns:

- Supporting staff to feel confident in their knowledge of vaping and how it compares to smoking
- Creating an inclusive ethos and values around health, wellbeing and sustainability
- Teaching about vaping as part of Personal, Social, Health and Economic Education and within the wider curriculum
- Ensuring all staff, children, young people and families are aware of how to get support.

The toolkit provides a detailed step by step checklist for what to do if a student is found vaping, with a focus on supporting them to stay in school.

Section 2
National and local policy on smoking and vaping

Key messages

- Smoking rates have decreased over the past 60 years
- Knowledge, policies and attitudes towards smoking have also changed over time
- Reducing rates of smoking, effective tobacco control and controlling long term vaping use and take up are priorities for many organisations across Norfolk.

The changing national picture

Knowledge, policies and attitudes towards smoking have changed greatly over the past 60 years and smoking rates have declined as it has become more socially unacceptable.

Smoking prevalence timeline for Great Britain, ages 16 and over by gender for 1974 to 2022

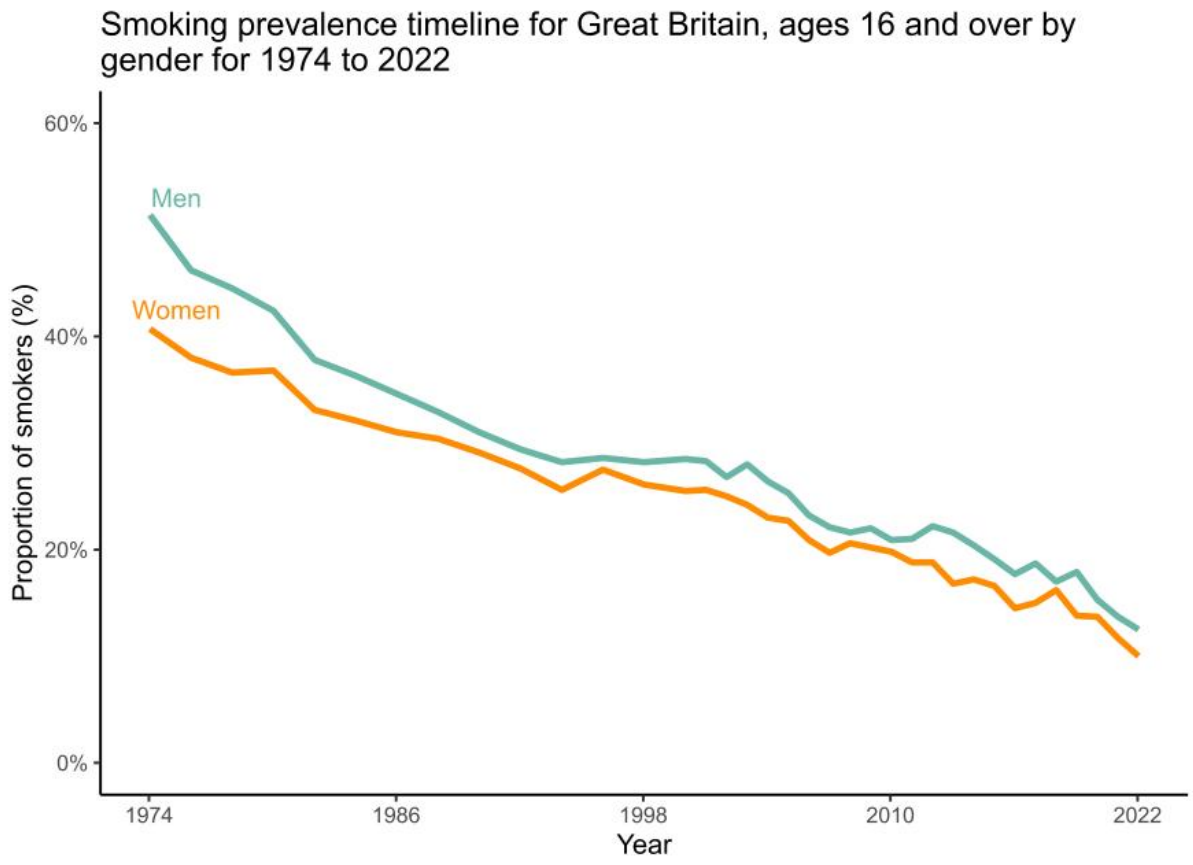
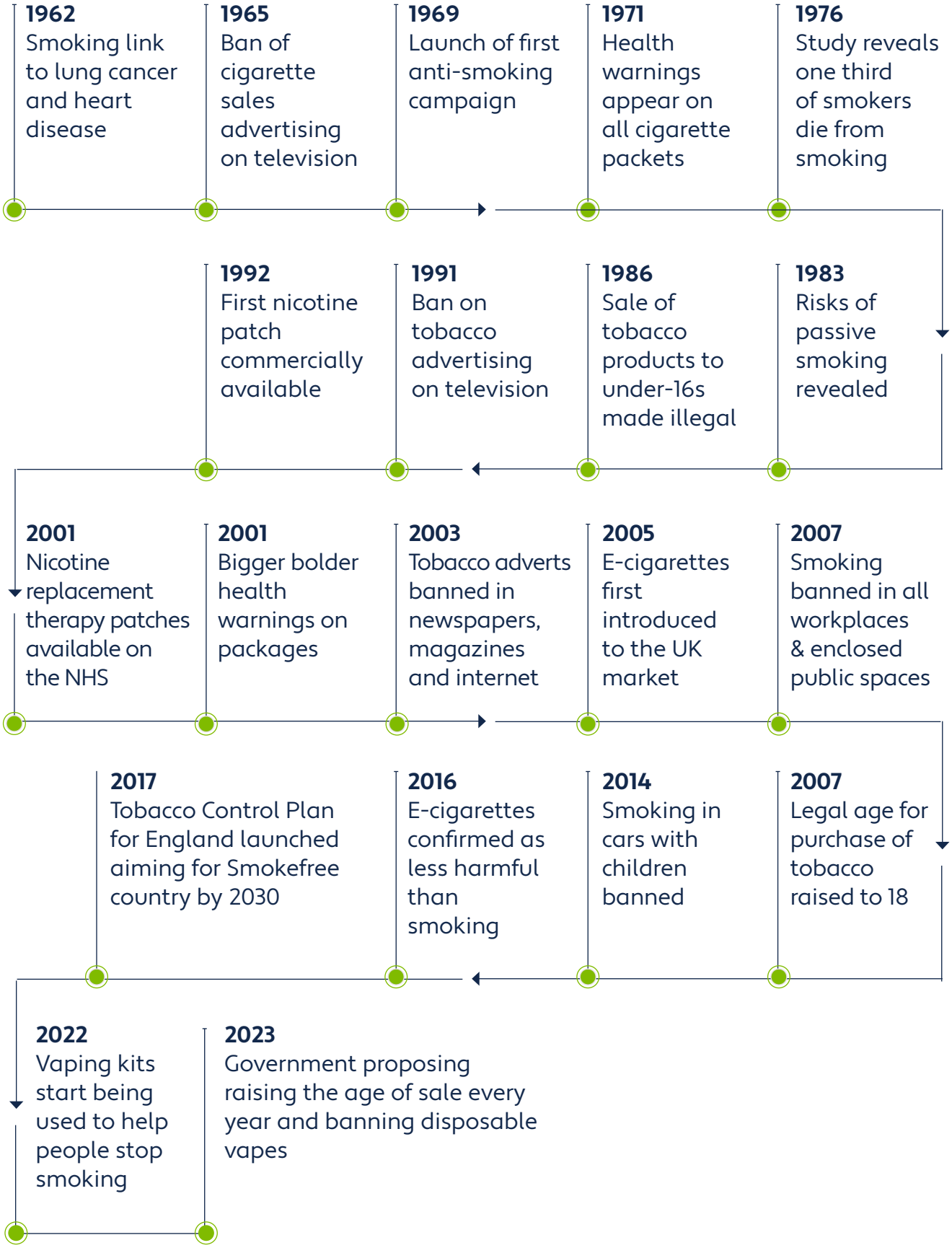


Figure 24: Timeline of the proportion of current smokers, for all persons aged 16 years and over, Great Britain, 1974 to 2022. Source: Office for National Statistics based on Opinions and Lifestyle Survey.


1962
Smoking link to lung cancer and heart disease
1965
Ban of cigarette sales advertising on television
1969
Launch of first anti-smoking campaign
1971
Health warnings appear on all cigarette packets
1976
Study reveals one third of smokers die from smoking
1983
Risks of passive smoking revealed
1986
Sale of tobacco products to under-16s made illegal
1991
Ban on tobacco advertising on television
1992
First nicotine patch commercially available
2001
Nicotine replacement therapy patches available on the NHS
2001
Bigger bolder health warnings on packages
2003
Tobacco adverts banned in newspapers, magazines and internet
2005
E-cigarettes first introduced to the UK market
2007
Smoking banned in all workplaces & enclosed public spaces
2007
Legal age for purchase of tobacco raised to 18
2014
Smoking in cars with children banned
2016
E-cigarettes confirmed as less harmful than smoking
2017
Tobacco Control Plan for England launched aiming for Smokefree country by 2030
2022
Vaping kits start being used to help people stop smoking
2023
Government proposing raising the age of sale every year and banning disposable vapes

Local plans and strategies

Ambitions around reducing rates of smoking, effective tobacco control and controlling long term vaping use and take-up are not just the priorities for the County Council's public health team – many organisations across Norfolk highlight their work on these aims:

- The Integrated Care System (ICS) **Integrated Care Strategy and Joint Health and Wellbeing Strategy** commits to addressing inequalities and prioritising prevention, to reduce years spent in poor health and differences in life expectancy due to deaths from circulatory, cancer and respiratory diseases, for which smoking is a chief contributor
- The ICS **Clinical Strategy** commits to acting early to improve health by predicting, detecting and acting early to prevent poor health by helping people make healthy choices, which includes stopping smoking
- The ICS **Joint Forward Plan** commits to developing and providing a maternity led stop smoking service for pregnant women and partners
- The ICS Health Improvement Transformation Group has agreed smoking as one of two priority areas for action across the Integrated Care System
- Norfolk County Council's Strategy **Better together for Norfolk** commits to supporting people to make healthy choices such as providing free stop smoking services
- Norfolk County Council's **Public Health Strategic Plan** commits to delivering a new programme of tobacco control and stop smoking initiatives to help people to stop smoking and create smokefree environments
- The Norfolk Tobacco and Vaping Control Alliance agreed a system-wide programme of work to help Norfolk to become smokefree by 2030 (defined as smoking rates of 5% or less), and developed a vaping delivery plan.

Section 3
The wider impacts of smoking on Norfolk residents and opportunities for improvement

Smoking has any number of negative impacts – some of these are described below.

Key messages

- Around 1,240 people in Norfolk die as a result of smoking every year
- On average, smokers spend around £3,100 each year on smoking
- Smoking costs Norfolk as a whole around £872 million per year
- Benefits from reducing or eliminating smoking could include:
    - Saving around 1,200 lives each year
    - Having around 1,130 fewer hospital admissions per year
    - Preventing 1,100 cases of cancer each year
    - Having around 480 more smokefree pregnancies
    - 16,500 less well-off households could be better off financially which could help them move out of poverty.

Cost of smoking to individuals, communities and services

Around 1,240 people in Norfolk die each year as a result of smoking. While the Norfolk rate overall is lower than the national average, deaths from smoking are largely preventable and rates will vary by place.

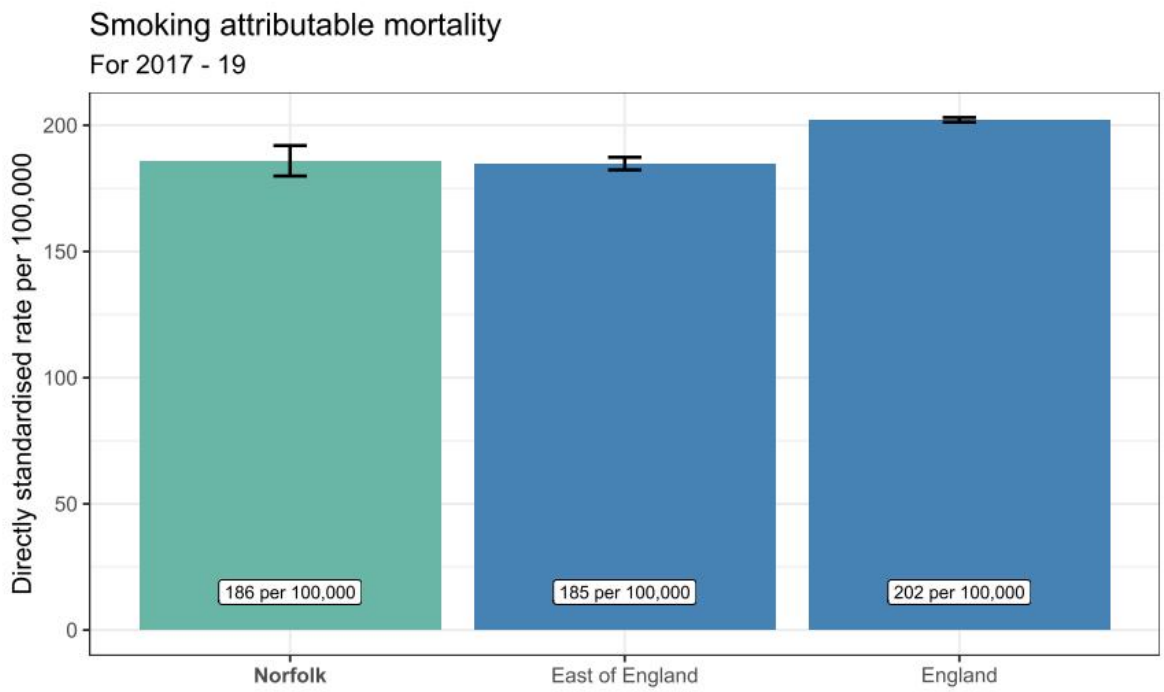


Figure 25: Smoking attributable mortality, 2017 to 2019. Source: Office of Health Improvement and Disparities using mortality data from the Office of National Statistics mortality data; Office for National Statistics (ONS) – mid-year population estimates; Smoking prevalence data from Annual Population Survey; and relative risks from the Royal College of Physician's Report 'Hiding in Plain Sight'.

Smoking has a financial cost[27] – to individuals and their families, to the economy, and to local services – as well as the personal impact of illness and death on individuals and loved ones.

Norfolk residents spend around £308 million on tobacco products each year, which is based on the average spend of about £3,100 per smoker each year. This generates around £198 million in tax revenue – however, it is estimated that smoking costs Norfolk far more, at around £872 million per year:

- £7 million as a result of house fires
- £239 million for social care due to smoking related conditions
- £30 million on hospital admissions and primary care services
- £596 million per year in productivity loss from the economy[28] including:
    - £136 million in lost earnings
    - £189 million due to smoking-related unemployment
    - £239 million loss to the local economy if people had switched their spending from tobacco to other products[29]
    - £31 million due to smoking related early deaths.

In Norfolk we have higher rates of hospital admissions related to smoking than England, indicating a potentially greater impact on health services in Norfolk when compared to the England average.

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[27] **ash.org.uk/resources/view/ash-ready-reckoner**

[28] Figures don't add up to £596 million due to rounding

[29] **Gross Value Added (GVA) ASH Ready Reckoner** – ASH

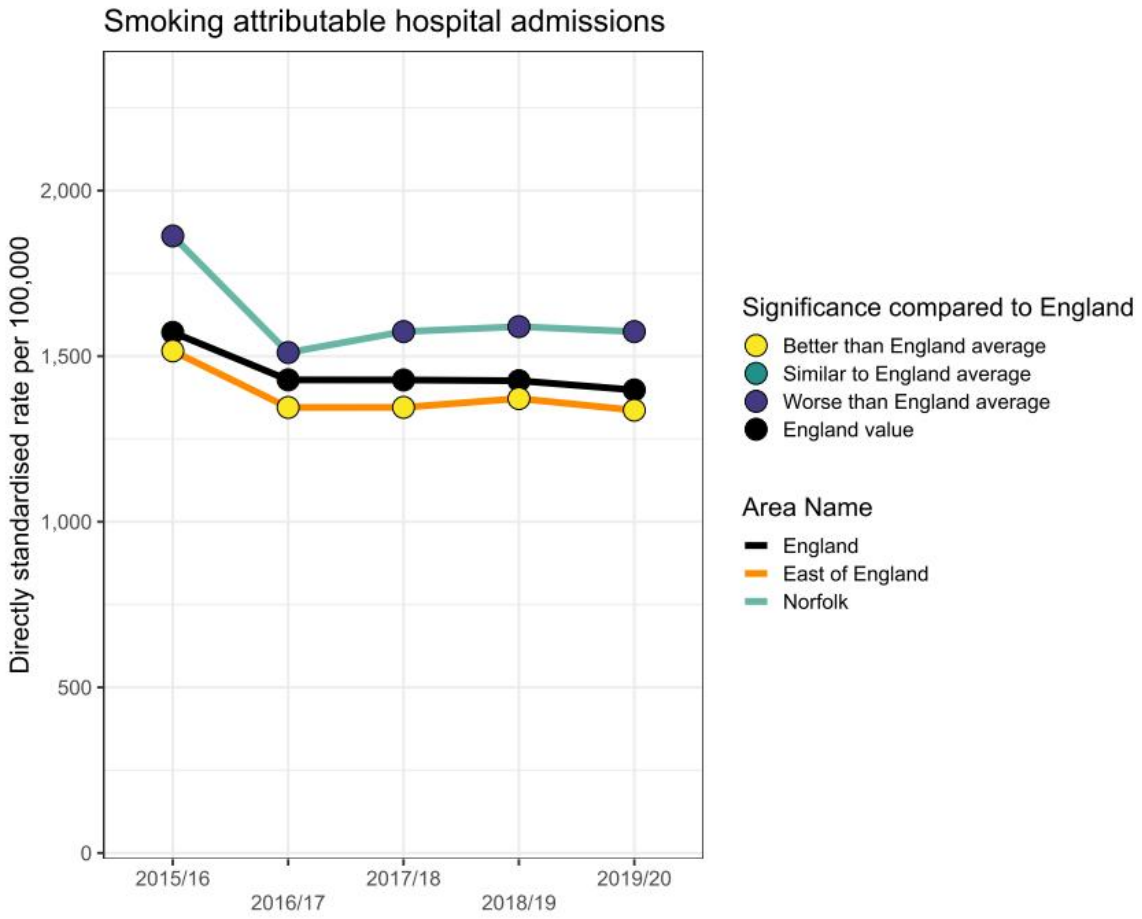

Figure 26: Smoking attributable hospital admissions over time. Source: Office of Health Improvement and Disparities using admissions data from Hospital Episode Statistics (HES); Office for National Statistics (ONS) – mid-year population estimates; Smoking prevalence data from Annual Population Survey; and relative risks from the Royal College of Physician's Report 'Hiding in Plain Sight'.

Case Study

Help for inpatients to stop smoking at the James Paget University Hospital

NHS England has committed that by 2023/24 all people admitted to hospital will be offered free tobacco treatment services. In Norfolk and Waveney, this started in May 2022, with stop smoking support being offered directly in hospitals for inpatients. The James Paget University Hospital in Great Yarmouth was chosen early because many people in the area smoke, and there are greater health inequalities in that area than in other parts of Norfolk.

When hospital patients are identified as smokers, they are referred to a specialist team to help them quit. The team provides nicotine replacement therapy (NRT) and other support to increase the patients' chances of quitting. When leaving hospital, patients receive extra NRT and are referred to Smokefree Norfolk for further support at home.

Since the project started, 87% of smokers have been referred to the team, with 79% receiving support and 24% successfully quitting smoking. These results are encouraging, especially as people may not have been planning to quit before they went into hospital.

Opportunities and benefits of reducing smoking in Norfolk

Over the longer term, rates of smoking have been decreasing, but there is still more we can all do to achieve a smokefree county. Below are examples of some of the opportunities and benefits that could be realised if we continue our joint working and focus:

If smoking were eliminated, we could eventually save future Norfolk generations around 1,240 lives per year.[30]

Smoking costs the average smoker around £3,100 a year.[31] If smoking were eliminated then around 16,500 less well-off households would be better off financially which could help them move out of poverty.[32]

Smoking results in over 10,000 hospital admissions each year in Norfolk.[33] If Norfolk had the same rate of admissions as the national average, that would result in around 1,130 fewer hospital admissions per year.

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[30] Office for Health Improvement & Disparities: Local Tobacco Control Profiles: Smoking attributable mortality (new method) 2017-19 directly standardised rate – per 100,000. [Accessed 05/02/2024] **fingertips.phe.org.uk** © Crown copyright 2023.

[31] **ash.org.uk/resources/view/ash-ready-reckoner**

[32] **ash.org.uk/resources/view/economic-and-health-inequalities-dashboard**

[33] Office for Health Improvement & Disparities: Local Tobacco Control Profiles: Smoking attributable hospital admissions (new method) 2019/20 directly standardised rate - per 100,000 [Accessed 05/02/2024] **fingertips.phe.org.uk** © Crown copyright 2023.

Eliminating smoking entirely would reduce cancer cases by around 15%.[34] This would mean that Norfolk and Waveney would see a reduction of over 1,100 cancer diagnoses per year.[35] Achieving the 2030 smokefree ambition of having fewer than 5% of the population smoke would prevent around 680 cancers per year across the system.

Norfolk has a higher than average rate of mothers who smoke during pregnancy. If Norfolk had the same rate of mothers who smoke during pregnancy as the national average, then 205 more babies would have been born smokefree in 2022/23. If Norfolk rates reduced to 5%, then around 480 more deliveries would have been smokefree, significantly improving the health of babies and children in Norfolk, as well as the health of their mothers.

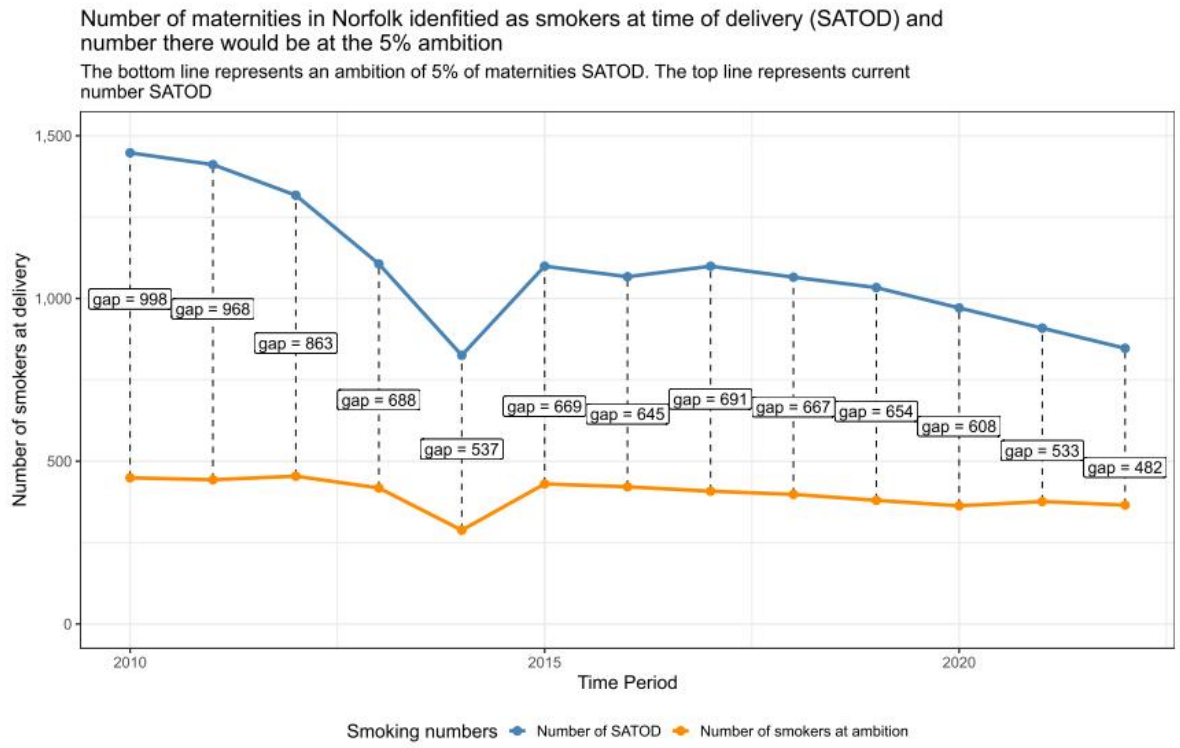

Figure 27: Number of deliveries that are recorded as smoking at time of delivery, and the number that there would be if only 5% of mothers were recorded as smokers, with the gap between the current and ambition over time. Source: Office for Health Improvement and Disparities based on the NHS digital Smoking at Time of Delivery data return.

[34] www.cancerresearchuk.org/health-professional/cancer-statistics/risk#heading-Two

[35] Cancer Services – Data – OHID phe.org.uk

Section 4
What next?

In 2024, organisations in Norfolk will intensify their efforts to tackle smoking and vaping – both dependency and take-up.

NCC Public Health plans to enhance free local stop smoking services by investing additional government funding in line with the goal of creating a smokefree generation. This will include supporting local organisations to train frontline staff to have effective conversations with people about their health and equipping them with techniques to help people to stop smoking.

The Norfolk Tobacco Control and Vaping Alliance will work together to implement the Norfolk Tobacco Control Strategy and vaping delivery plan.

NCC Public Health will promote swapping from smoking to vaping to help quit as a positive health move through prominent media campaigns and will continue to fund the provision of e-cigarettes in the main stop smoking service.

In hospitals, the **NHS** aims to expand smoking cessation options for patients, offering NHS funded tobacco treatment services to those admitted as acute, maternity or mental health inpatients.

NCC Public Health will continue to work with **Children's Services**, head teachers and other representative organisations to promote responsible messages on smoking and vaping and to work with young people to counter the rising trend of vaping among those who have never smoked.

NCC Trading Standards and Public Health will highlight the risks of illegal vapes, continue enforcement efforts and work with reputable retailers through information dissemination and exploring a trusted trader scheme.

Case Study

Trading Standards action on illegal tobacco and vapes

Norfolk County Council's Trading Standards team collaborates with Norfolk Police and district councils to enforce tobacco control laws. They conduct frequent operations, such as test purchases and inspections, prompted by intelligence indicating concerns about the sale of illegal products. Inspections during 2023 led to the removal of over 16,500 illegal disposable vapes from the market.

Tobacco search dogs are often employed to find hidden illegal cigarettes and hand-rolling tobacco. In a November 2023 operation, two premises in the county had 847 illegal vapes, 760 illegal cigarettes, and 950g of illegal hand-rolling tobacco seized. Both traders used concealment spaces to hide the products, which is a common practice.

Working in partnership with the Borough Council of King's Lynn & West Norfolk and Norfolk Constabulary, one of the businesses had a closure order issued against them through the Courts.

What we can all do

Helping achieve a smokefree generation and continuing to help eliminate smoking from society is something we can all contribute to.

Whether you...

- Are a smoker
- Are a professional who encounters people who smoke
- Are an employer
- Are a Norfolk resident
- Know someone who smokes

...there are things you can do to help Norfolk to become smokefree:

- Remember it's never too late to take action on smoking
- Remember that most people don't smoke
- Promote **Ready to Change** to family and friends, and share the **explainer video** with people you know who are looking to quit smoking
- Remember that free specialist stop-smoking support is available from **Smokefree Norfolk**, as well as some GP practices and pharmacies, for people who have found quitting by themselves difficult
- Remember that quitting smoking during and after pregnancy can help mothers and babies – and help is available from **Smokefree Norfolk**
- Remember that if you smoke, vaping is much less harmful, and swapping from smoking to vaping is a positive health move
- If you don't smoke, don't vape
- If you work with or know young people who might be smoking or vaping, have a look at the information from **Just One Norfolk**
- If you are part of an organisation working to improve the lives of your clients or patients, consider the free **Make Every Contact Count and Behaviour Change Training** for your staff offered by Public Health
- If you are an employer, consider smokefree workplace policies and signpost staff to **Ready to Change** and **Smokefree Norfolk**
- Be aware that the illicit trade of tobacco and vapes causes harm to individuals and society. If you are aware of traders selling illicit products, or selling tobacco or vapes to under 18s, please report them to Trading Standards via the **Citizens Advice Online Portal**
- Take action to reduce children and young people's exposure to smoking – whether at home, in cars, at school gates or anywhere else where children and young people congregate.

Section 5
Summary

Smoking, while decreasing over time, still causes too much harm and is a key cause of health inequalities in Norfolk. The good news is that there are steps we can all take to reduce the harm that smoking causes.

Smoking is addictive and it can be difficult to stop, but quitting smoking is one of the best things smokers can do to improve their health. Quitting is easier and more effective with support – free help to quit is available and increasing.

Vaping is much less harmful than smoking and can be a useful tool to help smokers to quit. However, the advice is: if you don't smoke, don't vape. There is a particular focus on children and young people to prevent them taking up vaping.

Organisations across Norfolk have prioritised smoking reduction and tobacco control and are working together to reduce smoking related harm to local residents. There are great opportunities for further action and achievement.

We all have a role to play in helping to achieve a smokefree county.

Acknowledgements

I would like to thank all the contributors to this Annual Report, especially Diane Steiner, Michael Woodward, Ciceley Scarborough, Josh Robotham, David Thurkettle, Katherine Attwell, Rosie Christmas, Andreas Sutter, Teresa Gibbon, Lou Banning, Sophie Harrison and Nina Brown amongst others.

Thanks are also due to all those in Norfolk who help to reduce smoking locally – including those who have successfully quit smoking, and those who are on the way.

Credits
Design: Tom Watson and Nina Brown
Images: Getty Images

More information

If you would like further facts and figures, you can find them here:

www.norfolkinsight.org.uk/resource-norfolk-tobacco-health-needs-assessment

and

www.norfolkinsight.org.uk/resource-norfolk-tobacco-health-needs-assessment-summary-infographic

Weblink for this report is **DPH Report 2023**

For help quitting smoking, visit Ready to Change **www.readytochange.co.uk**

IN TRAN communication for all

If you need this document in large print, in audio, Braille, in an alternative format or in another language, please contact customer services on **0344 800 8020** or, for Text Relay, call **18001 0344 800 8020** (text phone) and we will do our best to help you.

Norfolk Health and Wellbeing Board

Item No: 9

Report title: Better Care Fund Quarterly Reports

Date of meeting: 06 March 2024

Sponsor (HWB member): Debbie Bartlett, Executive Director of Adult Social Services, Norfolk County Council

Reason for the Report

The Health and Wellbeing Board (HWB) holds the responsibility for overseeing and signing off the Better Care Fund (BCF), plans each year and for signing of each of the quarterly reports requested by the national Better Care Team. We include Q2 report and Q3 reports for sign-off. We also provide an update on the Review of Core BCF Schemes as mentioned to the Board at its September 2023 meeting. The Q3 report gives an update of committed spend to date and with the Board's agreement, we will bring the end of year report to the June meeting of the Board.

Report summary

The Norfolk Better Care Fund Team welcomes the opportunity to share the recent quarterly reports with the Board and provides information to support the Board to fulfil its responsibility of signing off both reports. We are pleased to share that the schemes are working to key national and local metrics, supporting key programmes of work across the prevention and hospital discharge. Quarterly reporting on BCF spend and activity had been suspended during the Covid pandemic and did not commence until quarter two this year.

The Q2 report is attached for sign-off by the Board. Key highlights are included in the body of the report. This report offered the opportunity to refresh the Demand and Capacity data. Given the work undertaken following the ministerial visit and feedback last March, it was felt that our plan had been comprehensively reviewed and that the data remained valid therefore a refresh was not undertaken. National conditions were met and key metrics on track with the exception of the rate of admissions to residential care homes, where the planned performance figure was questioned as the data suggested a higher number of admissions were expected.

Q3 report is also attached for sign-off. This quarter we have been asked for data on spend to date and metrics on a number of schemes. As in quarter two we confirm we meet the 4 National Conditions, and three of the key metrics. Latest performance shows that we are not on track to meet the rate of admissions to residential care and the reasons behind this are being investigated.

We would like to take this opportunity to bring to the Board's attention to two case studies from Norfolk Schemes (see 2.3), that are featured in an ADASS East and NHS England jointly published report highlighting examples of good practice in use of the Better Care Fund, these are the NFR reablement service and the Housing with Care Flats scheme.

The BCF End of year report will be ready to present to the Board at the June meeting. The BCF review of schemes funded through the core BCF is underway. Key early findings show how varied and broad reaching the schemes are whilst also meeting national and locally agreed criteria and focussed on the prevention and hospital discharge agendas. A gap has been identified related to a clear understanding of how schemes are included in the BCF and how financial space is created to allow new schemes access to BCF funding. On of the outputs of the review will be to create a standard procedure that can be shared across the system.

Recommendations

The HWB is asked to:

a) Agree and sign-off the BCF Q2 and Q3 reports.
b) Endorse the work of the BCF review to date.
c) Support a presentation of the end of year report at the next meeting of the Health and Wellbeing Board.

1. Background

1.1 The Better Care Fund (BCF) is a nationally mandated programme, launched in 2013 with the aim of joining up health and care services, so that people can manage their own health and wellbeing and live independently.

1.2 The BCF is a priority for our Health and Wellbeing Board and a key element of joint working, focusing on some of the most important integration priorities in our Integrated Care System (ICS). Partners utilise the BCF to fund and develop critical services that support the health and wellbeing of our population, including care from the provider market, key health and care operational teams, and community-based support.
The BCF is made up of a number of elements:

- Core BCF (NHS Minimum Contribution)
- Improved BCF (iBCF)
- Disabled Facilities Grant (DFG)
- Additional Discharge Fund (ADF)

1.3 The BCF pools a statutory minimum contribution of funding between the ICB and the Local Authority (LA). Funding is fully allocated each year on a programme of jointly agreed schemes, the majority of which are long term commissioning commitments. Should a decision be made to include a new service in the BCF, then an existing service needs to be decommissioned or alternatively funded. This is unless an agreement is reached to include additional discretionary funding from the ICB or LA within the BCF.

1.4 We work together to agree the allocations between the ICB and the LA of the minimum NHS contribution and the annual joint BCF plan, both of which are signed off and governed by the Health and Wellbeing Board.

1.5 The Board is responsible for signing off the annual plans and quarterly reports. The 23/24 plan was signed off by the Board at the September 2023 meeting where an update was requested on the progress of the planned BCF review.

1.6 This is included in this report together with the quarter two and quarter three reports for sign-off by the Board.

2. BCF Quarterly Reports

2.1 The Quarter 2 Report

2.1.1 The overall headlines from the quarter two report (see appendix 1) shows that national conditions and key metrics are being met. Challenges to delivery included continuing high demand on urgent and emergency care and recruitment including into Norfolk First Support (NFS), our reablement service.

2.1.2 National Conditions; a jointly agreed plan, the objectives of enabling people to stay safe and well in their own home and, providing the right care in the right place at the right time, and the NHS's contribution to adult social care and investment in NHS commissioned out of hospital services, were all met.

2.1.3 The metrics tab shows that we are on track to meet the key targets on;

- Avoidable admissions,
- Discharging people to their normal place of residence,
- Reducing the number of emergency hospital admissions due to falls in the home,
- Evidencing that people who have received reablement support on discharge, remain living at home 91 days after discharge.

2.1.4 We are working on obtaining robust data to report accurately on rate of permanent admissions to residential homes. Whilst this appears high, the challenges across the county around availability of appropriate housing for people living with complex needs is being discussed as perhaps being a factor in the higher admission rates to residential care. Our falls prevention programme and the improved community support offer will have a longer term impact on admissions.

2.1.5 Key achievements include the setting up of the Norfolk and Waveney Unscheduled Care Coordination Hub which went live in August 2023 and the new Community Support Service which brings together a number of existing community support services and providers to work together to offer a more consistent community approach across Norfolk and Waveney. We have delivered Phase 1 of the Proactive Interventions Project which saw over two thousand letters being sent to individuals identified as being high risk of experiencing a fall, with follow up phone calls to discuss the risk and to offer referrals into a range of services.

2.1.6 Capacity and Demand – Whilst there was an opportunity to refresh our data in the Q2 report, we had carried out an extensive revision following on from the ministerial visit in March and therefore did not refresh the data. There is likely to be a further opportunity to re-visit capacity and demand in Q4.

2.1.7 A request to understand what is meant by ‘avoidable admissions’ was raised at the September 2023 meeting of the Board. This is the number of unplanned hospital admissions for people with specific long-term conditions such as diabetes, epilepsy and high blood pressure, which should not normally require hospitalisation but are admitted in an emergency. The outcome is concerned with how successfully the NHS manages to reduce emergency admissions for all long-term conditions where optimum management can be achieved in the community, (NHS Outcomes Framework indicator 2.3i). Prevention services are vital in working alongside NHS services to support individuals manage their long-term conditions, so this metric is supported by a range of services through the BCF.

2.2 Quarter 3 Report

2.2.1 The Quarter 3 report (see appendix 2) shows that national conditions continue to be met and that we are on target to meet all metrics as set out in quarter two report. The main concern being the rate of permanent admission to residential care.

2.2.2 We have been asked to update our spend profile to date and to confirm activity on a number of schemes. This is currently being collated with early data showing spend and activity on track.

2.3 Good Practice Case Studies

2.3.1 We would like to bring to the Boards’ attention two case studies from Norfolk Schemes that are featured in an ADASS East and NHS England jointly published report highlighting examples of good practice in use of the Better Care Fund. The schemes featured are Norfolk First Support, our reablement at home service and the development of Housing with Care flats to provide people with a place to stay and receive care whilst a home care package was being sourced. Go to adasseast.org.uk to read the East of England Better

Care Fund Emerging Practice Report December 2023, to learn more about these case studies and other examples from the East of England.

2.4 BCF Review

2.4.1 The review of the schemes funded through the core BCF has been developed in response to requests from the Board and the Integrated Care Board (ICB) Executive Management Team. It is to continue the review commenced in 2021 to further our understanding of how the BCF is utilised, and importantly, the impact the schemes have for our residents and across the system.

2.4.2 The review is focussed on schemes funded by the Core BCF and seeks to;

- Confirm alignment of schemes to agreed local priorities and national BCF criteria.
- Bring a greater understanding of how the BCF is used across Place.
- Improve data collection and presentation of data to inform understanding of impact.

2.4.3 The review commenced in quarter three and to date almost 80% of the commissioning leads of the schemes have been contacted. The data gathering is drawing to an end and ahead of the review report being published, key findings are emerging;

- All schemes meet national, and Norfolk agreed criteria with the delegated funding to Health and Wellbeing Partnerships supporting specific place based priorities.
- Identifying lead commissioners for some schemes took time and it became clear that there in some cases there is a disconnect between receiving funding, which in all cases was welcomed and there was accepted reassurance of the funding as an assured income, and any commitment to sharing performance and impact data with the Better Care Fund team. However, closer working has been welcomed by commissioners and this will lead to improved reporting and sharing of the successes of the schemes in the future.
- There is a mixture of contracts and grant funding. In the case of grant funded schemes, we need to ensure enough information is being gathered and shared to understand the impact of our spending.
- Many schemes receive funding from multiple sources, and it can be difficult to account for the exact impact of the BCF funding. However, it is clear that the funding contributes to overall outcomes achieved for each scheme, which otherwise would not be possible
- Service User feedback is often routinely gathered by providers but not shared with the BCF team.
- There is a gap in how we include and remove schemes from the fund making it clear that a process needs to be developed and shared to increase transparency.
- This is proving a valuable experience and opportunity to demonstrate the breadth of schemes and impact the BCF is having across Norfolk.

Officer Contact

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

Name: Nick Clinch Tel: 01603 223329 Email: Nicholas.clinch@norfolk.gov.uk

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

1. Guidance for Quarter 2

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities (DLUHC), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) In Quarter 2 to refresh capacity and demand plans, and in Quarter 3 to confirm activity to date, where BCF funded schemes include output estimates, and at the End of Year actual income and expenditure in BCF plans
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans, including performance metrics
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF reporting is likely to be used by local areas, alongside any other information to help inform Health and Wellbeing Boards (HWBs) on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

BCF reports submitted by local areas are required to be signed off by HWBs, including through delegated arrangements as appropriate, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background and those that are not for completion are in grey, as below:

Data needs inputting in the cell
Pre-populated cells
Not applicable - cells where data cannot be added

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste 'Values' only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

5. Please ensure that all boxes on the checklist are green before submitting to england.bettercarefundteam@nhs.net and copying in your Better Care Manager.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the HWB to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the HWB to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time

National condition 4: Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Reablement outcomes (people aged over 65 still at home 91 days after discharge from hospital to reablement or rehabilitation at home), and;
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process.

This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2023-24 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at HWB level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- on track to meet the ambition
- not on track to meet the ambition
- data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements.

- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Capacity & Demand Refresh

Please use this section to update both capacity and demand (C&D) estimates for the period November 2023 to March 2024.
This section is split into 3 separate tabs:

5.1 C&D Guidance & Assumptions

Contains guidance notes including how to calculate demand/capacity as well as 6 questions seeking to address the assumptions used in the calculations, changes in the first 6 months of the year, and any support needs and ongoing data issues.

5.2 C&D Hospital Discharge

Please use this section to enter updated demand and capacity related to Hospital Discharge in the bottom two tables. The table at the top then calculates the gap or surplus of capacity using the figures provided. expected capacity and demand from your original planning template has been populated for reference. If estimates for demand and/or capacity have not changed since your original plan, please re enter these figures in the relevant fields (i.e. do not leave them blank).

In Capacity and Demand plans for 2023-24, areas were advised not to include capacity you would expect to spot purchase. This is in line with guidance on intermediate care, including the new Intermediate Care Framework. However, for this exercise we are collecting the number of packages of intermediate/short term care that you expect to spot purchase to meet demand for facilitated hospital discharge. This is being collected in a separate set of fields. You should therefore:

- record revised demand for hospital discharge by the type of support needed from row 30 onwards
- record current commissioned capacity by service type (not including spot purchasing) in cells K22 to O26
- record the amount of capacity you expect to spot purchase to meet demand in cells P22 to T26.

Spot purchased capacity should be capacity that is additional to the main estimate of commissioned/contracted capacity (i.e. the spot purchased figure should not be included in the commissioned capacity figure). This figure should represent capacity that your local area is confident it can spot-purchase and is affordable, recognising that it is unlikely to be best value for money and local areas will be working to reduce this area of spend in the longer term.

5.3 C&D Community

Please use this section to enter updated demand and capacity related to referrals from community sources in the bottom two tables. The table at the top then calculates the gap or surplus of capacity using the figures provided. The same period's figures has been extracted from your planning template for reference.

If estimates for demand and/or capacity have not changed since your original plan, please re enter these figures in the relevant fields (i.e. do not leave them blank).

Data from assured BCF plans has been pre-populated in tabs 5.2 and 5.3. If these do not match with your final plan, please let your BCM and the national team know so that we can update out records and note the discrepancy in your response to question 1 on tab 5.1. Enter your current expected demand and capacity as normal in tabs 5.2 and 5.3.

HM Government

NHS England

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

2. Cover

Version 3.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Norfolk	
Completed by:	Nick Clinch	
E-mail:	nicholas.clinch@norflk.gov.uk	
Contact number:	01603 223329	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Mon 03/06/2024	<< Please enter using the format, DD/MM/YYYY

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC Discharge Fund tab.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D Hospital Discharge	Yes
5.3 C&D Community	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Norfolk

Has the section 75 agreement for your BCF plan been finalised and signed off?	No
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off	31/12/2023

Confirmation of National Conditions

National Conditions	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter:	Checklist Complete:
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

etter Care Fund 2023-25 Quarter 2 Quarterly Reporting Templa

4. Metrics

Selected Health and Wellbeing Board: Norfolk

National data may be unavailable at the time of reporting. As such, please use data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2023-24 planning				For information - actual performance for Q1	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
		Q1	Q2	Q3	Q4					
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	185.7	167.8	184.1	192.8	195.8	On track to meet target	Urgent and emergency care pressures in Norfolk and Waveney remain high, impacting on the capacity of services across the system. Work is ongoing to develop system-wide care coordination and single point of access that will identify patients urgent care needs via 999 and 111 calls, and coordinate care to prevent the need for an emergency episode of care. We expect this will reduce emergency admissions for ambulatory care sensitive conditions by facilitating community responses through Urgent Care Response Teams (UCRT,) Virtual Ward and Primary Care Network (PCN) teams with planned, urgent secondary appointments such as Same Day Emergency Care (SDEC), where necessary to avoid the need for an emergency admission.	A successful care homes pilot will continue over Winter 2023-24. For the pilot, the 111 provider (IC24) and the ICB's Digital Team work together to enable out of hours virtual clinical support, with supplementary on-the ground support when needed. Care home staff have benefitted from the clinical backup e.g. to give confidence when using the falls equipment (that they are trained to use) to pick up non-injured fallers (see also Row 17 re: care homes/falls). An Expression of Interest has been submitted to NHSE to extend the scope of this pilot with additional technology, such as fit-bit style wearable monitors that enable tracking of health conditions/issues e.g. alerting care home staff if the person is unstable on their feet or has had a fall. - The N&W Unscheduled Care Coordination Hub (UCCH) went live in August 2023. UCCH enables ambulance and Urgent Care Response (UCR) resources to discuss cases on the stack as a multi-disciplinary team (MDT), and agree a timely plan to support the person using local UCR resources to address the crisis/avoid an admission. All UCR cases receive a follow-up welfare call and can be referred to other relevant support services. - NEATs (Network of Escalation Avoidance Teams) support urgent cases in the community with complex needs. Each NEAT has MDT resources including social care, integrated care coordinators, a mental health nurse and community healthcare resources. Referrals are from any healthcare professional, often GPs and paramedics. NEAT coordinates an appropriate response to resolve the immediate crisis and address the person's needs. They can refer to 30+ system partner organisations e.g. housing, befriending, assistive technology, Men's Shed, etc. - Long Term Conditions (LTC) - the Enhanced Health & Wellbeing in Care (EHWC) programme supports care home residents with LTCs by providing support and training to the staff. The need may be identified by the care home staff or following a visit from the Integrated Quality Service (IQS) and can include • CDEP – Cambridge Diabetic Education Programme (an e-learning programme) • Hydration – supporting hydration interventions to reduce UTIs • Nutrition – promoting level 2 Chefs Award for adult social care settings, nutrition and hydration training for care home staff • Routine proactive management of long-term conditions to enhance quality of life • Wound care, leg and foot ulcers, skin care sessions, lower leg and diabetic foot care • Falls, strength and balance, chair based exercises, falls champions • Dementia level 2 qualifications • Dysphagia Champions • Long term breathlessness • Epilepsy • Pain Management • E-learning, videos, champions networks	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	92.0%	93.3%	93.0%	92.7%	93.25%	On track to meet target	Recruitment to the Norfolk First Support service continues to be challenging.	Norfolk First Support provides up to six weeks of support and reablement in a person's home to help people get back to doing things for themselves following a discharge from hospital and work out what help they will need in the future. This can be supplemented with input from the new Community Support Service for non-regulated tasks and wider social support. A new VCSE offer has been commissioned through the decommissioning/refocusing of funding from six legacy BCF VCSE (Voluntary, Community and Social Enterprise), schemes. Known as the "Norfolk & Waveney Community Support Service", it offers short-term, temporary practical support for individuals and aims to link clients with services, groups and support networks in their community. Support can be for 2-12 weeks depending on the complexity needs. The service can support individuals with underlying needs (e.g. multiple health issues, cognitive concerns, poor mobility) and/or help them to adjust and adapt to alterations in their life - such as illness, injury, long term health conditions and issues that affect their mental, social, physical and emotional health and wellbeing. Community healthcare providers and therapy outreach teams from the acute support individuals discharged with healthcare needs to enable their rehabilitation. Individuals with longer term needs beyond the up to 6-week discharge pathway will be assessed under the Care Act and suitable ongoing support will be arranged e.g. a package of care. Where appropriate for the complexity of the individual's needs (e.g. someone living with dementia) and under the NCC Caring for Better outcomes framework, a domiciliary care provider will be allocated to the case who can provide support for the first 6-weeks and beyond (if longer term needs are identified under the Care Act) to avoid a change of provider which could cause unnecessary distress to the person.	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,441.8	370.4	On track to meet target	There is a considerable focus on falls prevention and response across the system. There is work underway to ensure that the falls prevention and response pathways are aligned, robust and coherent and offer equity of outcome across the system. As the UCCH and the Virtual Ward models mature, and with support from ECIST (Emergency Care Improvement Support Team), it is hoped that the opportunities to improve the falls-response pathways will be identified - this may include the introduction of a single long-lie falls pathway and a pathway for fallers that have sustained a head injury whilst on blood thinners.	- A Strategic ICS Falls work programme has been initiated which incorporates three workstreams: Care Sector; Acute & Inpatient Settings; and Community (Prevention & Response). The aim is to share learning, innovation and expertise across the system to continually improve the falls offer for the population of Norfolk & Waveney. During Winter 2023-24, non-recurrent funding was allocated to the UCR teams to bolster their falls-related equipment which is used to enable more non-injurious fallers to be picked up safely. A Falls Car Pilot was also funded from Jan to March 2023, which was operated by Emergency Support Workers from the Ambulance Trust. Learning from these schemes is being fed back into the Community Falls workstream. Feedback is being sought on the community falls equipment funded through the Winter 22/23 budget and both ECCH (East Coast Community Health), and South Norfolk NCH&C (Norfolk Community Health and Care) have responded positively. The EEAST (East of England Ambulance Service), falls car data is being reviewed with EEAST to inform where we might target resource in the future. - Norfolk County Council (NCC) has delivered Phase 1 of a Proactive Interventions project which scours social care records to identify 80+ factors that identify individuals at high risk of experiencing a fall. 2000+ letters to this cohort have been followed up with a phone call to discuss the risk and offer referrals into a range of falls prevention services. Phase 2 starts in Autum 2023 which will include case-finding using District Council records. NCC have delivered falls training, falls equipment and access to the I-Stumble app to 200+ care homes. The Ambulance Trust and the UCCH are aware of the location of these care homes with falls equipment/training which supports with triage and planning a response. - Active NoW is a system approach to embedding physical activity in commissioned pathways. The ICB currently leads the Active NoW programme which has prioritised Falls prevention this year (year 2 of the project). Individuals can be referred to the exercise programmes by professionals working in the health and care system across Norfolk and Waveney.	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				444		Data not available to assess progress	Challenges around an ageing population, appropriate housing and complexity of need continue. Mitigations of additional support in the community , our falls prevention programme are taking time to impact on the number of long term residential starts	The figure of 444 was adjusted to 525.6 after our original submission. New starts for Q1 was 156.9, this will vary each quarter due to changing admissions profile over the year. Work will take place to refine numbers in Q3. Now ways of working, focussing on increased offer on home care and early prevention work through our connecting communities programme of work and community discharge support offer, will continue to be rolled out across all areas, resulting in reduced reliance on residential provision through 23-24.	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				85.0%		On track to meet target	Having had reablement is only one part of the picture and determinent of whether someone remains at home after 91 days therefore we have expanded our community support offer to enhance the holistic support being offered to individuals with ongoing social needs.	Norfolk First Support provides up to six weeks of support and reablement in a person's home to help people get back to doing things for themselves following a crisis and work out what help they will need in the future. This can be supplemented with input from the new Community Support Service for non-regulated tasks (see Row 18 for more information). Individuals with longer term needs beyond the up to 6-week discharge pathway will be assessed under the Care Act and suitable ongoing support will be arranged e.g. a package of care. Where appropriate for the complexity of the individual's needs (e.g. someone living with dementia) and under the NCC Caring for Better outcomes framework, a domiciliary care provider will be allocated to the case who can provide support for the first 6-weeks and beyond (if longer term needs are identified under the Care Act) to avoid a change of provider which could cause unnecessary distress to the person.	Yes

Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Norfolk

5.1 Assumptions

	Checklist Complete:
1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include how learning from the last 6 months was used to arrive at refreshed projections?	
DRAFT: Detailed work was undertaken across Summer 2023 to understanding the system's demand and capacity model for intermediate care. Early interventions to inform the model included the Ministerial visit to Norfolk and workshops with John Bolton/NHSE colleagues. The system has continued to monitor its IC demand & capacity modelling and take the learning from it to prepare for Winter 2023-24.	Yes
2. Please outline assumptions used to arrive at refreshed projections (including to optimise length of stay in intermediate care and to reduce overprescription of care). Please also set out your rationale for trends in demand for the next 6 months (e.g how have you accounted for demand over winter?)	
Demand:	
DRAFT: to be added depending on whether the data in the Plan is refreshed	Yes
Capacity:	
DRAFT: Data includes capacity to support individuals with a complexity of needs including learning disabilities, autism and/or mental health needs. It is assumed that the generalist discharge/community services are able to support individuals with less complex LD, MH and/or autism needs.	Yes
3. What impact have your planned interventions to improve capacity and demand management for 2023-24 had on your refreshed figures? Has this impact been accounted for in your refreshed plan?	
Not applicable as we haven't refreshed the data but we are continually monitoring to see if adjustments need to be made.	Yes
4. Do you have any capacity concerns or specific support needs to raise for the winter ahead?	
Yes, recruitment to reablement teams remains a challenge. There is also a gap identified in the data for short-term beds.	Yes
5. Please outline any issues you encountered with data quality (including unavailable, missing, unreliable data).	
Demand data for discharges does not currently include discharge demand from i) the community hospital providers, ii) the mental health provider and iii) out of area hospitals for repatriation to the N&W system e.g. West Suffolk hospital, Addenbrookes hospital. Demand data for community social support and mental health crisis support has not been identified.	Yes
6. Where projected demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?	
DRAFT: Tab 5.2, Row 11 - A new Community Support Service has been commissioned to help support discharges from hospital for individuals with practical support needs. Tab 5.2, Rows 12 and 13 should be read together as ST Dom Care is commissioned to fill the projected gap in the reablement capacity. The N&W system has shifted resources to support more cases at home, rather than in a bed-based setting. Tab 5.2, Rows 14 and 15 - demand for beds is higher than the commissioned capacity, however Spot Purchased beds were not included in the D&C Plan. All individuals are assumed to have some recovery potential on discharge so no cases are referred directly onto a Long Term Care pathway until they have been given the opportunity to recover and be assessed in a non-acute environment. Where appropriate individuals will be assessed under the Care Act to determine their longer term needs. Whenever possible, people with LT needs are supported to remain in their own home rather than in a care home. Tab 5.3, Row 11 - no demand data has been identified, so social/practical support capacity appears as a surplus. Tab 5.3, Row 12 - no demand data has been identified, so capacity appears to outstrip demand. Mental health demand from NSFT (see Q5 response above) has not been included and accounts for approximately 1/3rd of the apparent surplus. Demand from other sources for UCR is not recorded e.g. transfer of cases from the Ambulance Trust. UCR teams support discharges as well as providing a 2-hour urgent community response. The surplus in this Row contributes to the apparent gap in capacity in Tab 5.2 Row 12 (discharges to home). Tab 5.3, Row 14 - capacity is slightly higher for 'step-up' to a bedded solution from the community than our forecasts, however this gives us flexibility in the system.	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and question & answer document

5.1 Assumptions

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- actual demand in the first 6/7 months of the year
- modelling and agreed changes to services as part of Winter planning or following the Market Sustainability and Improvement Fund announcement
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

5.2 and 5.3 Summary Tables

The tables at the top of the next two tabs show a direct comparison of the demand and capacity for each area, by showing = (capacity) – (demand). These figures are pre-populated from the previous template as well as calculating new refreshed figures as you complete the template below. **Negative figures show insufficient capacity and positive figures show that capacity exceeds demand.**

5.2 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record their refreshed expectations of monthly demand for supported discharge by discharge pathway.

Data from the previous capacity and demand plans will be auto-populated, split by trust referral source. You will be able to enter your refreshed number of expected discharges from each trust alongside these. The first table may include some extra rows to allow for areas who are recording demand from a larger number of referral sources. If this does not apply to your area, please ignore the extra lines.

This section in the previous template asked for expected demand for rehabilitation and reablement as two separate figures. It was found that, by and large, this did not work well for areas so the prepopulated figures for these service types have been combined into one row. Please enter your refreshed expectations for rehabilitation and reablement as one total figure as well.

Virtual wards should not be included in intermediate care capacity because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, please select the relevant trust from the list.

From the capacity and demand plans collected in June 2023, it emerged that some areas had difficulty with estimating demand and capacity for Pathway 0 (social support). By social support, we are referring to lower level support provide outside of formal rehabilitation and reablement or domiciliary care. This is often provided by the voluntary and community sector. Demand estimates for this service type should only include discharges on Pathway 0 that require some level of commissioned low-level support and not all discharges on Pathway 0. If it is not possible to estimate figures in relation to this please put 0 rather than defaulting to all Pathway 0 discharges.

5.2 Capacity - Hospital Discharge

This section collects refreshed expectations of capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS) (pathway 0)
- Reablement & Rehabilitation at home (pathway 1)
- Short term domiciliary care (pathway 1)
- Reablement & Rehabilitation in a bedded setting (pathway 2)
- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

The recently published Intermediate Care Framework sets out guidance on improving capacity, and use of this capacity. You should refer to this in developing your refreshed BCF Capacity and Demand plans.

As with the 2023-24 template, please consider the below factors in determining the capacity calculation. Typically, this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay.

Caseload (No. of people who can be looked after at any given time).

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility.

Please consider using median or mode for Length of Stay where there are significant outliers.

Peak Occupancy (percentage) - What was the highest levels of occupancy expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

The template now asks for the amount of capacity you expect to secure through spot purchasing. This should be capacity that is additional to the main estimate of commissioned/contracted capacity (i.e. the spot purchased figure should not be included in the commissioned capacity figure). This figure should represent capacity that your local area is confident it can spot-purchase and is affordable, recognising that it may impact on people's outcomes and is unlikely to be best value for money and local areas will be working to reduce this area of spend in the longer term.

5.3 Demand - Community

This section collects refreshed expectations of demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. As with the previous template, referrals are not collected by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the 2023-25 Planning Requirements.

The units can simply be the number of referrals.

As with all other sections, figures from the 2023-24 template will be auto-populated into this section.

5.3 Capacity - Community

This section collects refreshed expectations of capacity for community services. You should input the expected available capacity across health and social care for different service types. As with the hospital discharge sheet, data entered in the assured BCF plan template has been prepopulated for reference. You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to
support recovery, including Urgent Community Response and VCS support. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Please see the guidance on 'Demand – Hospital Discharge' for information on why the capacity and demand estimates for rehabilitation and reablement services is now being collected as one combined figure. Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay.

Caseload (No. of people who can be looked after at any given time).

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility.

Please consider using median or mode for Length of Stay where there are significant outliers.

"Peak Occupancy (percentage) - What was the highest levels of occupancy expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services."

Better Care Fund 2023-24 Capacity & Demand Refrresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Norfolk

Hospital Discharge

Capacity - Demand (positive is Surplus)	Previous plan Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Refreshed capacity surplus. Not including spot purchasing Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Refreshed capacity surplus (including spot puchasing) Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS) (pathway 0)	-6374	-6127	-6066	-5973	-6386	354	354	354	354	354	354	354	354	354	354
Reablement & Rehabilitation at home (pathway 1)	-119	-156	-149	-53	-87	456	485	494	0	0	456	485	494	0	0
Short term domiciliary care (pathway 1)	96	132	132	32	63	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	-88	-91	-74	-49	-42	0	0	0	0	0	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Capacity - Hospital Discharge

Service Area	Metric	Prepopulated from plan: Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Refreshed planned capacity (not including spot purchased capacity Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Capacity that you expect to secure through spot purchasing Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Checklist Complete:
Social support (including VCS) (pathway 0)	Monthly capacity. Number of new clients.	354	354	354	354	354	354	354	354	354	354	0	0	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new clients.	456	485	494	398	443	456	485	494	0	0	0	0	0	0	0	Yes
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new clients.	96	132	132	32	63	0	0	0	0	0	0	0	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new clients.	260	252	252	233	268	0	0	0	0	0	0	0	0	0	0	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new clients.	81	96	91	101	99	0	0	0	0	0	0	0	0	0	0	Yes

Demand - Hospital Discharge

Pathway	Trust Referral Source	Prepopulated from plan: Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Please enter refreshed expected no. of referrals: Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Checklist
Social support (including VCS) (pathway 0)	**Total**	**6728**	**6481**	**6420**	**6327**	**6740**	**0**	**0**	**0**	**0**	**0**	Yes
	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	854	849	825	737	817	0	0	0	0	0	Yes
	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION	3540	3379	3511	3504	3538	0	0	0	0	0	Yes
	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION	2334	2253	2084	2086	2385	0	0	0	0	0	Yes
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Reablement & Rehabilitation at home (pathway 1)	**Total**	**575**	**641**	**643**	**451**	**530**	**0**	**0**	**0**	**0**	**0**	Yes
	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	68	75	53	64	76	0	0	0	0	0	Yes
	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION	428	481	503	319	376	0	0	0	0	0	Yes
	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION	79	85	87	68	78	0	0	0	0	0	Yes
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Short term domiciliary care (pathway 1)	**Total**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	Yes
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Reablement & Rehabilitation in a bedded setting (pathway 2)	**Total**	**348**	**343**	**326**	**282**	**310**	**0**	**0**	**0**	**0**	**0**	Yes
	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	57	59	55	48	54	0	0	0	0	0	Yes
	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION	221	222	212	174	204	0	0	0	0	0	Yes
	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION	70	62	59	60	52	0	0	0	0	0	Yes
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Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	**Total**	**81**	**96**	**91**	**101**	**99**	**0**	**0**	**0**	**0**	**0**	Yes
	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	6	7	6	5	6	0	0	0	0	0	Yes
	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION	64	79	76	86	85	0	0	0	0	0	Yes
	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION	11	10	9	10	8	0	0	0	0	0	Yes
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Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Norfolk

Community	Previous plan					Refreshed capacity surplus:				
Capacity - Demand (positive is Surplus)	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	162	162	162	162	162	0	0	0	0	0
Urgent Community Response	1072	1122	1079	1204	997	0	0	0	0	0
Reablement & Rehabilitation at home	839	873	1105	848	874	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting	64	59	64	63	65	0	0	0	0	0
Other short-term social care	37	37	37	37	37	0	0	0	0	0

Capacity - Community		Prepopulated from plan:					Please enter refreshed expected capacity:				
Service Area	Metric	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	162	162	162	162	162	0	0	0	0	0
Urgent Community Response	Monthly capacity. Number of new clients.	3008	3068	3059	2880	3063	0	0	0	0	0
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	1132	1167	1197	1172	1190	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	78	78	78	78	78	0	0	0	0	0
Other short-term social care	Monthly capacity. Number of new clients.	37	37	37	37	37	0	0	0	0	0

Demand - Community	Prepopulated from plan:					Please enter refreshed expected no. of referrals:				
Service Type	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	1936	1946	1980	1676	2066	0	0	0	0	0
Reablement & Rehabilitation at home	293	294	92	324	316	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting	14	19	14	15	13	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0

Checklist Complete:
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

1. Guidance for Quarter 3

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities (DLUHC), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) In Quarter 2 to refresh capacity and demand plans, and in Quarter 3 to confirm activity to date, where BCF funded schemes include output estimates, and at the End of Year actual income and expenditure in BCF plans
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans, including performance metrics
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF reporting is likely to be used by local areas, alongside any other information to help inform Health and Wellbeing Boards (HWBs) on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

BCF reports submitted by local areas are required to be signed off by HWBs, including through delegated arrangements as appropriate, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background and those that are not for completion are in grey, as below:

Data needs inputting in the cell
Pre-populated cells
Not applicable - cells where data cannot be added

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste 'Values' only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

5. Please ensure that all boxes on the checklist are green before submitting to england.bettercarefundteam@nhs.net and copying in your Better Care Manager.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the HWB to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the HWB to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
National condition 4: Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Reablement outcomes (people aged over 65 still at home 91 days after discharge from hospital to reablement or rehabilitation at home), and;
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process.

This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2023-24 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at HWB level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- on track to meet the ambition
- not on track to meet the ambition
- data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements.

- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

No actual performance is available for the ASCOF metrics - Residential Admissions and Reablement - so the 2022-23 outcome has been included to aid with understanding. These outcomes are not available for Hackney (due to a data breach issue) and Westmorland and Cumbria (due to a change in footprint).

5. Spend and Activity

The spend and activity worksheet will collect cumulative spend and outputs in the year to date for schemes in your BCF plan for 2023-24 where the scheme type entered required you to include the number of output/deliverables that would be delivered.

Once a Health and Wellbeing Board is selected in the cover sheet, the spend and activity sheet in the template will prepopulate data from the expenditure tab of the 23-25 BCF plans for all 2023-24 schemes that required an output estimate.

You should complete the remaining fields (highlighted yellow) with incurred expenditure and actual numbers of outputs delivered to the end of the third quarter (1 April to 31 December).

The collection only relates to scheme types that require a plan to include estimated outputs. These are shown below:

Scheme Type	**Units**
Assistive technologies and equipment	Number of beneficiaries
Home care and domiciliary care	Hours of care (unless short-term in which case packages)
Bed based intermediate care services	Number of placements
Home based intermediate care services	Packages
DFG related schemes	Number of adaptations funded/people supported
Residential Placements	Number of beds/placements
Workforce recruitment and retention	Whole Time Equivalents gained/retained
Carers services	Number of Beneficiaries

The sheet will pre-populate data from relevant schemes from final 2023-24 spending plans, including planned spend and outputs. You should enter the following information:
- **Actual expenditure to date in column I.** Enter the amount of spend from 1 April to 31 December on the scheme. This should be spend incurred up to the end of December, rather than actual payments made to providers.
- **Outputs delivered to date in column K**. Enter the number of outputs delivered from 1 April to 31 December. For example, for a reablement and/or rehabilitation service, the number of packages commenced. The template will pre-populate the expected outputs for the year and the standard units for that service type. For long term services (e.g. long term residential care placements) you should count the number of placements that have either commenced this year or were being funded at the start of the year.
- **Implementation issues in columns M and N.** If there have been challenges in delivering or starting a particular service (for instance staff shortages, or procurement delays) please answer yes in column M and briefly describe the issue and planned actions to address the issue in column N. If you answer no in column M, you do not need to enter a narrative in column N.

More information can be found in the additional guidance document for tab 5, which is published alongside this template on the Better Care Exchange.

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

2. Cover

Version 2.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Norfolk	
Completed by:	Nick Clinch	
E-mail:	nicholas.clinch@norfolk.gov.uk	
Contact number:	01603 223229	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Wed 06/03/2024	<< Please enter using the format, DD/MM/YYYY

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC Discharge Fund tab.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Spend and activity	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Norfolk

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	No	Yes
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off	23/02/2024	Yes

Confirmation of National Conditions

National Conditions	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter:	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Norfolk

National data may be unavailable at the time of reporting. As such, please use data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2023-24 planning				For information - actual performance for Q1	For information - actual performance for Q2	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs in Q3	Q3 Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
		Q1	Q2	Q3	Q4						
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	185.7	167.8	184.1	192.8	195.8	165.9	On track to meet target	Urgent and emergency care pressures in Norfolk and Waveney remain high, impacting on the capacity of services across the system. Work is ongoing to develop system-wide care coordination and single point of access that will identify patients urgent care needs via 999 and 111 calls, and coordinate care to prevent the need for an emergency episode of care. We expect this will reduce emergency admissions for ambulatory care sensitive conditions by facilitating community responses through Urgent Care Response Teams (UCRT,) Virtual Ward and Primary Care Network (PCN) teams with planned, urgent secondary appointments such as Same Day Emergency Care (SDEC), where necessary to avoid the need for an emergency admission.	A successful care homes pilot continued over Winter 2023-24. For the pilot, the 111 provider (ICAN) and the ICB's Digital Team worked together to enable out of hours virtual clinical support, with supplementary on-the ground support when needed. Care home staff have benefitted from the clinical backup e.g. to give confidence when using the falls equipment (that they are trained to use) to pick up non-injured fallers. An Expression of Interest has been submitted to NHSE to extend the scope of this pilot with additional technology, such as fit-bit style wearable monitors that enable tracking of health conditions/issues e.g. alerting care home staff if the person is unstable on their feet or has had a fall. - The N&W Unscheduled Care Coordination Hub (UCCH) went live in August 2023. UCCH enables ambulance and Urgent Care Response (UCR) resources to discuss cases on the stack as a multi-disciplinary team (MDT), and agree a timely plan to support the person using local UCR resources to address the crisis/avoid an admission. All UCR cases receive a follow-up welfare call and can be referred to other relevant support services. - NEATs (Network of Escalation Avoidance Teams) support urgent cases in the community with complex needs. Each NEAT has MDT resources including social care, integrated care coordinators, a mental health nurse and community healthcare resources. Referrals are from any healthcare professional, often GPs and paramedics. NEAT coordinates an appropriate response to resolve the immediate crisis and address the person's needs. They can refer to 10+ system partner organisations e.g. housing, befriending, assistive technology, Men's Shed, etc. - Long Term Conditions (LTC) – the Enhanced Health & Wellbeing in Care (EHWIC) programme supports care home residents with LTCs by providing support and training to the staff. The need may be identified by the care home staff or following a visit from the Integrated Quality Service (IQS).	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	92.0%	93.3%	93.0%	92.7%	93.3%	93.2%	On track to meet target	NPS assessment has improved, but recruitment overall in the sector remains difficult.	Norfolk First Support provides up to six weeks of support and reablement in a person's home to help people get back to doing things for themselves following a discharge from hospital and work out what help they will need in the future. This can be supplemented with input from the new Community Support Service for non-regulated tasks and wider social support. A new VCSE offer has been commissioned through the decommissioning/refocusing of funding from six legacy BCF VCSE (Voluntary, Community and Social Enterprise), schemes. Known as the "Norfolk & Waveney Community Support Service", it offers short-term, temporary practical support for individuals and aims to link clients with services, groups and support networks in their community. Support can be for 2-12 weeks depending on the complexity needs. The service can support individuals with underlying needs (e.g. multiple health issues, cognitive concerns, poor mobility) and/or help them to adjust and adapt to alterations in their life - such as illness, injury, long term health conditions and issues that affect their mental, social, physical and emotional health and wellbeing. Community healthcare providers and therapy outreach teams from the acute support individuals discharged with healthcare needs to enable their rehabilitation. Individuals with longer term needs beyond the up to 6-week discharge pathway will be assessed under the Care Act and suitable ongoing support will be arranged e.g. a package of care. Where appropriate for the complexity of the individual's needs (e.g. someone living with dementia) and under the NCC Caring for Better outcomes framework, a domiciliary care provider will be allocated to the case who can provide support for the first 6-weeks and beyond (if longer term needs are identified under the Care Act) to avoid a change of provider which could cause unnecessary distress to the person.	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000				1,441.8	370.4	379.8	On track to meet target	There is a considerable focus on falls prevention and response across the system. There is work underway to ensure that the falls prevention and response pathways are aligned, robust and coherent and offer equity of outcome across the system. As the UCCH and the Virtual Ward models mature, and with support from ECIST (Emergency Care Improvement Support Team), it is hoped that the opportunities to improve the falls-response pathways will be identified - this may include the introduction of a single long-fix falls pathway and a pathway for fallers that have sustained a head injury whilst on blood thinners.	There is a Norfolk and Waveney ICS Falls work programme with three workstreams: Care Sector; Acute & Inpatient Settings; and Community (Prevention & Response). The aim is to share learning, innovation and expertise across the system to continually improve the falls offer for the population of Norfolk & Waveney. The Acute & Inpatient Settings workstream is led by the Falls Lead for the NNUH and has seen effective collaborative working between system partners to reduce inpatient falls and increase the knowledge and awareness of staff around falls prevention. Activities include: staff education; Falls, Nutrition & Hydration Champions; an improved DATIX falls reporting system; a live falls dashboard at the JPUH; the introduction of falls alarms; and a monthly falls bulletin at the NNUH which includes graphs that show a steady decline in the number of inpatient falls from April 2023 through to Jan 2024. The Care Homes Falls workstream has been working with the 111 provider to provide direct access to clinical support out of hours and NCC have delivered falls training, falls equipment and access to the I-Stumble app to 200+ care homes. The Ambulance Trust and the UCCH are aware of the location of these care homes with falls equipment/training which supports with triage and planning a response. The Care Homes Power BI data dashboard has shown a steady decline in the number of emergency admissions from care homes due to a fall from July 2023 to Nov 2023. The Community Falls workstream has been collating information and sharing learning with system partners about the services and active projects underway in Norfolk and Waveney to either proactively identify people at risk of falls and/or prevent further falls and/ or respond to fallers. Example 1, Norfolk County Council (NCC) has delivered Phase 1 of a Proactive Interventions project which scours social care records to identify 80+ factors that identify individuals at high risk of experiencing a fall. 2000+ letters to this cohort were followed up with a phone call to discuss the risk and offer referrals into a range of falls prevention services. Phase 2 will link the County County records with District Council records to identify further individuals in the cohort. Example 2, an Unscheduled Care Coordination Hub (UCCH) was introduced in August 2023 and has made a significant and positive difference to the falls response by directing 2-hour Urgent Community Response teams to attend clinically-appropriate Level 1/ 2 falls cases, instead of ambulance crews. The UCCH model has contributed to a reduction in the ambulance wait times for Winter 2023-24, in comparison to Winter 2022-23. Future steps for the Community Falls workstream include mapping the falls prevention pathways for Norfolk and Waveney to identify where there are opportunities to improve and developing a Community Falls data dashboard to evidence the current model and the impact of the changes being made to prevent and respond to falls in the community.	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				444	2022-23 ASCOF outcome: 566		Not on track to meet target	Latest performance shows 537 per 100,000 against the target of 444. The figure of 444 was adjusted to 525.6 after our original submission. Challenges around an ageing population, appropriate housing and complexity of need continue. Mitigations of additional support in the community , our falls prevention programme are taking time to impact on the number of long term residential starts	New ways of working, focussing on increased offer on home care and early prevention work through our connecting communities programme of work and community discharge support offer, will continue to be rolled out across all areas, resulting in reduced reliance on residential provision through 23-24.	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				85.0%	2022-23 ASCOF outcome: 85.7%		On track to meet target	Having had reablement is only one part of the picture and determinant of whether someone remains at home after 91 days therefore we have expanded our community support offer to enhance the holistic support being offered to individuals with ongoing social needs.	Current performance is 87.5% vs target of 85%. Norfolk First Support provides up to six weeks of support and reablement in a person's home to help people get back to doing things for themselves following a crisis and work out what help they will need in the future. This can be supplemented with input from the new Community Support Service for non-regulated tasks (see Row 18 for more information). Individuals with longer term needs beyond the up to 6-week discharge pathway will be assessed under the Care Act and suitable ongoing support will be arranged e.g. a package of care. Where appropriate for the complexity of the individual's needs (e.g. someone living with dementia) and under the NCC Caring for Better outcomes framework, a domiciliary care provider will be allocated to the case who can provide support for the first 6-weeks and beyond (if longer term needs are identified under the Care Act) to avoid a change of provider which could cause unnecessary distress to the person.	Yes

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

6. Spend and activity

Selected Health and Wellbeing Board: Norfolk

Checklist						Yes		Yes		Yes	Yes
Scheme ID	Scheme Name	Scheme Type	Sub Types	Source of Funding	Planned Expenditure	Actual Expenditure to date	Planned outputs	Outputs delivered to date (estimate if unsure) (Number or NA)	Unit of Measure	Have there been any implementation issues?	If yes, please briefly describe the issue(s) and any actions that have been/are being implemented as a result.
2	A Social Impact Bond for Carers	Carers Services	Carer advice and support related to Care Act duties	Minimum NHS Contribution	£1,416,720	£1,062,540	2,244	2,658	Beneficiaries	No	£131,040 is ICB
9	ICES (Integrated Community Equipment Service)	Assistive Technologies and Equipment	Community based equipment	Minimum NHS Contribution	£7,172,953	£5,379,715	37,450	28,088	Number of beneficiaries	No	£4,970,335 is ICB
20	Norfolk First Response	Home-based intermediate care services	Reablement at home (accepting step up and step	Minimum NHS Contribution	£10,242,162	7,681,622	6,827	6,065	Packages	No	£1,839,617 is ICB
51	Caring for Better Outcomes	Home Care or Domiciliary Care	Short term domiciliary care (without	Minimum NHS Contribution	£1,224,000	£918,000	380	285	Hours of care (Unless short-term in which case it is packages)	No	
64	LD, MH and Autism Packages of Care	Home Care or Domiciliary Care	Domiciliary care packages	Minimum NHS Contribution	£3,343,270	£2,507,453	138,610	103,957	Hours of care (Unless short-term in which case it is packages)	No	Estimated, based on Home Care hourly rate of £24.12
67	Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG grants	DFG	£9,157,782	£7,416,442	1,400	2,519	Number of adaptations funded/people supported	No	There was a further £799,106.00 additional DFG funding received for 23/24, make the total DFG funding allocation £9,956,888.00
70	ASC Core Care Services (underlying spend since 2017/18)	Residential Placements	Other	iBCF	£21,586,564	£16,189,923	245	245	Number of beds/placements	No	
70	ASC Core Care Services (underlying spend since 2017/18)	Home Care or Domiciliary Care	Domiciliary care packages	iBCF	£14,524,000	£10,893,000	657,789	451,617	Hours of care (Unless short-term in which case it is packages)	No	Estimated, based on Home Care hourly rate of £24.12
40	West Norfolk Carers Project	Carers Services	Other	Minimum NHS Contribution	£19,245	£14,434	164	123	Beneficiaries	No	
64	LD, MH and Autism Packages of Care	Residential Placements	Other	Minimum NHS Contribution	£13,450,646	£10,087,985	-	170	Number of beds/placements	No	Based on the average weekly price for the year, converted to cover 1st April to 31st December and then used to calculate the number of beds the figure in J19 would buy
82	Home Support Enhanced Discharge Incentive Scheme	Home Care or Domiciliary Care	Short term domiciliary care (without	Local Authority Discharge Funding	£1,114,000	£835,500	380	285	Hours of care (Unless short-term in which case it is packages)	No	
84	Provider: CAB and Carers Matters Norfolk: Carers hardship support	Carers Services	Carer advice and support related to Care Act duties	Local Authority Discharge Funding	£35,000	£26,250	520	390	Beneficiaries	No	
88	Workforce recruitment and retention	Workforce recruitment and retention		Local Authority Discharge Funding	£2,705,216	£2,028,912		84,117	WTE's gained	No	
7	HomeWard (Norwich)	Home-based intermediate care services	Rehabilitation at home (accepting step up and step	Minimum NHS Contribution	£1,589,803	£1,192,352	24	18	Packages	No	
8	Rapid Assessment Team (RATS) & Virtual Ward (West Norfolk)	Home-based intermediate care services	Rehabilitation at home (accepting step up and step	Minimum NHS Contribution	£2,019,335	£1,514,501	30	23	Packages	No	
11	Intermediate Spot Purchase Beds	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with rehabilitation	Minimum NHS Contribution	£1,836,864	£1,377,648	306	230	Number of placements	No	
12	Equipment at home (BOC)	Assistive Technologies and Equipment	Community based equipment	Minimum NHS Contribution	£8,059	0	-	0	Number of beneficiaries	No	
14	Medical Loans Service	Assistive Technologies and Equipment	Community based equipment	Minimum NHS Contribution	£192,375	£144,281	4,861	3,646	Number of beneficiaries	No	
19	Palliative Beds & Hospice (West Norfolk)	Residential Placements	Nursing home	Minimum NHS Contribution	£883,924	£662,943	225	169	Number of beds/placements	No	
51	Learning Disability Beds	Residential Placements	Learning Disability	Minimum NHS Contribution	£592,665	£444,499	-		Number of beds/placements	No	
52	Q1 beds	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with rehabilitation	ICB Discharge Funding	£1,382,627	£1,684,897	73	55	Number of placements	No	Scheme ID 52 (Q1 beds) was reinvested against ICB discharge funding slippage for Scheme ID 54 (Bridging the Gap) (detailed below) which now means Q1 beds (Scheme ID 52) runs above the original Q1 estimate plan.
54	Bridging the Gap	Home Care or Domiciliary Care	Domiciliary care packages	ICB Discharge Funding	£1,694,838	£506,737	-		Hours of care (Unless short-term in which case it is packages)	No	The ICB discharge funding had slippage in Scheme ID 54 (Bridging the Gap) was reinvested against scheme 52 (Q1 beds) (detailed above).

Norfolk Health and Wellbeing Board

Report title: NHS Norfolk and Waveney Integrated Care Board Annual Report

Date of meeting: 06 March 2024

Sponsor (HWB member): Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney Integrated Care Board

Reason for the Report

NHS Integrated Care Boards (ICBs) must include a narrative in their annual reports about how they have contributed to the delivery of the priorities of their local health and wellbeing boards. Health and wellbeing boards must also be consulted in the preparation of these narratives.

Report summary

NHS Norfolk and Waveney ICB has drafted the narrative set out in this paper for their 2023/24 annual report about how they have supported and contributed to the delivery of the priorities of the Norfolk and Suffolk Health and Wellbeing Boards (as set out in their respective Joint Health and Wellbeing Strategies).

Recommendations

The HWB is asked to:

a) Comment on the draft narrative and propose any amendments they would like made.

1. Background

1.1 NHS integrated care boards (ICBs) are required to consult health and wellbeing boards about the part of their annual report which sets out how they have contributed towards delivery of local joint health and wellbeing strategies.

1.2 This paper provides an extract of NHS Norfolk and Waveney Integrated Care Board's (ICB) draft annual report for 2023/24. It outlines how the ICB has contributed towards the delivery of the Norfolk Joint Health and Wellbeing Strategy, and by default as they are the one and the same document, the Norfolk and Waveney Integrated Care Strategy.

1.3 The ICB is sharing the below extract with the Board for comment. The final version of the ICB's annual report for 2023/24 is not due to be submitted to NHS England until June 2024. The narrative remains draft and subject to minor changes up to that point.

1.4 The Board should also note that the system's Joint Forward Plan is currently being refreshed. The plan sets-out how local NHS and care services will help to deliver the Norfolk Joint Health and Wellbeing Strategy / Norfolk and Waveney Integrated Care Strategy. We are required to refresh it each year so we have a current, rolling five-year plan, however because the plan was only finalised in June 2023, it will not be significantly changed this year. The refreshed plan will be published by April.

1.5 Go to improvinglivesnw.org.uk to read the current version of the Joint Forward Plan.

2. The draft narrative

2.1 Here is the draft extract from NHS Norfolk and Waveney ICB's annual report for 2023/24:

2.1.1 Joint Health and Wellbeing Strategies

NHS Norfolk and Waveney ICB is an active member of both the Norfolk and Suffolk Health and Wellbeing Boards. The ICB has worked to support the four priorities in Norfolk's Joint Health and Wellbeing Strategy, as well as the cross-cutting themes in Suffolk's strategy.

2.1.2 Norfolk priority: Driving integration
Suffolk cross-cutting theme: Greater collaboration and system working

The ICB has continued to work with partners to develop and strengthen our Integrated Care System over the past year. Notably, we agreed our first Joint Forward Plan in June 2023, which sets out how the local NHS and care services will implement our Integrated Care Strategy / the Norfolk Joint Health and Wellbeing Strategy. The plan has subsequently been refreshed for 2024/25, taking account of what had been delivered and to incorporate new projects.

As a system, we have delivered and made progress with a wide range of projects and changes that have and will improve the health, wellbeing and care of local people. The ICB has played an important role as a convenor, bringing together partners from across the system and providing skills and expertise, data and insight to enable us transform how we care for local people. Examples include:

- **Working as a system to improve ambulance handovers and response times:** As a result of changes introduced at our hospitals, patients are now spending less time waiting in ambulances when they arrive at one of our hospitals. This in turn is enabling our ambulances to quickly get back on the road and to the next person who needs help.

- **Making changes to help ensure people are getting the right care, at the right time and by the right person:** RightCareNoW is a programme of work that has helped improve the way people are discharged from hospital back into the community, and reduced the number of people in our hospitals that have no medical reason to be there and who could be better cared for in their own home or another setting.

- **Sharing data better to make it easier for frontline health and care professionals to understand people's conditions and to treat them:** For example, the Norfolk and Waveney Shared Care Record can now be accessed by appropriate staff from general practice, our acute hospital trusts, the mental health trust, community services, Norfolk's Adult Social Services and Children's Services and Integrated Care 24. We have also developed and approved the Full Business Case for the Electronic Patient Record, which will see our three acute hospital trusts move from paper-based records to electronic ones. The plan is for the system to go live in March 2026.

While our Integrated Care System is not fundamentally about structures and governance, to achieve our mission and to deliver more projects and changes like these, it is vital that we have the right foundations and ways of working in place. A significant amount of work was done in 2023/24 on the ICB's organisational review. The ICB's new structure and operating model will enable greater collaboration and support system working, as well as deliver a reduction in the organisation's running costs. The structure takes account of the organisation's new functions and its role as a convener of the system. While this change has been challenging for the organisation and hard for staff this year, the benefits to the system will be felt in 2024/25.

As a system, we are strengthening integration at all levels. The ICB has:

- Continued to support the development of our 17 Primary Care Networks (PCNs) and integrating our workforce.

- Worked with partners to develop our five Place Boards, which bring together colleagues from across health and care to integrate services at a more local level.
- Been an active partner in the eight local health and wellbeing partnerships, working with district councils, VCSE organisations and others to address the wider determinants of health.
- Continued to contribute to the development of our Integrated Care Partnership and both North and Suffolk's Health and Wellbeing Boards.
- Supported greater collaboration between providers, including through the Norfolk and Waveney Acute Hospital Collaborative and the development of two mental health collaboratives (one for adults and one for children and young people).

2.1.3 Norfolk priority: Prioritising prevention
Suffolk cross-cutting theme: Prevention: stabilising need and demand

The ICB has worked with a wide range of partners to make real progress with the prevention agenda, both through the use of population health management techniques and by commissioning services. Examples include:

- **Building on the success of Protect Norfolk and Waveney:** Protect NoW has continued to make strong progress and delivered a range of population health management projects over the past year. This is helping our system to provide more anticipatory and preventative care.

- **Joining-up primary care services:** On 1 April 2023, the ICB became responsible for pharmaceutical services, primary care optometry services and dental services, in addition to general practice, which we were already responsible for. This provides us with a real opportunity to commission services differently now that we are responsible for the whole of primary care. We want to use this opportunity to join-up services and to improve preventative care and the health of the population.

2.1.4 Norfolk priority: Addressing inequalities
Suffolk cross-cutting theme: Reducing inequalities

As a system, we are committed to working together to tackle unfair and avoidable differences in health outcomes between residents. We do this by listening to communities, prioritising prevention, and taking action together, making health inequalities everybody's business.

The ICB works with partners to reduce health inequalities by:
- Using population health management techniques.
- Improving access to services.
- Collaborating through our place boards and local health and wellbeing partnerships
- Having a Patients and Communities Committee, whose remit includes examining how the ICB is reducing health inequalities.

A key step we have taken this year is to develop our Norfolk and Waveney Health Inequalities Strategic Framework for Action, which sets out the actions we want to take as a system to tackle health inequalities.

2.1.5 Norfolk priority: Enabling resilient communities
Suffolk cross-cutting theme: Connected, resilient and thriving communities

The ICB is committed to supporting people to live independent healthy lives in their community for as long as possible, through promotion of self-care, early intervention and digital technology where appropriate. As set out above, we are using population health

management techniques to provide more anticipatory care and early intervention. We are also using technology to empower people to manage their health and wellbeing better, for example by giving people greater visibility and control over their treatment and care journeys.

Vital to creating more resilient communities is building capacity in the voluntary, community, faith and social enterprise sector. The ICB values the work of the sector and wants to work with the sector as a trusted partner. The ICB has worked with both the sector and other partners to establish the VCSE Assembly, as well as to involve colleagues from the sector in the governance of the ICB, including by having a VCSE member on the ICB Board.

Officer Contact

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

Item No: 5

Report title: Learning Disability Plan 2023-2028

Date of meeting: 06 March 2024

Sponsor (ICP member): Debbie Bartlett, Executive Director Adult Social Services & Tracey Bleakley, Chief Executive Officer, Norfolk & Waveney Integrated care Board

Reason for the Report

The new Learning Disability Plan 2023-2028 partnership document has been developed by the Norfolk Adults Learning Disability Partnership, and this includes Norfolk County Council (NCC), Norfolk and Waveney Integrated Care Board (ICB) and all those providers who work with NCC and the ICB, as well as people with a learning disability and their family and carers. Delivery of the Plan will be overseen by the Norfolk & Waveney Learning Disability and Autism Programme Board which includes partnership working by NCC, the ICB and other health partners, and so this report is being shared with the Integrated Care Partnership (ICP) for their partnership oversight.

Report summary

This report outlines the 8-month process (from April – November 2023) taken to develop the new Norfolk Adults Learning Disability Plan 2023-2028 (previously known as 'Strategy' but renamed 'Plan' by people with a learning disability). Priority was to ensure the voices of people with a learning disability and their carer were an integral part of the new Plan and so, the easy read version was agreed first and signed off by the independent Learning Disability Partnership Board in November 2023.

The expressed outcomes of people with a learning disability (LD) and their carers shared in the easy read version formed the basis for the detailed delivery plan. This was drawn up in partnership with the range of professionals and providers working together to outline the actions they will take to support people with a learning disability, and their carer, living in Norfolk to live a good life. The report also outlines how these actions and identification of community resources and commitment to partnership working align with ICP strategic priorities of prioritizing prevention and addressing inequalities, particularly reducing health inequalities for people with a learning disability.

This Plan has been developed in partnership with people with a learning disability, their parents, carers, professionals, and providers, and with the oversight of the Making it Real Board and the Learning Disability Partnership Board. As this is an integrated partnership document, the full sign off Process has been taken following both NCC and ICB processes. Monitoring of the Plan will be led by the integrated partnership, with the Learning Disability Partnership (independently co-ordinated by ASD Helping Hands) leading on gathering feedback as part of 6-monthly monitoring and reporting, as well as facilitating dissemination of information through the Partnership.

It is important to note that since the death of Oliver McGowan in hospital, his mother Paula McGowan has instigated a programme of work, alongside NHSE, in rolling out training that assists practitioners across all services in understanding the importance of reasonable adjustments. A second part of the training also gives more specialist knowledge to people working in the field of Learning Disability and Autism. A specific strength of this training, that sets it apart from other training, is the commitment to training being co-delivered with Experts by Experience. The Learning Disability Partnership Board and Opening Doors, a group of self-advocates, are actively working with the Integrated Care Board in the roll out of this programme of work across the Norfolk and Waveney system.

Recommendations

The ICP is asked to:

a) Agree the Norfolk Adults Learning Disability Plan 2023-2028.
b) Champion the implementation of this new Learning Disability Plan (formerly known as 'strategy') with Norfolk people with a learning disability, their unpaid carers and the providers and professionals working with them.
c) Promote the sharing of information about how the Plan is working with all stakeholders and support the feedback process to enable effective communication with people with a learning disability and their carers.

1. Background

1.1 The previous Adults Learning Disability Strategy was from 2018-2022, so starting in April 2023, this Norfolk Adults Learning Disability plan has been developed by the Norfolk Adults Learning Disability Partnership, which includes NCC Adult Social Services, Norfolk and Waveney Care ICB and all those providers who work with NCC and the ICB, as well as people with a learning disability and their family and carers. This has been possible through a range of engagement, consultation, co-design, and co-production with people across Norfolk to understand what is important to them and to make sure their ideas are expressed in this plan. This included the re-naming of the use of the word 'Strategy' to the word 'Plan' by people with a learning disability, as this was a word they understood better.

2. Norfolk Adults Learning Disability Plan 2023-2028

2.1 In producing a new Learning Disability Plan (see appendix 1), the aim was that as many people as possible would be helped to share their views and ideas to be included as part of developing a new Plan. People were enabled to share their ideas in a range of ways including face-to-face meetings across Norfolk from May to November 2023, and through feedback received by email, by post or through an online and easy read survey. Providers working with people with a learning disability were also asked to help in consulting with people with a learning disability as part of helping to gather their views and ideas to develop the agreed Plan.

2.2 The first draft of the easy read version of the Plan was shared at the September face to face partnership Locality meetings and sent out to stakeholders by email, to check the suggested wording and make changes as suggested by people with a learning disability and their carers. With the emphasis on making sure the voice of people with a learning disability and their carer is paramount in this Plan, the agreed final version of the easy read plan was signed off by the Learning Disability Partnership Board in November 2023 (see appendix 2).

2.3 **People we know were involved in developing the LD Plan over eight months:**
201 people with a LD = 56%, 63 unpaid carers = 17%, 97 professionals & providers = 27%.

2.4 The Plan does not try to cover everything we know about learning disability or every issue. It sets out the details of the five priority areas identified through the engagement and co-production and the key actions that will be taken by the different partners working together to deliver this plan over the next five years with the strategic priorities of prioritizing prevention and addressing inequalities. Work to develop the detailed delivery Plan (see appendix 3) was also aligned to the learning from the Conversations Matter engagement and development of new Promoting Independence Strategy for Adult Social Services, as well as the work to develop the Ethical Framework – now called 'The Real Care Deal'.

2.5 In developing the new Learning Disability Plan, support for carers was Identified as a very important part of any support for a person with a learning disability, although it was

acknowledged that the person with a learning disability did not necessarily recognise the 'caring' role played by their family member, and the unpaid carers themselves acknowledged that they did not necessarily recognise their 'caring role'. The Plan outlines the importance of improving information about available support for unpaid carers and help to access support, particularly in times of crisis or as part of preparing for when they can no longer care for the person with a learning disability.

2.6 In hearing from people as part of developing the new Plan it was identified that there is already a range of innovative and practical support being provided by local providers that was not widely known about across Norfolk. As part of the strategic aim of enabling resilient communities, the Plan outlines the role of the Learning Disability Partnership in helping providers share what they are doing in their local area and in finding ways to collaborate in improving communication of what is available within the community for people with a learning disability and their carer.

2.7 As part of the process of developing the new Plan, people with a learning disability outlined their desire to continue to be involved in the ongoing review of / and feedback on whether the Plan is working or not. The detailed delivery plan outlines specific measurable achievable realistic targets and the specific measures that will be used to help people with a learning disability and their carers know if these are being achieved and what 'success' will look like. People with a learning disability and their carers co-designed the ways that they would like to be able to provide feedback as part of sharing whether they feel the Plan is working or not, and what needs changing, and these are included as part of the Plan. It is also acknowledged that people with a learning disability and their carers report that they are not aware of what is being done to support them and so as part of the commitment to this Plan, there needs to be greater emphasis on sharing 'good news stories' and outlining what progress is being made.

2.8 The Learning Disability Partnership Board will have a role to gather feedback from stakeholders on what is working well and what needs improving as part of reporting back to the Programme Board for the planned 6-monthly monitoring process. A commitment to improving information sharing for people with a learning disability and the carers about the range of ongoing available support and progress being made should be a priority for all professionals and providers in Norfolk. It is hoped that the partnership support of this Plan will support progress towards this goal of improving the support for people with a learning disability and the carers.

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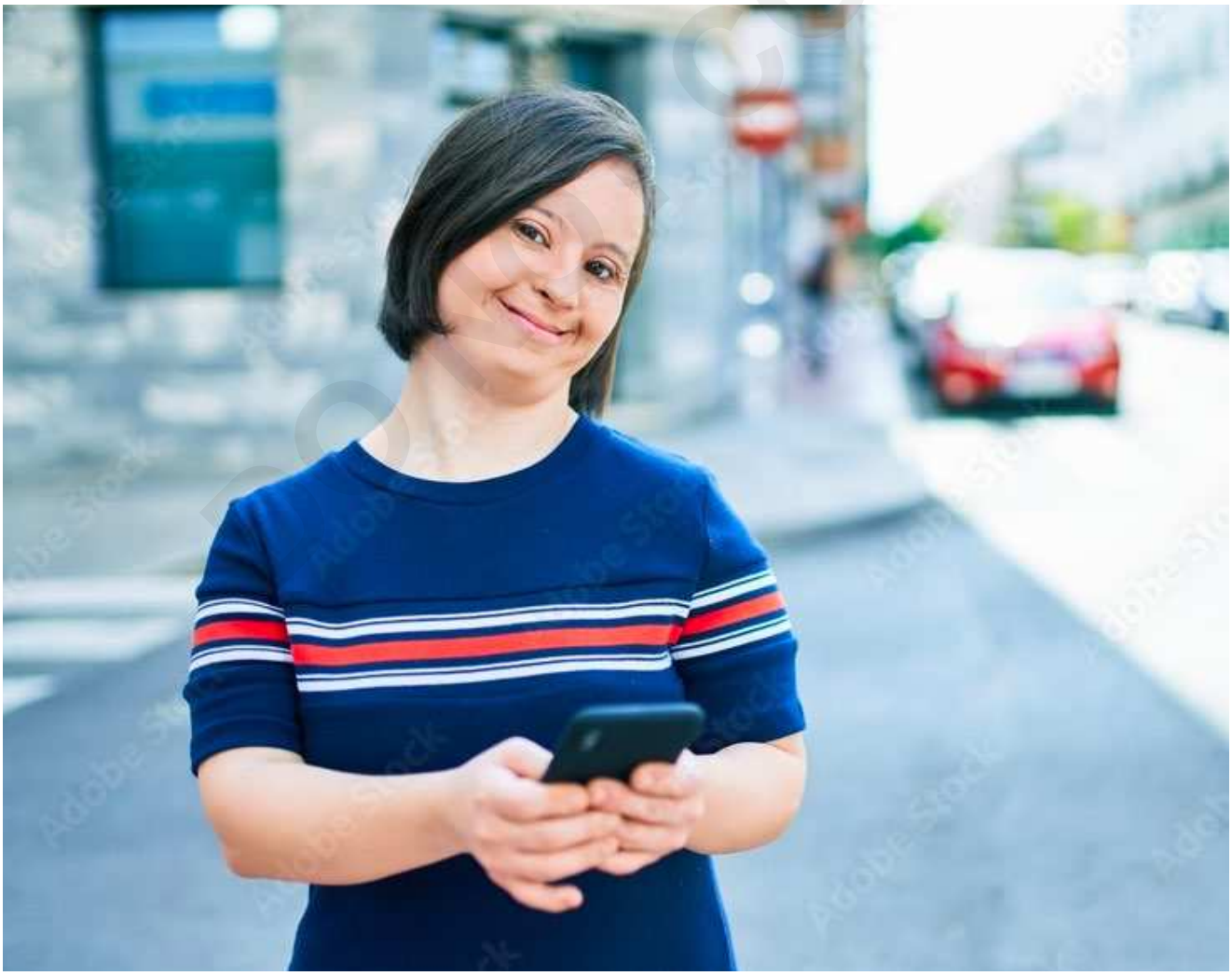
NORFOLK LEARNING DISABILITY PARTNERSHIP

NHS
Norfolk and Waveney
Integrated Care Board

Norfolk Adults Learning Disability Plan (formerly called 'Strategy')

2023-2028



Norfolk County Council

Contents

Foreword from the co-chairs of the Norfolk Adults Learning Disability Partnership Board

This plan, formerly known as 'Strategy' sets out our vision for adults with a learning disability and their carer(s) in Norfolk for the period from November 2023 – March 2028.

We are proud to present this Norfolk Adults Learning Disability plan because it has been developed with and based on the views of people with a learning disability and their parents and carers. This has been possible through a range of engagement, co-design and co-production with people across Norfolk to understand what is important to them and to make sure their ideas are expressed in this plan. This included the re-naming of the use of the word 'Strategy' to the word 'Plan' by people with a learning disability, as this was a word they understood better.

This plan does not try to cover everything we know about learning disability or every issue. It sets out the details of the five priority areas identified through the engagement and co-production and the key actions that will be taken by the different partners working together to deliver this plan over the next five years. Delivery of The Learning Disability Plan 2023 - 28 will be monitored by the Norfolk & Waveney Learning Disability and Autism Programme Board which includes people from Norfolk County Council and the Integrated Care Board and other health partners.

The Learning Disability Partnership Board will have a role to gather feedback from stakeholders on what is working well and what needs improving as part of reporting back to the Programme Board as part of the monitoring process. This way, people with a learning disability and their carers will be able to continue to be engaged in sharing their ideas and feedback and being part of making improvements to the plan as needed.

Rachel Gates (co-chair)
Co-chair Norfolk Adults Learning Disability Partnership Board & Assistant Director of Commissioning - LD, Autism & MH, Adult Services

June Walton (co-chair)
Self-advocate & co-chair Norfolk Adults Learning Disability Partnership Board

"I thought the process for the Learning Disability Plan was really good! People's voices were heard, and you can see them in the Plan. I liked how they went round all the locality groups in person to get people's views and see what people are finding challenging in each area. I find the easy read Learning Disability Plan clear to read and understand".
(Comments from June Walton, self-advocate and co-chair, about the process taken to develop the new plan). November 2023

1. Our ambitions for adults with a learning disability

This Adults Learning Disability plan was developed by the Norfolk Adults Learning Disability Partnership. This includes Norfolk County Council (NCC) Adult Social Services, Norfolk and Waveney Integrated Care Board (ICB) and all those providers who work with NCC and the ICB, as well as people with a learning disability and their family and carers.

The Norfolk Adults Learning Disability Partnership

The Norfolk Learning Disability Partnership is independently coordinated by ASD Helping Hands who took on this role in October 2022. ASD Helping Hands also coordinate the Learning Disability Partnership Board who meet four times a year. Membership of the Learning Disability Partnership Board include people with a learning disability, family carers, people who work for NCC, the NHS and other organisations and charities.

The goal of the Norfolk Adults Learning Disability Partnership Board is to improve the lives of people with disabilities in Norfolk aged 18 and above and to help those who care for people with a learning disability. The Board do this by:

- talking about the issues that people with a learning disability can face;
- talking about the learning disability services that run in Norfolk;
- running locality groups across each area of Norfolk to talk about local issues that people are facing;
- working on priority outcomes outlined in the Norfolk Adult Learning Disability Plan;
- sharing information through their independent website.

The Norfolk Adults Learning Disability Partnership Board provided oversight for the process of developing the new Learning Disability Plan and will lead on ensuring stakeholders are involved in the process of gathering the feedback on whether the new plan is working or not.

The NHS Norfolk and Waveney Integrated Care Board (ICB)

The new Norfolk and Waveney Integrated Care System (ICS) was formed on July 1, 2022, and is made-up of a wide range of partner organisations, working together to help people lead longer, healthier and happier lives. The ICS includes the NHS Norfolk and Waveney Integrated Care Board (ICB) and Norfolk County Council (NCC), along with a range of other charitable organisations and partnerships.

The ICB plans and buys the healthcare services for the local population of Norfolk and Waveney and is accountable for the performance and finances of the NHS across Norfolk and Waveney. The values of the Norfolk and Waveney Integrated Care Board are outlined as: "Connected to; each other, the work we do, a common purpose, our partners across the system... and always to our patients/public. At all times being respectful, inclusive, and embracing new ways of working by being innovative and continually improving."

Norfolk County Council Adult Services

The Adult Services vision is 'to support people to be independent, resilient and well and hold aspirations for their future' and this is supported by the current 'Promoting Independence' approach which is shaped by the Care Act with its call to action across public services to prevent, reduce and delay the demand for social care. The commitment in the approach is a vision for quality social work which builds on the strengths of individuals.

Promoting Independence is at the core of the Norfolk County Council Strategic plan 'Better Together, For Norfolk 2021-2025'. This ambitious plan aims to make Norfolk a place where we put people first, where everyone works together to create a better place to live and includes the vision statements:

- *"We want Norfolk to be the place where everyone can start life well, live well and age well, and where no one is left behind."*
- *"We want our communities to feel safe, healthy, empowered and connected, their individual distinctiveness respected and preserved."*

Promoting Independence has these main elements:

Prevention and early help

Empowering and enabling people to live independently for as long as possible through giving people good quality information and advice which supports their wellbeing and stops people becoming isolated and lonely. We will help people stay connected with others in their communities, tapping into help and support already around them – from friends, families, local voluntary and community groups. For working age adults with a disability, we want them to have access to work, housing and social activities which contribute to a good quality of life and wellbeing.

Staying independent for longer

Our social care teams will look at what extra input could help people's quality of life and independence – this might be some smart technology, some adaptations to their homes to prevent falls, or access via telephone or on-line to specialist tailored advice. When people do need a service from us, we want those services to help people gain or re-gain skills so they can live their lives as independently as possible. This could mean a spell of intensive reablement after a stay in hospital to restore their confidence and their ability to do as many day-to-day tasks as possible.

Living with complex needs

For some people, there will be a need for longer term support. This might mean the security of knowing help is on tap for people with conditions like dementia, and that carers can have support. There is a focus on ensuring people in Norfolk access the right services for them at the right time. For some people, moving into residential care or to housing where there are staff close by will be the right choice at the right time, but such decisions should be made with good information and not in a crisis.

2. Introduction to our Norfolk Adults Learning Disability Plan

Overview

In starting to develop this new plan, the focus was on involving those with a learning disability and their parent or carer from the start to ensure their involvement in how the plan was developed and in sharing their personal views and ideas for what needed to be part of the plan.

How the plan would be developed was agreed by the Norfolk Adults Learning Disability Partnership Board co-chairs in a Board pre-meeting in April 2023 before being agreed at the Board meeting in May 2023. In June, the Norfolk Making it Real Board, the independent reference group of people with lived experience who represent Think Local Act Personal and who provide leadership and guidance for NCC and members of the ICB around planned co-production activities, were consulted about the planned approach to involve people in developing a new learning disability plan.

With the agreement of the Making it Real Board, the process of a range of participation activities from consultation, engagement, co-design, and co-production were carried out with people with a learning disability across Norfolk, their parents and carers to understand what is important to them and to make sure their ideas were expressed in this plan. This included the renaming of the use of the word 'Strategy' to the word 'Plan' by people with a learning disability, as this was a word they understood better. Practitioners, commissioners and providers supporting people with a learning disability were also involved in developing this new plan.

Feedback received by partnership members from people with a learning disability and their carers outlined that they did not know what had been achieved in the previous 2018 – 2022 Learning Disability Strategy. So as part of starting the overall engagement process to develop a new plan, we shared with people a 'Looking Back – You Said, We Did' document outlining the different things that had been achieved by the various members of the Learning Disability Partnership and what was still to do.

Looking Back on the 2018 - 2022 Learning Disability Strategy - You Said, We Did summary - Full Version.
Full version Looking Back on Learning Disability Strategy 2018 - 2022

Looking Back on the 2018 - 2022 Learning Disability Strategy - You Said, We Did summary - Easy Read.
Easy Read Looking Back on Learning Disability Strategy 2018 - 2022

As part of putting the document together, partnership members shared the wide range of things they were doing in supporting people with a learning disability and their carer that were not necessarily being recognised and celebrated. Information about these 'hidden gems' of identified support were included in the documents that were shared.

This helped identify the commitment across the various organisations and providers supporting people with a learning disability and their carer in providing a wide range of innovative and practical support for individuals. It was agreed the new LD Plan would include actions that would be taken by different LD Partnership members and other providers, as part of making it clearer the range of support available to people with a learning disability and their carer.

What we still need to do

Gathering information for the 'Looking back' document also helped identify potential resources that could be part of helping to deliver the things not yet achieved in the previous strategy and new ideas being received. An example of this was the training for taxi drivers that had been developed in 2019 by About with Friends in North Norfolk. This training was well received by the taxi companies who had paid to attend the sessions which helped them better understand how best to support a person with a learning disability travelling in their taxi. Since then, there have been discussions about how this training could be made available to taxi drivers across Norfolk and so has been included as an action in the new plan.

The impact of the Covid pandemic meant that many people with a learning disability were shielding and therefore unable to go to work, other employment opportunities or feel comfortable going out into the community, as well as having an impact on what could be delivered in the previous LD Strategy. Information gathered as part of the 'Looking back' also identified the range of employment or training support different providers are helping individuals with, in addition to what is being offered by Norfolk County Council. It is planned that as part of the new plan, LD Partnership providers will agree the way to share information about the range of employment support they are offering as part of demonstrating the breadth of employment support and help to develop work skills or other work opportunities being offered across Norfolk.

One innovative example shared as part of the engagement with providers highlighted the individual support given by Stepping Stones in Norwich to one of their members who was able to move from a four-week work experience placement at Norwich Airport into a paid role at the Airport. The positive impact of this is reflected in the report given by the Airport manager who shared:

> *"(the individual) has received many compliments from customers and passengers. Their pleasant, outgoing, and smiley personality is a winner for those they meet. We are very proud to have them working with us."*

There is more information about some of the different types of employment support being offered by other providers in the 'Looking Back' summary. As part of developing this new plan, there is a commitment to finding ways to share the wide range of support being provided across Norfolk by all the different providers and organisations supporting a person with a learning disability, and proactively looking at ways to ensure people with a learning disability and their carer know about them.

National priorities and commitment to supporting people with a learning disability

Alongside the local support being provided across Norfolk, there are statutory and government policy requirements that members of the Learning Disability Partnership have a duty to provide and are part of making improvements to the support to be provided for people living with a learning disability in Norfolk, which are included as part of the overall approach to be taken in delivering the new LD Plan.

The National Disability Strategy

The National Disability Strategy, which was first published in July 2021, sets out the actions the government is committed to take to improve the everyday lives of all disabled people. This government strategy is incorporated into the approaches to be taken locally which includes a focus on improvements of the physical and social environments for people with a disability:

> *"Disabled people's aspirations for their lives are no different from non-disabled people's aspirations.*
>
> *"We all want to live fulfilling lives. We want to be safe and healthy. We want autonomy about where we live, how we live, and with whom we live. We want to go outside, meet other people, and go places. We want to easily access the support we need to live an independent life and to feel confident that we won't lose it. We want to be able to participate in society, to be valued, to go to work".*

However, disabled people's everyday experience is very different from non-disabled people. Every day many disabled people:

- wake up in a home that is not adapted to their needs;
- rely on an unpredictable transport network to get out and about;
- navigate inaccessible and inflexible workplaces or education settings;
- face limited choice and additional expense when shopping around for goods and services;
- use unresponsive and fragmented public services that do not meet their needs;
- feel excluded from leisure opportunities and socialising;
- find themselves barred from exercising rights such as voting and serving on a jury.

Building the Right Support

Updated in August 2022, this Building the Right Support national action plan outlines a commitment to strengthen community support for people with a learning disability and autistic people and reduce reliance on mental health inpatient care.

The key areas of focus set out in this action plan are:

- ensuring that people with a learning disability and autistic people of all ages experience high-quality, timely support that respects individual needs and wishes, and upholds human rights;
- understanding that every citizen has the right to live an ordinary, self-directed life in their community;

- keeping each person at the centre of our ambitions and ensuring that we consider a person's whole life journey;
- collaborating across systems to put in place the support that prevents crisis and avoids admission;
- ensuring that, when someone would benefit from admission to a mental health hospital, they receive therapeutic, high-quality care and remain in hospital for the shortest time possible;
- making sure that the people with a learning disability and autistic people who are in mental health hospitals right now are safe, and that they are receiving the care and treatment that is right for them;
- working together to ensure that any barriers to an individual leaving a mental health hospital, when they are ready to do so, are removed.

In 2022, the Norfolk Adults Safeguarding Board, Norfolk & Waveney ICB, NCC, including the Transforming Care Programme team, and other partners took part in a Peer Review of Norfolk's execution of the Building the Right Support national model in response to a Safeguarding Adults Review of support for people in a Norfolk specialist hospital.

As a result of the Peer Review and recommendations by the Norfolk Safeguarding Adults Board, a process of coproduction was started to agree better ways of working. This co-production included people with a learning disability and/or autism and their families. This was known initially as the 'Ethical Framework and there are plans for a new name to be coproduced to make the framework more understandable and training materials to be developed. The principles and ways of working developed as part of the Ethical framework will be aligned to the new LD Plan.

Implementation of the Building the Right Support is aligned to these local and national approaches:

Transitional Integrated Care Strategy and Joint Health and Wellbeing Strategy Norfolk and Waveney Integrated Care Strategy; and Norfolk and Waveney Clinical Strategy.

NHS Long Term Plan » Learning disability and autism where Learning Disability and Autism is one of the 4 priorities with a 3-year plan.

The NHS Long Term Plan was published in 2019, outlining the ambitions of the NHS over the next 10 years and including learning disability as one of its four clinical priorities. This includes improving community-based support, reducing the number of people with a learning disability in hospital settings and reducing health inequalities through a focus on increasing uptake of annual health checks and reducing overmedication of children and young people with a learning disability.

Norfolk & Waveney Mental Health and LD & Autism Inpatient Framework Delivery

As part of the national Mental Health (MH) and LD&A Quality Transformation Programme we will transform inpatient care. The key focus of this programme is to improve poor quality and outdated services, eliminate out of area placements, reduce extended hospital stays, enable equal access for all and ensure services are designed based on service user needs rather than diagnosis.

We will work with the Inpatient Provider Services, including the local authority, the voluntary sector, service users and wider partners to coproduce and deliver a three-year plan as part of this process. We will submit this plan to NHS England regional team, with the first draft due in March 2024 and final draft in June 2024. We will also align this programme with the delivery of the Learning Disability Plan.

Norfolk & Waveney ICB LD & Autism Funding Plan

We are reviewing our current and future funding commitments across the Integrated Care System for Learning Disabilities and Autism (LD&A). This plan will support the movement of the Service Development Funding (SDF) into the Integrated Care Board (ICB) funding baselines for 2024/2025. The plan is aligned to the NHS Long Term Plan, and the National Community Service Mapping, and aims to improve quality, reduce the number of inpatients, reduce waiting times and expand support within the community. We will also align the funding plan with the delivery of the Learning Disability Plan.

3. The local context – population data

To receive support from Norfolk Adult Services Learning Disability Team, a person aged 18 or older must have a learning disability, autism or both and be registered with a Norfolk GP. Depending on the individual's needs, they may get support from Adult Social Services or their local health and care services.

A learning disability is a permanent developmental disability which affects a person's ability to learn and cope with everyday activities, such as housework, socialising and managing money.

It will have been present since before the person turned 18 and usually from birth. A learning disability is permanent and affects a person's entire life. It is different from difficulties such as reading and writing problems (e.g., dyslexia). In April 2023, Health reported that there were 6683 adults in Norfolk registered as having a learning disability.

Norfolk population 2023

Using projecting adult needs and service information (PANSI), it is estimated that there are 12,714 working age adults with a learning disability in Norfolk. Out of those people, an estimated 2,892 have a moderate or severe learning disability.

Using the Projecting Older People Population Information System (POPPI), information to include people over the age of 65, estimates that there are 17,653 adults (aged 18 or over). Of these, it is estimated that 3,541 adults have a moderate or severe learning disability.

People being supported by Adult Social Services from April 2022 – March 2023

The published **figures for the Number of clients accessing long term support at the end of the year with a primary support reason of 'Learning Disability Support'** for 2022-23:

18-64	65+	Total
2338	315	2653

Gender

Gender	18-64	65+	Total
Female	971	148	1119
Male	1367	167	1534
Total	2338	315	2653

Female	Male
42%	58%

Ethnic Category

Ethnic Category	18-64	65+	Total	Ethnicity %
Black / African / Caribbean / Black British	13	0	13	<5%
Other ethnic group	12	0	12	<5%
No data	30	3	33	<5%
Mixed / multiple ethnic groups	29	1	30	<5%
White	2236	311	2547	96%
Asian / Asian British	18	0	18	<5%
Total	2338	315	2653	100%

We do not have sufficient reported information to be able to provide data in relation to reported religion or sexual orientation for people with a learning disability in Norfolk.

Population predictions from 2020 – 2040

The following information is taken from the Market position statement for Norfolk October 2023.

It is estimated, using projecting adult needs and service information (PANSI) and Projecting Older people Population Information System (POPPI), that in **2020** there were 17,322 adults living in Norfolk who have a learning disability, which is around 2% of the Norfolk population.

Of the 17,322 it is estimated that:

- 12,594 are aged between 18 and 64 years of age;
- 4,728 people (27% of adults with a learning disability and 1.8% of the total Norfolk population) are aged 65 years and above;
- 4% are 85 years old and over;
- 3,491 adults have a moderate to severe learning disability. 629 (18%) are aged 65 years old an`d above and 2% are aged 85 years old and above.

Population predictions of adults with learning disabilities in Norfolk

By **2040** it is estimated that:

- 33% of the learning disability population will be aged 65 years and above (highlighting that people with a learning disability are living longer);
- 6% of the learning disability population will be 85 years old and over;
- 21% of those with a moderate to severe learning disability will be 65 years old and over;
- 3% of those with a moderate to severe learning disability will be 85 years old and over.

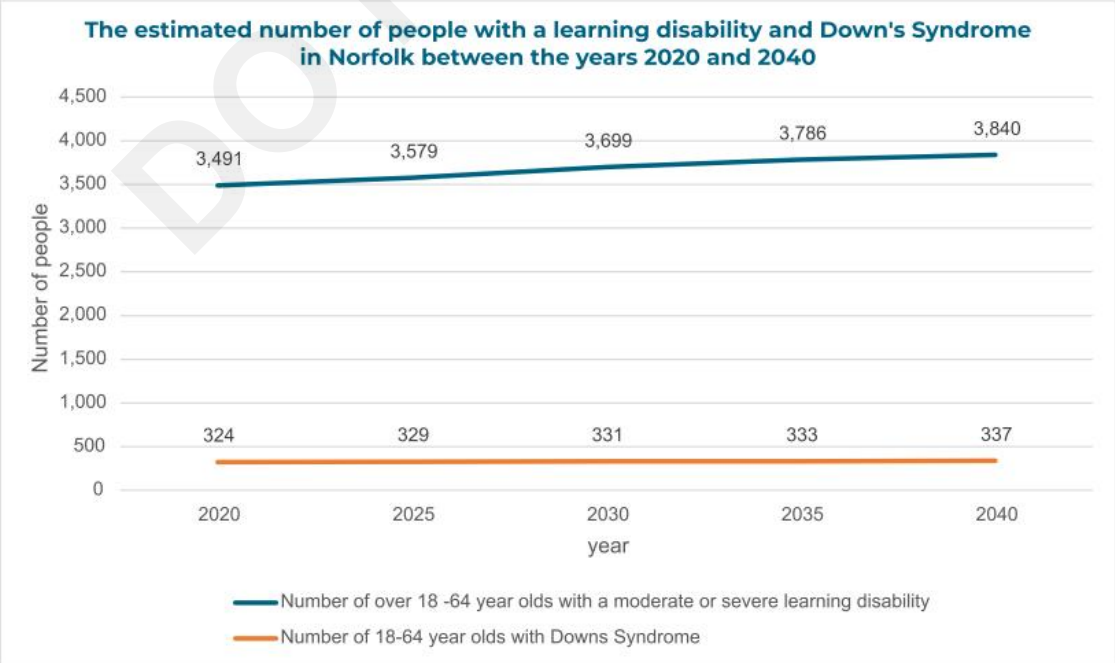
Not all people with a learning disability will be in receipt of services. People predicted to have a moderate or severe learning disability are more likely to be in receipt of services.

Population predictions by Norfolk districts.

Locality	2020	2025	2030	2035	2040
Breckland	534	550	570	588	599
Broadland	496	511	530	542	552
Great Yarmouth & Waveney	374	378	385	391	394
Kings Lynn and West Norfolk	566	567	575	580	583
North Norfolk	392	399	410	417	424
Norwich	597	608	629	642	644
South Norfolk	532	566	600	626	644
Total Norfolk	**3,491**	**3,579**	**3,699**	**3,786**	**3,840**

People aged 18 – 64 predicted to have Down syndrome 2020 – 2040

PANSI estimates the number of people with learning disabilities (moderate or severe and Down syndrome) from 2020 to 2040 in Norfolk will be:



Adults with a learning disability and dementia

People with a learning disability and those with Down Syndrome are living longer and more likely to develop health conditions associated with older age. People with a learning disability are at greater risk of developing dementia as they get older compared with the general population.

Three studies found the following prevalence rates of dementia among people with a learning disability:

- 13% of people over 50 years of age;
- 22% of people aged over 65 years of age.

For people with Down Syndrome, the risk of developing dementia is significant with a higher estimated prevalence rate of:

- 36.1% of people aged 50-59 years old;
- 75% for people over 60 years old.

These estimations came from the research that is available on the social care institute for excellence website.

It is important that with people living longer, services adapt to be able to meet the needs of people with dementia who also have a learning disability or Down Syndrome. We need to grow the number of providers that have the settings and skills to support people with these needs.

4. What you told us

Gathering people's shared views and ideas

At the start of the process to develop a new LD Plan, there was a commitment to ensuring that the views and ideas of people with a learning disability and their carers were central. It was agreed that the easy read version of the LD Plan should be the first version of the LD Plan that was agreed. The information included would then form the basis of the more detailed plan that would be needed to outline the specific actions that would be taken by NCC, ICB and the organisations involved in working with and supporting people with a learning disability and their carers in delivering the LD Plan.

In September 2023, all of the ideas people shared were put together into the first draft of the easy read plan. This draft easy read plan was then shared with people across Norfolk and at the Partnership locality meetings to check it included what people had said and made sense.

Over eight months from April 2023 – November 2023, more than 361 people shared their ideas and these have been used to develop the new LD plan. The plan was developed by gathering the views and ideas of parents and carers, providers, practitioners, commissioners and adults and older young people with a learning disability. The Norfolk Adults Learning Disability Partnership provided ongoing oversight of the process and an update was shared with the Norfolk Adults Partnership Board in August 2023 to help develop the new LD Plan.

People were encouraged to share their ideas in various ways, including face-to-face meetings that took place across Norfolk, from June through to November 2023, as well as via email and post. In August 2023, an easy read and online survey was created to enable a wider range of people to share their ideas for the new plan, which was promoted by email, social media and word of mouth. The survey was hosted by the Norfolk Adults Learning Disability Partnership website and people were able to either complete the survey online or receive an easy read questionnaire by post. People contributed their ideas by post, email, as part of face-to-face meetings. Providers and independent organisations who had discussed the new plan with people with a learning disability they support, also provided feedback which was included as part of agreeing what would be in the new LD plan. This feedback included information from older young people with a learning disability (aged from 14 – 25 years) who are part of the independent Disability Real Action Group of Norfolk (DRAGONS) to ensure that the plan would be helpful for older young people with a learning disability who were approaching adulthood.

People we know were involved in developing the LD Plan over eight months:

- 201 people with a LD = 56%
- 63 unpaid carers = 17%
- 97 professionals & providers = 27%

People's expressed outcomes

People shared a range of things that are important to help them live a good life in Norfolk. The different things people told us have been grouped into five main areas.

The phrasing used to outline people's expressed outcomes comes from what people with a learning disability and / or their carers shared as part of face-to-face engagement, or what people told us through the online survey, by email, easy read questionnaire and from other information gathered from providers working with people with a learning disability.

1. Choices about where I live

- "I want to be able to choose who I live with."
- "I want help to stay living in my own home."
- "I would like to be able to move to my own home so that I can cook my own meals instead of these being made for me."
- "I want to move nearer the town so that I can be nearer my friend(s)."
- "I want to move somewhere that will let me have a dog."

2. Being healthy

- "I want support with health and dentist appointments."
- "I want support with my mental health."
- "I want help in choosing a healthy diet."
- "I want help to get exercise."
- "I want help in losing weight."
- "I want advice about sex and relationships."

3. Help to be an independent as possible

- "I want help with getting a job."
- "I would like to know about the different things there are for me to do in my neighbourhood."
- "I would like help learning to cook."
- "I would like to feel safe in my own home and when I am out and about."
- "I would like to know about what is on in the evenings and weekends that I could join."
- "I want help with managing my money and paying my bills on time."

4. Getting out and about

- “I want there to be more public transport where I live.”
- “I would like more people to be able to use accessible toilets.”
- “I would like to feel safe when I am out and about.”
- “I would like there to be training for people who provide transport for people with a learning disability.”
- “I would like there to be a festival for adults with a learning disability.”

5. Support for carers

- “I want to know what help is out there to support me as a carer.”
- “I want to be able to contact someone when things are getting more difficult for me as a carer.”
- “It is not clear to me how I can get help for me as a carer.”
- “I want to know what will happen when I am too old to continue in my role.”
- “I need regular breaks to support me to keep on being a carer.”
- “I would like to be able to join a carers’ support group.”

5. The agreed priorities for people with a learning disability and their carers

Throughout the process of engagement, consultation, coproduction and codesign, people shared their views and ideas about what was important to them as a person with a learning disability or as someone caring for a person with a learning disability. As part of asking people what things they felt they needed help with to live a good life in Norfolk, people were also asked about the things they felt they could do for themselves or already knew how to do with help. From this, we were able to identify five main priority areas that people with a learning disability and their carer felt they need support with to live a good life in Norfolk.

Five main priority areas

1. Choices about where I live

This was the top priority identified from the engagement process. People shared their positive experiences of moving into supported housing, as well as the help they had received to be able to stay living in their own home. Others shared their concerns about 'being forced into residential care' or not having any choice about where they might be moved to or who they would be living with as well as the challenges and highlights of living with others. These are reflected in the expressed outcomes about 'choices about where I live' and the actions to be taken as part of responding to what people have said.

This engagement identified the lack of knowledge about the housing options available for people with a learning disability. It was also identified that there are a range of providers who are supporting people with a learning disability to move into alternative accommodation that they provide or can help people to access, in addition to the options available with the support of Adult Services. Information about some of the additional support with housing being provided by independent charities and organisations was shared as part of the 'Looking Back' document.

2. Being healthy

People identified a range of goals they had to help them 'be healthy' and things they knew they needed to do or were already doing to improve their health. People shared good news stories about the ways they had been helped to lose weight and others spoke about the things they were hoping they would be able to do to feel healthier.

Help with mental health was identified by some people with a learning disability who outlined that they did not always know who they could get support from in the community to help with this.

As part of the support for mental health, people with a learning disability asked about whether support for people with a learning disability who were detained in secure units on a temporary or longer-term basis was included in the overall LD Plan. The work of NCC and the ICB, as part of the Transforming Care Programme, is focussed on supporting people with a learning disability to be able to move into some kind of housing in the community, to be supported to be as independent as possible when in the community and to be able to have help to get out and about. These aims are for all people living in Norfolk with a learning disability.

The additional specific support being provided by health to support people with a learning disability with mental health needs has been included in the 'Be Healthy' section of the LD Delivery Plan.

3. Help to be an independent as possible

There were a range of things identified by people with a learning disability that emphasises people's desire to be 'as independent as possible' and to be able to live a 'normal life' like other people. In the discussions around the kinds of support available to help people with a learning disability, there were additional areas of support and community resources identified by professionals who joined the meetings and so this information has been included in the LD Delivery Plan.

4. Getting out and about

At the start of the engagement process, there was an expectation that 'help to get out and about' would be higher on the list of priorities due to the many challenges being experienced around reduction in the number of taxis available and lack of transport in rural areas. With the focus on asking people what they could already do with help, people identified that they already felt confident in taking public transport or knew about, or were about to start, travel training, or already had help in place to get there where they needed to be, and so help with getting out and about is a priority area, but number four in this list.

5. Support for carers

Carers here are defined as family members or friends who provide unpaid support for someone with a learning disability. In speaking with people with a learning disability, they did not always recognise the 'caring' role played by their family member and thought that 'carer' referred to the paid carers they saw as part of their day-to-day care and support. Family carers themselves do not always recognise themselves as a 'carer' and entitled to support.

Support for unpaid carers was identified as a very important part of any support for a person with a learning disability, though current data does not give an accurate indication of how many carers of someone with a learning disability are accessing any kind of support to help them as a carer in Norfolk.

Support for unpaid carers was also highlighted as key issue in the summer 2023 engagement with Norfolk residents - called Conversations Matter. Conversations Matter listened to residents' experiences of adult social care and to better understand their expectations and how we can help them. The engagement feedback has formed the basis for how the Promoting Independence Strategy will be updated, which outlines the vision and priorities for Adult Social Services in Norfolk, including our ambitions to better support unpaid carers, and this new approach will sit alongside the new LD Plan.

Although Carers Matter Norfolk took on the role for NCC of providing carer's assessment, information, support and advice in 2021, some carers expressed confusion about whether Carers Matter Norfolk could be used to support them, and others shared that knew of friends who had received excellent support and were hoping to try and access support for themselves. Figures from Carers Matter Norfolk suggests they provided support to 113 carers of someone with a learning disability in 2022. As part of the new LD Plan, there is a commitment to improving the data in relation to numbers of carers for someone with a learning disability receiving carer support, and also in sharing the range of caring support that can be provided by other providers, as part of helping carers have access to different types of support.

Help with transition to Adult Services – a new NCC Preparing for Adult Life Service (PfAL)

This LD Plan is focussed on the support for adults with a learning disability but also includes planning for the needs of those young people who are transitioning into adulthood. A focus is on young people who from the age of fourteen will be supported by the NCC PfAL team, as they are likely to be supported by Adult Social Services when the turn eighteen.

The new PfAL team was designed in partnership with young people and their carers, as well as professionals from all the different agencies supporting young people and adults. This new service started in January 2020 and is funded by both Adult Services and Children's Services and supports young people with a disability from aged 14 as they prepare for adulthood.

Children who are currently being supported by Children's Services or Specialist Health services and who are likely to still need support after they turn 18, can be referred from the age of 15 onwards to the PfAL team for an initial Care Act assessment. Each Norfolk locality has their own transition social worker who will make the referral.

There are four preparing for adult life outcomes which are – employment, being healthy, being part of your community and being independent and these outcomes align with the expressed outcomes in the new LD Plan.

The Preparing for Adult Life team works with a wide range of people from education, health, Children's Services, Adult Services and the voluntary sector as part of carrying out a Care Act (2014) assessment and helping to develop a 'transition care and support plan' for each person.

People have told us that they really like the new Preparing for Adult Life Service as it has helped them to understand everything that is being done to help a person who is moving from Children's Services to being supported by Adult Services.

Young people and their families have said that they like that finding the right place to live, being healthy, being part of your community and thinking about work or further education and training is included as part of a person's transition plan.

6. Actions and outcomes

In drawing up the LD Plan, the specific actions that would be needed to help support the expressed outcome and who would lead on carrying out each action has been identified. A detailed LD Delivery Plan was drawn up to help practitioners in carrying out their specific actions and ensuring they are gathering the suggested evidence to demonstrate the measures of success that will enable a person with a learning disability and their carer to know whether the plan is working or not. This detailed non-easy read plan will also be published on the Norfolk Adults Learning Disability Partnership Board website.

Members of the Norfolk Adults Learning Disability Partnership, including NCC and the ICB and all those providers who work with people with a learning disability and their carers, are included in having a role to play in carrying out the actions to help people achieve their desired outcomes.

Specific Actions linked to outcomes and who is leading on each area

1. Choices about where I live

"I want to be able to choose who I live with"

a) Adult Services Operational Teams will support people to think about where they would like to live and who they would like to live with as part of their Care Act assessment & plan of support;

b) NCC Specialist Housing Team will develop promotional / educational materials to help the Council provide better information about the different types of housing being developed and how to help people find a place to live;

c) NCC Specialist Housing Team will provide more easy read information to explain the specialist housing options in Norfolk. (See also current easy read Supported housing information).

Types of Supported Living we now offer:

- Supported Living in shared housing is a shared house where people have their own bedrooms. It has shared spaces where people can come together, like a living room and kitchen;
- Supported Living for enablement are shared homes or groups of homes where people live on their own, that are close together. People live in them for a short time to build their skills and confidence, so they can move into more independent housing;
- Supported Living in community housing are Individual homes that are close together. People live on their own, but with support available. There might be some shared spaces where people can come together;

- Supported Living for higher care and support needs are homes for people who need more help to do the things that want to do. They are self-contained houses or bungalows;

d) LD Partnership members will share information about the housing support they are providing;

e) Through the Promoting Independence pilot for Life Opportunities, Adult Services LD Commissioners will work with providers and individuals to identify established friendship groups who require accommodation to help them in choosing who they want to live with.

"I want help to stay living in my own home"

a) Adult Services Operational Teams will support people to think about where they would like to live and what help they might need to stay living at home, as part of their Care Act assessment & plan of support;

b) Adult Services Operational Teams and NCC Assistive Technology Team will make sure that people have the right equipment and technology to feel safe and happy in their home;

c) Support from Integrated Housing Adaptation Teams to help people access Disabled Facility Grants available through district councils.

"I would like to be able to move to my own home so that I can cook my own meals instead of these being made for me"

a) Specialist Housing Team & Adult Services LD Commissioners are investing in building more types of housing to support people with a learning disability to live as independently as possible, which can include having access to a kitchen;

b) Specialist Housing Team will publish information on the **Specialist Housing** website;

c) Adult Services Operational Teams & LD Commissioners will support people to develop the skills they need to move into their own home.

"I want to move nearer the town so that I can be nearer my friend(s)"

a) Development of housing solutions in market towns by Specialist Housing Team so that people are close to local facilities.

"I want to move somewhere that will let me have a dog"

a) Adult Services & Specialist Housing will explain about the different types of housing available;

b) Development of a range of housing solutions across Norfolk, including working with landlords to encourage pets to be permitted in housing is carried out by Specialist Housing Team & LD Partnership providers.

2. Being healthy

"I want support with health and dentist appointments"

a) Primary Care will support people to register with a local doctor and to receive an annual health check and health action plan (which includes dental check information);

b) Primary Care & Community Health teams will support people to register with a dentist;

c) Primary Care & Community Health teams will identify those individuals who need extra support and preparation to attend appointments, such as desensitisation support for blood tests and preparation for screening appointments;

d) Acute & Community Health teams will involve the familiar carer in a person's support where this is needed;

e) Acute & Community Health teams will support staff at hospitals to make sure they make decisions about people with a LD in the right way;

f) Acute & Community Health teams will provide information about the named LD nurses at hospitals;

g) Acute & Community Health teams and Advocacy Support will involve advocacy & care coordination support for those with complex health profiles and limited social support.

"I want support with my mental health"

a) Medicines Optimisation, Community Learning Disability Teams, and LD Psychiatry Service will work with health professionals, care providers, families, and learning-disabled people to ensure no one is on too much medication;

b) NHS providers and private inpatient hospital will monitor the progress of anyone held in seclusion or segregation in inpatient settings and provide support to ensure efforts are made to mitigate this from happening;

c) Hertfordshire Partnership Foundation Trust (HPFT) and Norfolk & Suffolk Foundation Trust (NSFT) are going to Transform Inpatient Provision;

d) Intensive Support will be available to Learning Disabled people entering a crisis in the community, who have been flagged to the Intensive Support Services through the use of the Dynamic Support Register;

e) Small Supports Project and Individual Service Funds project will support more people to access a Personal Health budget;

f) Small Supports Project and Individual Service Funds project will transform our approach in services to understand behaviour and how to mitigate risk, in a positive way, building on people's strengths with the use of the Positive Behaviour Support approach.

"I want help in choosing a healthy diet"

a) Primary Care, Specialist Dieticians, Community Health teams and all care providers will support people to eat better (and this will be recorded as part of the health action plan);

b) Primary Care, Specialist Dieticians, Community Health teams and all care providers will work with all care environments to train staff around supporting residents with better nutrition and building more exercise into social activities.

"I want help to get exercise"

a) Community Health teams and all care providers will support people to live healthier lives by exercising more;

b) Community Health & LD Partnership members will share information about the different groups and activities available in the local area to support better health. (This includes information available from **Active Norfolk**)

"I want help in losing weight"

a) Community Health teams and all care providers will work with all care staff to help learning disabled people lose weight and be more active;

b) Primary Care, Community Health teams & Specialist LD nursing services will support people to live healthier lives (and this will be recorded as part of the health action plan).

"I want advice about sex and relationships"

a) Specialist LD services and Norfolk care providers will support people with information and training about sex and relationships;

In the community people can self-refer to access free Integrated Contraception and Sexual Health Service (**ICaSH**).

"I would like to be sent a text to remind me about my health appointment"

a) Primary, Acute & Community Health teams will provide information for people in a way they understand, such as using hospital passports;

b) Primary, Acute & Community Health teams will ensure that person centred reasonable adjustments are made in communicating with a person with LD as part of helping individuals to access their health care support. This includes supporting people who cannot use technology or text messages.

3. Help to be an independent as possible

"I want help with getting a job"

a) Employment Team (Adult Services) & Life Opportunities providers supported by LD Commissioners will support people who are currently being supported by Adult Social Services, into paid employment through help from the Norfolk Employment Service or the Life Opportunities – Skills & Employment pathway with Day Services;

b) Adult Services Employment Team will support people with a LD and / or autism into employment through the Local Supported Employment (LSE) Scheme;

c) Adult Services Employment Team (Skills & Employment Team) will work with employers to become 'Disability Confident' and more able to support someone with a LD at work;

d) As a partnership, LD Partnership members will share information about the types of **employment support** we are offering and will also signpost people to things such as supported internships, apprenticeships or vocational training.

"I would like to know about the different things there are for me to do in my neighbourhood"

a) LD Commissioners & Adult Services Operational Teams will help people to find out about the different activities they can do as part of the Life Opportunities - Promoting Independence or Enriching Lives support from day services;

b) As a partnership, LD Partnership members, including links with Community Connectors, Libraries, Adult Learning, Social prescribers & Development workers will agree the best way to work together with the different organisations and available resources as part of identifying the range of community support & activities available for people with a LD.

See Information about **social prescribers**.

See Information about **Community Connectors**.

See Information also available from **Norfolk Community Directory**.

See Information about courses from **Adult learning**.

c) As a partnership LD Partnership members will identify the best ways of sharing information about the range of activities available in each area for a person with a LD, to help people know about what is available in their area as each locality may have different things available.

"I would like help learning to cook"

a) As part of a person's Care Act assessment or Review, & plan of support Adult Services Operational Teams will discuss how to help a person develop their independence skills;

b) LD Commissioning of Day Services will help people to develop life skills through the Life Opportunities - Promoting Independence support from day services;

c) As a partnership, LD Partnership members will share information about the types of support to develop independence skills they are offering and other local information such as **Adult learning**.

"I would like to feel safe in my own home and when I am out and about"

a) Adult Services Operational Teams, Health teams, Adult Safeguarding Team and Norfolk Safeguarding Adults Board will take any safeguarding concerns seriously and will encourage an individual to talk to someone they trust and ask for their help to report this **safeguarding concern**.

Easy read **protecting adults** information.

b) LD Commissioning of Day Services will support people with complex needs to learn skills to keep themselves safe through the Life Opportunities – Enriching Lives support from day services;

c) LD Partnership members, Adult Services, Health teams and Norfolk Safeguarding Adults Board will support the commitment to safeguarding principles in helping someone with a LD to understand about **keeping themselves safe**.

See other training resources available:

Making Safeguarding Personal - YouTube

Tricky Friends animation | Norfolk Safeguarding Adults Board

"I would like to know about what is on in the evenings and weekends that I could join"

a) As a partnership, LD Partnership members, including links with Community Connectors, Libraries, Social prescribers & Development workers will agree the best way to work together with the different organisations and available resources as part of identifying and sharing information about the range of community support & activities available in the evenings and at weekends for people with a LD.

"I want help with managing my money and paying my bills on time"

a) LD Commissioning of Day Services will help people to develop life skills around handling money through the Life Opportunities – Skills & Employment support from day services;

b) As part of a person's Care Act assessment or Review, & plan of support Adult Services Operational teams and NCC Finance team can discuss support for a person to develop the money management skills and possible support from the Money Support Service;

c) As a partnership, LD Partnership members will share information about the types of support with money management skills we are aware of locally.

4. Getting out and about

"I want there to be more public transport where I live"

a) LD Partnership with links with Active Norfolk, Community Connectors and other agencies will work together with partners involved in making improvements to public transport to share ideas for improvements;

b) LD Partnership members to identify key links to help explore ways to enable people to use their bus pass to travel to work for free before 09:30 (currently, people with a bus pass pay the reduced 'concessionary' rate if they travel before 09:30);

c) LD Commissioners and Specialist Housing Team will consider the availability of good transport links when developing new housing provisions.

"I would like more people to be able to use accessible toilets"

a) LD Partnership members to identify key people to help with this, including links with Community Health, Community Connectors, Social Prescribers & Development workers to work together with partners to identify ways of improving access to toilets for the disabled across Norfolk.

See information about Changing Places.

"I would like to feel safe when I am out and about"

a) Adult Services Operational teams, Preparing for Adult Life Service & LD Commissioners will support people to feel confident in travelling independently using travel training such as Titan for Adults or other travel training provided as part of Life Opportunities – Skills & Employment support from day services;

b) LD Partnership members will help people to develop skills around being able to travel independently, including help to access support from Adult Learning if appropriate;

c) As a partnership, LD Partnership members, including links with Community Connectors, Social prescribers & Development workers will work together to identify how the Safe places Scheme could be re-started to help people find a 'safe place' when they are out in the community.

"I would like there to be training for people who provide transport for people with a learning disability"

a) LD Partnership members will explore what training they could use to help taxi and bus drivers in supporting people with a LD.

"I would like there to be a festival for adults with a learning disability"

a) As a partnership, LD Partnership members and possible help from other partners will work together to explore the various options and funding help to plan for a festival for adults with a LD in Norfolk.

5. Support for carers

"I want to know what help is out there to support me as a carer"

a) Adult Social Services & Carers Matter Norfolk will clarify what support carers can access using the Norfolk County Council website and the types of support available from Carers Matter Norfolk. Carers Matter Norfolk offer printed resources to organisations / people who request them;

b) Health partners, LD Partnership members and Carers' Voice will share information about the different groups and support available in the local area to help carers.

"I want to be able to contact someone when things are getting more difficult for me as a carer"

a) Adult Social Services will provide contact information for carers for when things are changing or getting more challenging (Tel: **0344 800 8020** or Text Relay (18001 0344 800 8020);

b) Carers Matter Norfolk provide telephone support for carers and offer a resource of information and access to a range of possible support, including linking with Adult Social Services as needed.

"It is not clear to me how I can get help for me as a carer"

a) As part of our Care Act assessment or review of the person you care for, Adult Services Operational Teams & Health partners will also discuss possible support for you as a carer (this may include support to specifically recognise yourself as an (unpaid) carer);

b) Adult Services Operational Teams & Health partners will provide information about help for carers through an online form or by completing a Carers online request;

c) Carers Matter Norfolk will provide information about how to get support from Carers Matter Norfolk.

"I want to know what will happen when I am too old to continue in my role"

a) As part of our Care Act assessment or review of the person you care for, Adult Social Services will discuss with you planning for the future care of the person with a LD, such as helping the person develop their independence skills or planning for alternative care or move into own housing;

b) Carers can complete a Carer's Emergency plan or by calling Tel: **0344 800 8020** or through Carers Matter Norfolk.

"I need regular breaks to support me to keep on being a carer"

a) As part of our Care Act assessment or review of the person you care for, Adult Social Services will look at providing replacement care for the person you care for, to allow the unpaid carer to have a break;

b) Adult Social Services, Health partners & care providers will work together with health & care providers in providing carer break / respite;

c) Carers Matter Norfolk offer planned short-term breaks which can be accessed by contacting them via their website or by their Carer Advice Line.

"I would like to be able to join a carers' support group"

a) LD Partnership members will identify and share information about the range of carer support available in each area, including carer support groups;

b) Carers Matter Norfolk have a full list of carer support groups and provide information about these on their website, newsletter, or by telephoning (Tel: **0800 083 1148**).

7. How will you know if it's successful?

Within this plan is the commitment to provide evidence for people and their families about what is being achieved and what is still to happen. In drawing up the LD Delivery Plan, the success criteria for each outcome were aimed to be SMART that is Specific, Measurable, Achievable, Realistic and have a Timescale to when it was likely to be achieved.

Within the LD Plan, information is given as to which department will provide a report or update on their planned actions and whether this is provided every 6-months or annually.

Responsibility for the delivery of the LD Plan 2023 - 28 will be led by the Norfolk & Waveney Learning Disability and Autism Programme Board which includes people from NCC and the ICB and other health partners. It was agreed that the Norfolk Adults Learning Disability Partnership Board will have a role to monitor what is, and what is not, being delivered from the Partnership's perspective and to feed this into the Programme Board. In this way, people with a learning disability and their carers will be able to continue to be engaged in sharing their ideas and feedback and being part of making improvements to the plan as needed.

As well as providing information and updates for the Norfolk & Waveney Learning Disability and Autism Programme Board, it was identified that the Norfolk Adults Learning Disability Partnership Board have a key role to play in sharing information from the programme Board about the progress towards agreed actions and where any changes to the LD Plan that have been suggested are being made.

Success criteria linked to expressed outcomes

1. Choices about where I live

"I want to be able to choose who I live with"

a) Individuals report that they felt able to choose where they live and who they live with (or live by themselves);

b) Specialist Housing produce four case study videos and an animated educational overview video to help individuals and carers understand the different housing options available;

c) Easy read information will be available to provide clear information to support people to understand the different housing schemes;

d) LD Partnership website will share good news stories and data about people helped to find their choice of home;

e) Report from Life Opportunities Programme outlines how people are being helped to increase their friendship skills as part of helping them choose who they want to live with.

"I want help to stay living in my own home"

a) Individuals are supported to make a choice about where they will live and understand the possible care options to enable them to stay at home;

b) More people will benefit from home adaptations to meet their needs;

c) Data about numbers supported will be shared annually.

"I would like to be able to move to my own home so that I can cook my own meals instead of these being made for me"

a) 181 new homes for people with LD and / or autism made available across Norfolk. Implementation of Small Support Programme for bespoke housing opportunities is carried out;

b) Information about the different types of housing available is published on the Specialist Housing website;

c) Increase in number of people being supported to develop independence skills to manage their own home, or with specific support.

"I want to move nearer the town so that I can be nearer my friend(s)"

a) Responding to what people have told us, the majority of new homes to be in market towns or the city, and to be in a range of locations covering all districts across Norfolk.

I want to move somewhere that will let me have a dog

a) Supported Living webpages that remain up to date with the information people need to make decisions about their housing;

b) Good news stories from providers about range of housing support being provided is shared on LD Partnership website and communicated more widely. Scheme is introduced to support responsible pet ownership.

2. Being healthy

"I want support with health and dentist appointments"

a) A minimum of 75% of people with LD will have an annual health check and 100% of those people will have a health action plan as part of their annual health check;

b) More people will be able to register with a dentist;

c) More people will attend screening appointments and feel better prepared for medical appointments;

d) The health action plan is shared with the community teams and family / carer, as well as the person with a LD. Health will request evidence from providers about how they support individuals and their carers;

e) Evidence of compliance with Mental Capacity Act and good documentation / medical records. Health will provide information about the experience of the patient, family and carer as they navigate health services;

f) People will be able to find information about support for a person with a LD in hospital;

g) People with LD and their familiar carers receive advocacy support to help in understanding complex health needs and plan of support.

"I want support with my mental health"

a) There will be a reduction in pharmacological responses to managing learning disabled people in the community;

b) There will be a reduction in the cases/incidents that require seclusion or segregation;

c) An improvement in poor quality and outdated services, sees less people needing to go out of county for an inpatient admission; a reduction in length of stay and ensuring needs led admission, on basis of needs not diagnosis;

d) There will be a reduction in hospital admission or admission avoidance work of learning-disabled people as we work with people more proactively before a crisis emerges;

e) There will be an increase in people entitled to NHS Continuing Healthcare and subject to Section 117 aftercare being considered for Personal Health budgets;

f) A better understanding of behaviour will emerge with the continued effort to roll out Positive Behaviour Support training and extra support for care providers, in this area of specialism. Implementation of the pilot of the specialist positive behaviour support service and see a corresponding increase in quality improvement in LD services.

"I want help in choosing a healthy diet"

a) Increase in the number of people with LD being supported to eat better;

b) Care Quality reports will outline improved focus on weight management.

"I want help to get exercise"

a) Increase in the number of people being supported to increase their levels of exercise;

b) Information about the range of different activities available to help people with LD live healthier lives is shared across the LD partnership.

"I want help in losing weight"

a) Increase in the number of people with LD being supported to lose weight;

b) Increase in the number of people with LD being supported to live more healthy lives.

"I want advice about sex & relationships"

a) People with LD, and their carers, can receive information and support to be able to discuss sex and relationships as outlined by the Care Quality Commission.

"I would like to be sent a text to remind me about my health appointment"

a) People receive information about their health in a way they understand;

b) People receive individualised support. Familiar carers are involved in the decision-making around the person's care and support in line with the Mental Capacity Act.

3. Help to be an independent as possible

"I want help with getting a job"

a) There is an increase in the number of people with a LD, known to Adult Social Services, getting into paid employment (goal of 10% by 2028);

b) There is an increase in the number of people with a LD and / or autism being supported into employment (goal of 30% of LSE participants by March 2025);

c) Information about number of Norfolk employers who are registered as 'Disability Confident' is published on gov.uk website;

d) LD Partnership members share information and good news stories about people with LD they have supported into employment.

"I would like to know about the different things there are for me to do in my neighbourhood"

a) As part of the Life Opportunities Scheme, individuals are able to choose a range of activities they can access, including things like gardening and working with animals;

b) LD Partnership Board develops wider network of members to extend ability of the LD Partnership to broaden knowledge about range of support being provided across Norfolk;

c) People with LD, their families and care providers are able to find out about a wide range of activities available for a person with LD in Norfolk.

"I would like help learning to cook"

a) Increase in number of people being supported to develop independence skills;

b) Report from Life Opportunities Programme outlines how people are being helped to increase their life skills;

c) LD Partnership members share information and good news stories about types of skills they have supported people with LD to develop.

"I would like to feel safe in my own home and when I am out and about"

a) Safeguarding report outlines Norfolk's partnership work in seeking to keep people safe and free from abuse and neglect;

b) Report from Life Opportunities Programme outlines how people are being supported to keep safe through the Enriching Lives support;

c) Safeguarding report outlines Norfolk's partnership work in making sure people with a LD and staff supporting them receive updated safeguarding training to support people with a LD from abuse or neglect.

"I would like to know about what is on in the evenings and weekends that I could join"

a) Information about activities and events for people with LD that are on in the evenings or at the weekends is made available.

"I want help with managing my money and paying my bills on time"

a) Report from Life Opportunities Programme outlines how people are being helped to increase their life skills;

b) People feel able to discuss possible support to help them manage their money and find support to help with this;

c) LD Partnership members share information and good news stories about how they have supported people with LD to develop money management skills.

4. Getting out and about

"I want there to be more public transport where I live"

a) The LD Partnership members are able to link with relevant agencies to provide feedback & make improvements;

b) The LD Partnership works together with partners to agree possible ways to make changes so that people can use their bus pass before 09:30;

c) Information about new housing and access to public transport and shops is made available.

"I would like more people to be able to use accessible toilets"

a) LD Partnership works together with partners to agree possible ways to make changes.

"I would like to feel safe when I am out and about"

a) Report from Life Opportunities Programme outlines how people are being helped to increase their skills around traveling independently;

b) LD Partnership members share information and good news stories about types of travel training skills they have supported people with LD to develop;

c) Shops and other places display the 'Safe Places' sign and have staff who can support a person with a LD who asks for help 'to be safe'

"I would like there to be training for people who provide transport for people with a learning disability"

a) LD Partnership works together with About with Friends to agree possible ways to provide training for taxi drivers across Norfolk.

"I would like there to be a festival for adults with a learning disability"

a) LD Partnership works together with other agencies & organisations in identifying planning for a festival for adults with a LD in Norfolk.

5. Support for carers

"I want to know what help is out there to support me as a carer

a) Support for carers is made clearer

(Carers Matter provide a Carer Advice Line for people to call (Tel: **0800 083 1148**). and an online self-assessment service. They have a team of Community Advisers who can provide a Care Act Carer's Assessment and Carer's support plan, as well as a range of other types of community support based on the individual carer's needs. They can also refer carers to other organisations as needed);

b) The range of support for carers across Norfolk is identified and shared through the LD Partnership website and other communications, including Carers' Voice Norfolk.

"I want to be able to contact someone when things are getting more difficult for me as a carer"

a) Carers will be able to make to make contact with Adult Services (as expressed within NCC's Customer Service Charter - Norfolk County Council);

b) Carers will be supported in their caring role and to support their physical health & wellbeing.

"It is not clear to me how I can get help for me as a carer"

a) Information for carers is kept up to date;

b) As in point a)

c) Carers Matter Norfolk provides up to date information that can help carers access support for themselves.

"I want to know what will happen when I am too old to continue in my role"

a) Carers are supported to discuss their concerns and make plans for the future;

b) Carers are able to plan for what can happen for the person they care for should something happen to them.

"I need regular breaks to support me to keep on being a carer"

a) Carers receive support to take regular breaks from their caring responsibilities;

b) Carers are able to access a break away from being a carer;

c) Carers Matter Norfolk provides up to date information that can help carers access a range of support.

"I would like to be able to join a carers' support group"

a) LD partnership members identify & share information about range of carer support they identify;

b) Carers Matter Norfolk provides up to date information that can help carers access a range of support.

8. Agreed ways of collecting feedback

As part of developing the Learning Disability Plan, people were able to codesign how they would like to be involved in the ongoing monitoring and feeding back on whether the new plan is working or not. All the feedback was used to design the process that will be used for monitoring the plan, and people were able to identify the wide range of ways that they would like to be involved in giving feedback.

Face to face meetings

Zoom meetings

Using email and/or an online survey

Social media

Using games or tools that help people who do not want to speak, to share their ideas

Having audio or video recordings of the Plan available

Sharing your ideas with someone else who can speak for you

Sending a postcard

It was also highlighted from the 'Looking Back' document and the overall engagement process that there needs to be a commitment by all the LD Partnership members in providing improved communications. This will ensure that more people with a learning disability, their families and the people working or supporting them, are able to find out about how the plan is working and to receive updates in a format they can access, as well as being given the opportunity to engage in providing feedback on whether they feel the plan is working or not. In this way it is envisioned that people living in Norfolk and their carers will feel they are receiving support as part of the agreed LD Plan 2023 – 2028.

Norfolk County Council

NORFOLK LEARNING DISABILITY PARTNERSHIP

NHS Norfolk and Waveney Integrated Care Board

Our plan about making life better for people with a learning disability and their carers in Norfolk

this plan is about our work from 2023 to 2028

Norfolk **Adults** Learning Disability Plan 2023 – 2028

About this Plan (1)

We are the Norfolk Adults Learning Disability Partnership, and this includes Norfolk County Council and the NHS Norfolk and Waveney Integrated Care Board and all those providers who we work with.

This plan is about how we will work together to make life better for adults with a learning disability, and their carers, in Norfolk.

All people with a learning disability should have a good, safe and healthy life.

About this Plan (2)

From April 2023 to November 2023, people living in Norfolk with a learning disability and their carers helped make this plan.

More than 201 people across Norfolk with a learning disability and 63 unpaid carers shared their ideas for the new plan.

About this Plan (3)

97 professionals and people from the voluntary sector also shared their ideas for the new plan.

There were other people with a learning disability who shared their ideas with someone who supports them. These ideas were then shared for the plan, but we do not know how many people did this.

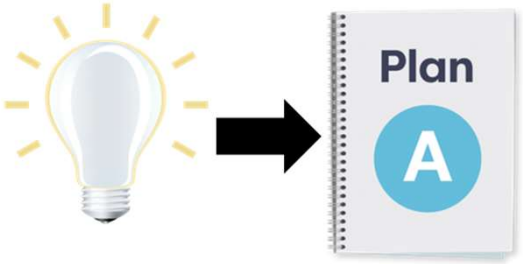
About this Plan (4)

People shared their ideas in face to face meetings across Norfolk or through the easy read and online survey.

This was shared through social media and the Learning Disability Partnership website.

About this Plan (5)

People also sent their easy read questionnaires to us by post *and* other people sent us their ideas by email.



All the ideas and things people had said or written were put together into a first version of the new Learning Disability Plan.

About this Plan (6)

This draft plan was then shared with people to check that it included what people had said and that it made sense.

There were 5 main things people told us were important to support people with a learning disability living in Norfolk.

We have used the words of people with a learning disability and their carers to describe what is important to them in each section.

About this Plan (7)

There are different organisations and charities who support people with a learning disability and their carers.

This easy read plan will describe the main things that the different organisations will do to help.

1. Choices about where I live

I want to move somewhere that will let me have a dog

I want to move nearer the town so that I can be near my friends

I would like to be able to move somewhere that I can cook my own meals instead of these being made for me

I want help to stay living in my own home

I want to be able to choose who I live with

1. The main things we will do

Adult Services and Norfolk County Council Housing Services will share information about the different types of housing for people with a learning disability and what new supported housing is being built.

Members of the Learning Disability Partnership and other providers will share information about the housing support they help people with.

1. The main things we will do

Adult Services and other providers will support people with a learning disability to live independently.

Adult Services will provide equipment or other changes to support a person in the home and to help keep them safe.

2. Being healthy

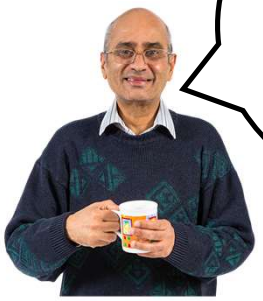
I want support with my mental health

I want help to get to exercise

I would like to be sent a text to remind me about my health appointment

I want advice about sex and relationships

I want support with health and dentist appointments



I would like help with losing weight

I want help in choosing a healthy diet

2. The main things we will do

Primary Health teams will help people to register with a local doctor and to have an annual health check and health action plan.

Health and learning disability providers will help people register with a local dentist.

Health staff will provide extra support to people with learning disabilities to help them be able to attend hospital and other medical appointments.

2. The main things we will do

Health will provide information about the named learning disability nurse at hospital and how to get help from them.

Specialist learning disability nurses and care providers will support people with information and training about sex and relationships.

Members of the Learning Disability Partnership will share information about the different groups and activities going on in the local area to support better health.

3. Help to be as independent as possible

I would like to feel safe in my own home and when I am out and about

I want help with getting a job

I would like help learning to cook

I want help with managing my money and paying my bills on time

I would like to know about the different things there are for me to do in my neighbourhood

I want to know about what is on in the evenings and weekends that I could join

3. The main things we will do

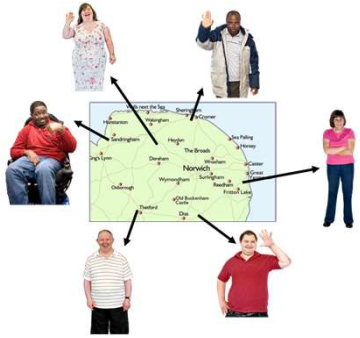
Members of the Learning Disability Partnership, other providers and professionals will work together to find out about the different activities in each area and agree the best way to tell people about these.

Adult Services and learning disability providers will help people with a learning disability into a paid job or other work experience and volunteering opportunities.

3. The main things we will do

Norfolk County Council and learning disability providers to tell people about the help for people to manage their money.

Members of the Learning Disability Partnership will tell people about the different groups and activities going on in the local area to help a person feel more independent.



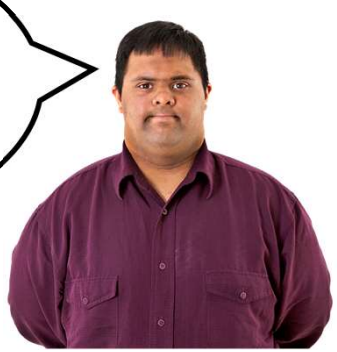
Learning Disability Partnership to develop a wider network of members to develop support available across Norfolk.

4. Getting out and about

I want there to be more public transport where I live

I would like there to be a festival for adults with a learning disability

I would like more people to be able to use accessible toilets

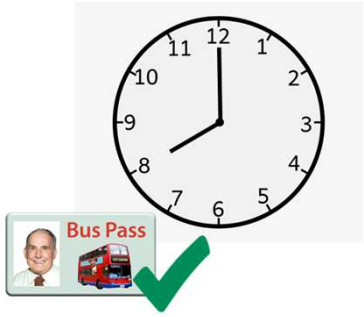


I would like there to be training for people who provide transport for people with a learning disability

I would like to feel safe when I am out and about

4. The main things we will do

Adult Services and learning disability providers to help people with travel training.



Learning Disability Partnership members to look at ways to help people to use their bus pass to travel to work before 09:30.

4. The main things we will do

Members of the Learning Disability Partnership will work together to find out how 'Safe places' can be re-started to help people feel safe when they are out and about.

Adult Services, Health partners and other Learning Disability Partnership members to link with About with Friends to see what training is available for taxi drivers to support people with learning disabilities.

5. Support for unpaid carers

I want to know what help is out there to support me as a carer

I want to know what will happen when I am too old to continue in my role

I want to be able to contact someone when things are getting more difficult for me as a carer

It is not clear to me how I can get help

I would like to be able to join a carers support group

I need regular breaks to support me to keep on being a carer

5. The main things we will do

Adult Services, including Business Lead for Carers and Norfolk Carers Matter will make it clearer what support carers can get and how they can get this.

Adult Services and Norfolk Carers Matter will provide contact information for carers to use for when things are changing or getting harder for them.

Members of the Learning Disability Partnership will collect and share information about what support is available nearby for carers, such as carer support groups.

How we will check whether the plan is working or not (1)

As part of putting this plan together, people with learning disabilities, carers and other professionals and providers shared their ideas for how they can provide feedback on whether the new plan is working or not.

It was agreed that people will be helped to share their ideas in different ways, and to make sure their ideas are at the centre.

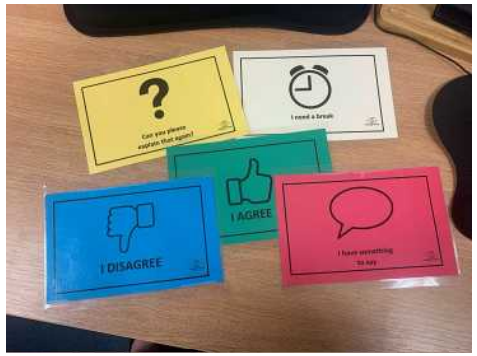
How we will collect feedback (1):

Face to face meetings

Zoom meetings

Using email and / or an online survey

How we will collect feedback (2):



Using games or tools that help people who do not want to speak, to share their ideas

Having audio or video recordings of the Plan available

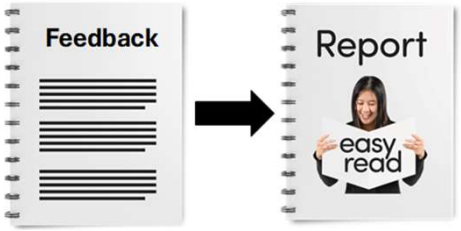
Sharing your ideas with someone else who can speak for you

How we will collect feedback (3):

Social media

Sending a postcard

How we will check whether the plan is working or not (2)

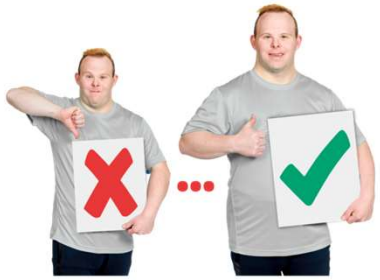


Every 6 months, members of the Learning Disability Partnership Board will gather together all the feedback from as many people as possible and put this into a report.

The Learning Disability Partnership Board will share this report with the Norfolk and Waveney Learning Disability and Autism Programme Board every 6 months.

This Programme Board includes people from the NHS, Norfolk County Council and organisations they work with.

How we will check whether the plan is working or not (3)



The Programme Board are responsible for checking whether the Learning Disability Plan is working or not and looking at what changes are needed to make it better.

Members of the Learning Disability Partnership will share information to let people know how the plan is working.

This information will be shared in different ways so that as many people as possible can hear how the Learning Disability Plan is working, or what changes are being made.

Detailed Delivery Plan for the agreed Learning Disability Plan 2023 - 2028

Delivery of The Learning Disability Plan 2023 - 28 will be led by the **Norfolk & Waveney Learning Disability and Autism Programme Board** which includes people from Norfolk County Council and the Integrated Care Board and other health partners.

The **Learning Disability Partnership Board** will have a role to monitor what is, and what is not, being delivered from the Partnership's perspective and to feed this into the Programme Board.

The Learning Disability Partnership Board will support sharing information from the partners in relation to progress towards agreed actions to assist in improved communications and updates on 'You said, what we are doing / have done'.

There are five identified priority areas:
1. Where I live;
2. Being Healthy;
3. Being independent;
4. Getting out and about; and
5. Support for unpaid carers.

Please click on each of the Tabs below to identify the specific actions and who is responsible for carrying out the action and reporting back on progress being made.

Detailed Delivery Plan for the agreed Learning Disability Plan 2023 - 2028

1 CHOICES ABOUT WHERE I LIVE

Expressed outcome (shared by people in co-production or in the online survey)	Key Actions (what will be done to help achieve this)	Timescale (when will we realistically achieve this?)	Who will be doing this (and any partners)	Who will report back on this to the Programme Board?	How will you know if we are successful?	Latest Update	Completed? (YES/NO)
(i) I want to be able to choose who I live with.	a) We will support people to think about where they would like to live and who they would like to live with as part of their Care Act assessment & plan of support.	Ongoing	Adult Services Operational Teams	Assistant Director Integrated Operations	Individuals report that they felt able to choose where they live and who they live with (or live by themselves)		
	b) We will develop promotional / educational materials to help the Council provide better information about the different types of housing being developed and how to help people find a place to live	2024	Specialist Housing team (NCC)	Specialist Housing report	Production of 4 case study videos and an animated educational overview video to help individuals and carers understand the different housing options available.		
	c) We will provide more easy read information to explain the specialist housing options in Norfolk. (See also current easy read Supported housing information).	2024 - 2028	Specialist Housing team (NCC)	Specialist Housing report	Easy read information will be available to provide clear information to support people to understand the different housing schemes.		
	d) LD Partnership members will share information about the housing support they are providing.	2024 - 2028	LD Partnership members	Report from LD Partnership Board	LD Partnership website will share good news stories and data about people helped to find their choice of home.		
	e) Through the Promoting Independence pilot for Life Opportunities, we will work with providers and individuals to identify established friendship groups who require accommodation to help them in choosing who they want to live with.	2024 - 2025	LD Commissioning	Assistant Director Integrated Operations	Report from Life Opportunities Programme outlines how people are being helped to increase their friendship skills.		
(ii) I want help to stay living in my own home.	a) We will support people to think about where they would like to live and what help they might need to stay living at home, as part of their Care Act assessment & plan of support.	Ongoing	Adult Services Operational Teams	Adult Services Operational Teams	Individuals are supported to make a choice about where they will live and understand the possible care options to enable them to stay at home.		
	b) We will make sure that people have the right equipment and technology to feel safe and happy in their home.	Ongoing	Adult Services and support from Assistive Technology team	Assistant Director Integrated Operations	More people will benefit from home adaptations to meet their needs.		
	c) Support from Integrated Housing Adaptation Teams to help people access Disabled Facility Grants available through district councils,	Ongoing	Integrated Housing Adaptation Teams	Assistant Director Housing & Capital programme	Data about numbers supported will be shared annually.		

(iii) I would like to be able to move to my own home so that I can cook my own meals instead of these being made for me.	a) We are investing in building more types of housing to support people with a learning disability to live as independently as possible, which can include having access to a kitchen.	2026	Specialist Housing Team & LD Commissioning	Assistant Director Integrated Operations	181 new homes for people with LD and / or autism made available across Norfolk. Implementation of Small Support Programme for bespoke housing opportunities is carried out.		
	b) We will publish information on the Specialist Housing website.	Ongoing	Specialist Housing Team	Specialist Housing report	Information about the different types of housing available is published on the Specialist Housing website.		
	c) We will support people to develop the skills they need to move into their own home.	Ongoing	Adult Services Operational Teams & LD Commissioning	Assistant Director Integrated Operations	Increase in number of people being supported to develop independence skills to manage their own home, or with specific support.		
(iv) I want to move nearer the town so that I can be nearer my friend(s).	a) Development of housing solutions in market towns so that people are close to local facilities.	2026	LD Commissioning and Specialist Housing Team	Specialist Housing report	Responding to what people have told us, the majority of new homes to be in market towns or the city, and to be in a range of locations covering all districts across Norfolk.		
(v) I want to move somewhere that will let me have a dog.	a) We will explain about the different types of housing available.	Ongoing	Adult Services & Specialist Housing	Specialist Housing report	Supported Living webpages that remain up to date with the information people need to make decisions about their housing.		
	b) Development of a range of housing solutions across Norfolk, including working with landlords to encourage pets to be permitted in housing.	2026 - 2028	Specialist Housing Team & LD Partnership providers	Specialist Housing report & report from LD Partnership Board	Good news stories from providers about range of housing support being provided is shared on LD Partnership website and communicated more widely. Scheme is introduced to support responsible pet ownership.		

Detailed Delivery Plan for the agreed Learning Disability Plan 2023 - 2028

2 BEING HEALTHY

Expressed outcome (shared by people in co-production or in the online survey)	Key Actions (what will be done to help achieve this)	Timescale (when will we realistically achieve this?)	Who will be doing this (and any partners)	Who will report back on this to the Programme Board?	How will you know if we are successful?	Latest Update	Completed? (YES/NO)
(i) I want support with health and dentist appointments.	a) Support to register with a local doctor and to receive an annual health check and health action plan (which includes dental check information). See helpful LeDeR video. Form to complete before health check.	Ongoing	Primary Care	Annual LeDeR report	A minimum of 75% of people with LD will have an annual health check and 100% of those people will have a health action plan as part of their annual health check.		
	b) We will support people to register with a dentist.	2024 - 2028	Primary Care & Community Health teams	Norfolk & Waveney ICB	More people are able to register with a dentist.		
	c) We will identify those individuals who need extra support and preparation to attend appointments, such as desensitisation support for blood tests and preparation for screening appointments.	Ongoing	Primary Care & Community Health teams	Norfolk & Waveney ICB	More people attend screening appointments and feel better prepared for medical appointments.		
	d) We will involve the familiar carer in a person's support where this is needed.	2024 – 2028	Acute & Community Health teams	Norfolk & Waveney ICB	The health action plan is shared with the community teams and family / carer, as well as the person with a LD. Health will request evidence from providers about how they support individuals and their carers.		
	e) We will support staff at hospitals to make sure they make decisions about people with a LD in the right way.	2024 – 2028	Acute & Community Health teams	Norfolk & Waveney ICB	Evidence of compliance with Mental Capacity Act and good documentation / medical records. Health will provide information about the experience of the patient, family and carer as they navigate health services.		
	f) We will provide information about the named LD nurses at hospitals.	2024 – 2028	Acute & Community Health teams	Norfolk & Waveney ICB	People will be able to find information about support for a person with a LD in hospital.		
	g) We will involve advocacy & care coordination support for those with complex health profiles and limited social support.	2024 – 2028	Acute & Community Health teams & Advocacy support.	Norfolk & Waveney ICB	People with LD and their familiar carers receive advocacy support to help in understanding complex health needs and plan of support.		
(ii) I want support with my mental health.	a) We will work with health professionals, care providers, families, and learning-disabled people to ensure no one is on too much medication.	Ongoing	Medicines Optimisation, Community Learning Disability Teams, LD Psychiatry Service.	Norfolk & Waveney ICB	There will be a reduction in pharmacological responses to managing learning disabled people in the community.		

	b) We will monitor the progress of anyone held in seclusion or segregation in inpatient settings and provide support to ensure efforts are made to mitigate this from happening.	Ongoing	NHS providers and private inpatient hospital	Norfolk & Waveney ICB	There will be a reduction in the cases/incidents that require seclusion or segregation.		
	c) We are going to Transform Inpatient Provision	2024 – 2028	Hertfordshire Partnership Foundation Trust (HPFT) / Norfolk & Suffolk Foundation Trust (NSFT).	Norfolk & Waveney ICB and NHSE	An improvement in poor quality and outdated services, sees less people needing to go out of county for an inpatient admission; a reduction in length of stay and ensuring needs led admission, on basis of needs not diagnosis.		
	d) **Intensive Support** - Intensive Support will be available to Learning Disabled people entering a crisis in the community, who have been flagged to the Intensive Support Services through the use of the Dynamic Support Register.	2024 – 2028	Norfolk Community Health Care / HPFT	Norfolk & Waveney ICB	There will be a reduction in hospital admission or admission avoidance work of learning-disabled people as we work with people more proactively before a crisis emerges.		
	e) We will support more people to access a Personal Health budget.	2024 – 2028	Small Supports Project and Individual Service Funds project.	Norfolk and Waveney ICB and Norfolk County Council.	We will see an increase in people entitled to NHS Continuing Healthcare and subject to Section 117 aftercare being considered for Personal Health budgets.		
	f) We will transform our approach in services to understand behaviour and how to mitigate risk, in a positive way, building on people's strengths with the use of the Positive Behaviour Support approach.	2024 – 2028	Small Supports Project and Individual Service Funds project.	Norfolk & Waveney ICB and Norfolk County Council.	A better understanding of behaviour will emerge with the continued effort to roll out Positive Behaviour Support training and extra support for care providers, in this area of specialism. Implementation of the pilot of the specialist positive behaviour support service and see a corresponding increase in quality improvement in LD services.		
(iii) I want help in choosing a healthy diet.	a) We will support people to eat better (and this will be recorded as part of the health action plan)	Ongoing	Primary Care, Specialist Dieticians, Community Health teams and all care providers	Norfolk & Waveney ICB	Increase in the number of people with LD being supported to eat better.		
	b) We will work with all care environments to train staff around supporting residents with better nutrition and building more exercise into social activities	2024 - 2028		Annual LeDeR report & Care Quality reports.	Care Quality reports will outline improved focus on weight management.		
(iv) I want help to get exercise.	a) We will support people to live healthier lives by exercising more.	Ongoing	Primary Care, Community Health teams and all care providers	Norfolk & Waveney ICB & Assistant Director Integrated Operations	Increase in the number of people being supported to increase their levels of exercise.		

	b) We will share information about the different groups and activities available in the local area to support better health. (This includes information available from Active Norfolk).	2024 - 2028	Primary Care, Community Health & LD Partnership members	Report from LD Partnership Board	Information about the range of different activities available to help people with LD live healthier lives is shared across the LD partnership.		
(v) I want help in losing weight.	a) We will work with all care staff to help learning disabled people lose weight and be more active.	2024 - 2028	Primary Care, Community Health teams and all care providers	Norfolk & Waveney ICB	Increase in the number of people with LD being supported to lose weight.		
	b) We will support people to live healthier lives (and this will be recorded as part of the health action plan).	ongoing	Primary Care, Community Health teams & Specialist LD nursing services	Annual LeDeR report	Increase in the number of people with LD being supported to live more healthy lives.		
(vi) I want advice about sex & relationships.	a) We will support people with information and training about sex and relationships. In the community people can self-refer to access free Integrated Contraception and Sexual Health Service (ICaSH).	2024 - 2028	Primary Care & ICaSH services, Specialist LD services and Norfolk care providers	Norfolk & Waveney ICB & Assistant Director Integrated Operations	People with LD, and their carers, can receive information and support to be able to discuss sex and relationships as outlined by the Care Quality Commission.		
(vii) I would like to be sent a text to remind me about my health appointment.	a) We will provide information for people in a way they understand, such as using hospital passports.	2024 – 2028	Primary, Acute & Community Health teams	Norfolk & Waveney ICB	People receive information about their health in a way they understand.		
	b) We will ensure that person centred reasonable adjustments are made in communicating with a person with LD as part of helping individuals to access their health care support. (This includes supporting people who cannot use technology or text messages)	2024 – 2028	Primary, Acute & Community Health teams	Norfolk & Waveney ICB	People receive individualised support. Familiar carers are involved in the decision-making around the person's care and support in line with the Mental Capacity Act.		

Detailed Delivery Plan for the agreed Learning Disability Plan 2023 - 2028

3 HELP TO BE AS INDEPENDENT AS POSSIBLE

Expressed outcome (shared by people in co-production or in the online survey)	Key Actions (what will be done to help achieve this)	Timescale (when will we realistically achieve this?)	Who will be doing this (and any partners)	Who will report back on this to the Programme Board?	How will you know if we are successful?	Latest Update	Completed? (YES/NO)
(i) I want help with getting a job.	a) We will support people who are currently being supported by Adult Social Services, into paid employment through help from the Norfolk Employment Service or the Life Opportunities – Skills & Employment pathway with Day Services.	2024-2028	Employment Team (Adult Services) & Life Opportunities providers supported by LD Commissioning	Assistant Director Integrated Operations	There is an increase in the number of people with a LD, known to Adult Social Services, getting into paid employment (goal of 10% by 2028).		
	b) We will support people with a LD and / or autism into employment through the Local Supported Employment (LSE) Scheme.	LSE Scheme ends March 2025	Employment Team	Assistant Director Integrated Operations	There is an increase in the number of people with a LD and / or autism being supported into employment (goal of 30% of LSE participants by March 2025)		
	c) We will work with employers to become 'Disability Confident' and more able to support someone with a LD at work.	Ongoing	Employment Team (Skills & Employment Team)	Assistant Director Integrated Operations	Information about number of Norfolk employers who are registered as 'Disability Confident' is published on gov.uk website.		
	d) As a partnership, we will share information about the types of employment support we are offering and will also signpost people to things such as supported internships, apprenticeships or vocational training.	2023 - 2028	LD Partnership members	Report from LD Partnership Board	LD Partnership members share information and good news stories about people with LD they have supported into employment.		
(ii) I would like to know about the different things there are for me to do in my neighbourhood.	a) We will help people to find out about the different activities they can do as part of the Life Opportunities - Promoting Independence or Enriching Lives support from day services.	2024 – 2028	LD Commissioning & Adult Services Operational Teams	Assistant Director Integrated Operations	As part of the Life Opportunities Scheme, individuals are able to choose a range of activities they can access, including things like gardening and working with animals.		
	b) As a partnership, we will agree the best way to work together with the different organisations and available resources as part of identifying the range of community support & activities available for people with a LD. See Information about social prescribers. See Information about Community Connectors See Information also available from Norfolk Community Directory.	2024 – 2028	LD Partnership members, including links with Community Connectors, Libraries, Adult Learning, Social prescribers & Development workers.	Report from LD Partnership Board	LD Partnership Board develops wider network of members to extend ability of the LD Partnership to broaden knowledge about range of support being provided across Norfolk.		

	See Information about courses from Adult learning.						
	c) As a partnership we will identify the best ways of sharing information about the range of activities available in each area for a person with a LD, to help people know about what is available in their area as each locality may have different things available.	2024 - 2028	LD Partnership members	Report from LD Partnership Board	People with LD, their families and care providers are able to find out about a wide range of activities available for a person with LD in Norfolk.		
(iii) I would like help learning to cook.	a) As part of a person's Care Act assessment or Review, & plan of support we will discuss how to help a person develop their independence skills.	Ongoing	Adult Services Operational Teams	Assistant Director Integrated Operations	Increase in number of people being supported to develop independence skills.		
	b) We will help people to develop life skills through the Life Opportunities - Promoting Independence support from day services.	2024 – 2028	LD Commissioning	Asst Director Integrated Operations	Report from Life Opportunities Programme outlines how people are being helped to increase their life skills.		
	c) As a partnership, we will share information about the types of support to develop independence skills we are offering and other local information such as Adult learning.	2024 - 2028	LD Partnership members	Report from LD Partnership Board	LD Partnership members share information and good news stories about types of skills they have supported people with LD to develop.		
(iv) I would like to feel safe in my own home and when I am out and about.	a) We will take any safeguarding concerns seriously and will encourage an individual to talk to someone they trust and ask for their help to report this Safeguarding concern. See easy read protecting adults information.	Ongoing	Adult Services Operational Teams, Health teams, Adult Safeguarding Team and Norfolk Safeguarding Adults Board	Norfolk Safeguarding Adults Board report	Safeguarding report outlines Norfolk's partnership work in seeking to keep people safe and free from abuse and neglect.		
	b) We will support people with complex needs to learn skills to keep themselves safe through the Life Opportunities – Enriching Lives support from day services.	2024 – 2028	LD Commissioning	Assistant Director Integrated Operations	Report from Life Opportunities Programme outlines how people are being supported to keep safe through the Enriching Lives support.		
	c) We will support the commitment to safeguarding principles in helping someone with a LD to understand about keeping themselves safe. **See other resources:** Making Safeguarding Personal - YouTube Tricky Friends animation | Norfolk Safeguarding Adults Board	2024 – 2026	LD Partnership members, Adult Services, Health teams and Norfolk Safeguarding Adults Board	Norfolk Safeguarding Adults Board report	Safeguarding report outlines Norfolk's partnership work in making sure people with a LD and staff supporting them receive updated safeguarding training to support people with a LD from abuse or neglect.		

(v) I would like to know about what is on in the evenings and weekends that I could join.	a) As a partnership, we will agree the best way to work together with the different organisations and available resources as part of identifying and sharing information about the range of community support & activities available in the evenings and at weekends for people with a LD.	2024 - 2028	LD Partnership members, including links with Community Connectors, Libraries, Social prescribers & Development workers.	Report from LD Partnership Board	Information about activities and events for people with LD that are on in the evenings or at the weekends is made available		
(vi) I want help with managing my money and paying my bills on time.	a) We will help people to develop life skills around handling money through the Life Opportunities – Skills & Employment support from day services.	2024 – 2028	LD Commissioning	Assistant Director Integrated Operations	Report from Life Opportunities Programme outlines how people are being helped to increase their life skills.		
	b) As part of a person's Care Act assessment or Review, & plan of support we can discuss support for a person to develop the money management skills and possible support from the Money Support Service.	Ongoing	Adult Services Operational teams and NCC Finance team	Assistant Director Integrated Operations	People feel able to discuss possible support to help them manage their money and find support to help with this.		
	c) As a partnership, we will share information about the types of support with money management skills we are aware of locally.	2024 - 2028	LD Partnership members	Report from LD Partnership Board	LD Partnership members share information and good news stories about how they have supported people with LD to develop money management skills.		

Detailed Delivery Plan for the agreed Learning Disability Plan 2023 - 2028

4 GETTING OUT & ABOUT

Expressed outcome (shared by people in co-production or in the online survey)	Key Actions (what will be done to help achieve this)	Timescale (when will we realistically achieve this?)	Who will be doing this (and any partners)	Who will report back on this to the Programme Board?	How will you know if we are successful?	Latest Update	Completed? (YES/NO)
(i) I want there to be more public transport where I live.	a) We will work together with partners involved in making improvements to public transport to share ideas for improvements.	2023 – 2028	Links with Active Norfolk, Community Connectors and other agencies	Report from LD Partnership Board	The LD Partnership members are able to link with relevant agencies to provide feedback & make improvements.		
	b) We will explore ways to enable people to use their bus pass to travel to work for free before 09:30 (currently, people with a bus pass pay the reduced 'concessionary' rate if they travel before 09:30)	2024 - 2025	LD Partnership members to identify key links to help with this.	Report from LD Partnership Board	The LD Partnership works together with partners to agree possible ways to make changes so that people can use their bus pass before 09:30.		
	c) We will consider the availability of good transport links when developing new housing provisions.	Ongoing	LD Commissioning and Specialist Housing Team	Specialist Housing report	Information about new housing and access to public transport and shops is made available.		
(ii) I would like more people to be able to use accessible toilets.	a) We will work together with partners to identify ways of improving access to toilets for the disabled across Norfolk. See information about Changing Places.	2025 - 2026	LD Partnership members to identify key people to help with this, including links with Community Health, Community Connectors, Social Prescribers & Development workers.	Report from LD Partnership Board	LD Partnership works together with partners to agree possible ways to make changes		
(iii) I would like to feel safe when I am out and about.	a) We will support people to feel confident in travelling independently using travel training such as Titan for Adults or other travel training provided as part of Life Opportunities – Skills & Employment support from day services	Ongoing	Adult Services Operational teams, Preparing for Adult Life Service & LD Commissioning	Assistant Director Integrated Operations	Report from Life Opportunities Programme outlines how people are being helped to increase their skills around traveling independently.		
	b) We will help people to develop skills around being able to travel independently, including help to access support from Adult Learning if appropriate.	2024 – 2028	LD Partnership members	Report from LD Partnership Board	LD Partnership members share information and good news stories about types of travel training skills they have supported people with LD to develop.		

	c) As a partnership, we will work together to identify how the Safe places Scheme could be re-started to help people find a ‘safe place’ when they are out in the community.	2025 - 2026	LD Partnership members, including links with Community Connectors, Social prescribers & Development workers.	Report from LD Partnership Board	Shops and other places display the ‘Safe Places’ sign and have staff who can support a person with a LD who asks for help ‘to be safe’.		
(iv) I would like there to be training for people who provide transport for people with a learning disability.	a) We will explore what training we could use to help taxi and bus drivers in supporting people with a LD.	2024 - 2025	LD Partnership members	Report from LD Partnership Board	LD Partnership works together with About with Friends to agree possible ways to provide training for taxi drivers across Norfolk.		
(v) I would like there to be a festival for adults with a learning disability.	a) As a partnership, we will work together to explore the various options and funding help to plan for a festival for adults with a LD in Norfolk.	2026-2027	LD Partnership members and possible help from other partners.	Report from LD Partnership Board	LD Partnership works together with other agencies & organisations in identifying planning for a festival for adults with a LD in Norfolk.		

Detailed Delivery Plan for the agreed Learning Disability Plan 2023 - 2028

5 SUPPORT FOR UNPAID CARERS

Expressed outcome (shared by people in co-production or in the online survey)	Key Actions (what will be done to help achieve this)	Timescale (when will we realistically achieve this?)	Who will be doing this (and any partners)	Who will report back on this to the Programme Board?	How will you know if we are successful?	Latest Update	Completed? (YES/NO)
(i) I want to know what help is out there to support me as a carer.	a) We will clarify what support carers can access using the Norfolk County Council website and the types of support available from Carers Matter Norfolk.	Ongoing	Adult Social Services & Carers Matter Norfolk	Report from Operational Business lead – Carers & Carers Matter	Support for carers is made clearer. (Carers Matter provide a Carer Advice Line for people to call (Tel: 0800 083 1148).and an online self-assessment service. They have a team of Community Advisers who can provide a Care Act Carer's Assessment and Carer's support plan, as well as a range of other types of community support based on the individual carer's needs. They can also refer carers to other organisations as needed).		
	Carers Matter Norfolk offer printed resources to organisations / people who request them.						
	b) We will share information about the different groups and support available in the local area to help carers.	2024-2028	Health partners, LD Partnership members & Carers' Voice	Report from LD Partnership Board	The range of support for carers across Norfolk is identified and shared through the LD Partnership website and other communications, including Carers' Voice Norfolk.		
(ii) I want to be able to contact someone when things are getting more difficult for me as a carer.	a) We will provide contact information for carers for when things are changing or getting more challenging (**Tel: 0344 800 8020** or Text Relay (18001 0344 800 8020)	Ongoing	Adult Social Services	Assistant Director Integrated Operations	Carers will be able to make to make contact with Adult Services (as expressed within NCC's Customer Service Charter - Norfolk County Council)		
	b) Carers Matter provide telephone support for carers and offer a resource of information and access to a range of possible support, including linking with Adult Social Services as needed.	Ongoing	Carers Matter Norfolk	Report from Operational Business lead – Carers & Carers Matter	Carers will be supported in their caring role and to support their physical health & wellbeing		
(iii) It is not clear to me how I can get help for me as a carer.	a) As part of our Care Act assessment or review of the person you care for, we will also discuss possible support for you as a carer. (This may include support to specifically recognise yourself as an (unpaid) carer)	Ongoing	Adult Services Operational Teams & Health partners	Assistant Director Integrated Operations	Information for carers is kept up to date.		
	b) We will provide information about help for carers through an online form or by completing a Carers online request.	Ongoing	Adult Services Operational Teams & Health partners	Assistant Director Integrated Operations	As in point a)		

	c) We will provide information about how to get support from Carers Matter Norfolk.	Ongoing	Carers Matter Norfolk	Report from Operational Business lead – Carers & Carers Matter	Carers Matter Norfolk provides up to date information that can help carers access support for themselves.		
(iv) I want to know what will happen when I am too old to continue in my role.	a) As part of our Care Act assessment or review of the person you care for, we will discuss with you planning for the future care of the person with a LD, such as helping the person develop their independence skills or planning for alternative care or move into own housing.	Ongoing	Adult Social Services	Assistant Director Integrated Operations	Carers are supported to discuss their concerns and make plans for the future.		
	b) Carers can complete a Carer's Emergency plan or by calling Tel: 0344 800 8020 Or through Carers Matter Norfolk.	Ongoing	Carers Matter Norfolk	Report from Operational Business lead	Carers are able to plan for what can happen for the person they care for should something happen to them.		
(v) I need regular breaks to support me to keep on being a carer.	a) As part of our Care Act assessment or review of the person you care for, we will look at providing replacement care for the person you care for, to allow the unpaid carer to have a break.	Ongoing	Adult Social Services	Assistant Director Integrated Operations	Carers receive support to take regular breaks from their caring responsibilities.		
	b) We will work together with health & care providers in providing carer break / respite.	2023-2028	Adult Social Services, Health partners and care providers	Assistant Director Integrated Operations	Carers are able to access a break away from being a carer.		
	c) Carers Matter Norfolk offer planned short-term breaks which can be accessed by contacting them via their website or by their Carer Advice Line.	Ongoing	Carers Matter Norfolk	Report from Operational Business lead – Carers & Carers Matter	Carers Matter Norfolk provides up to date information that can help carers access a range of support.		
(vi) I would like to be able to join a carers' support group.	a) We will identify and share information about the range of carer support available in each area, including carer support groups.	2023 - 2028	LD Partnership members	Report from LD Partnership Board	LD partnership members identify & share information about range of carer support they identify.		
	b) Carers Matter Norfolk have a full list of carer support groups and provide information about these on their website, newsletter, or by telephoning (Tel: 0800 083 1148).	Ongoing	Carers Matter Norfolk	Report from Operational Business lead – Carers & Carers Matter	Carers Matter Norfolk provides up to date information that can help carers access a range of support.		

Norfolk County Council

Equality impact assessment (EqIA) template

Tip: You have a 'duty of inquiry'.

This means you must consider what evidence is required to undertake this assessment and whether further information may be needed. If you do not have relevant evidence, there is a duty to acquire it.

Your assessment must be genuine and objective.

It may be considered inadequate if issues are only partially considered, missed or if relevant evidence is missing from the assessment.

1. Title of EqIA

Working in partnership with people to develop a new Norfolk Adults Learning Disability Plan 2023-2028.

2. What is the aim of the proposal? (max. 250 words)

Tip: Summarise here the aim of your 'proposal' in max. 250 words.

Your 'proposal' could be anything – a change to a service; an existing or new service, policy, or procedure; a way of working; a project or a funding bid.

In developing a new Norfolk Adults Learning Disability Plan (formerly known as 'Strategy') there is the commitment to ensuring that people with a learning disability and their parent or carer in Norfolk are involved from the start, and have an ongoing role in how the plan is co-designed, including how they will be involved in the ongoing evaluation and monitoring of the finished plan, as part of regular reviews of the plan over the next five years.

3. Context to the proposal

Tip: Summarise any context it is important to be aware of – e.g., the proposal may be required to meet legal requirements or achieve savings.

If this information is available in another document, you can provide a hyperlink to avoid repeating the same information.

A new Norfolk Adults Learning Disability Plan (formerly known as 'Strategy') needs to be developed as the previous LD Strategy was for 2018-2022. This new LD Plan will be developed in partnership with members of Norfolk Adults LD Partnership which includes Norfolk County Council, Norfolk & Waveney

Integrated Care Board and the various organizations who work with NCC and the ICB. The LD Partnership also includes people with a learning disability and carers, as well as professionals and providers.

In responding to feedback from people about the previous 2018-2022 LD Strategy, it was identified that people did not know what had been achieved, and what still needed doing. As a result, an easy read and non-easy read 'Looking Back on the LD Strategy 2018-2022 – You said, we did' will be shared with people as part of starting the process to gather people's ideas about what needs to be in the new LD Plan 2023 – 2028.

It is acknowledged that as many people as possible will be helped to share their views and ideas to be included as part of developing a new LD Plan, and so people will be enabled to share their ideas in a range of ways including face-to-face meetings across Norfolk from June through to November 2023 and through feedback received by email, by post or through an online and easy read survey. Providers working with people with a LD will also be asked to help in consulting with people with a LD as part of gathering their views and ideas to develop the agreed LD Plan.

The Norfolk Adults LD Partnership Board will be responsible for gaining agreement from Board members for the suggested easy read LD Plan. Alongside the easy read plan, there will be a non-easy read plan outlining the context for the LD Plan and providing more details of the specific actions to be taken by practitioners to meet the identified outcomes expressed by people with a LD and their parent or carer.

4. Who will the proposal impact on?

Tip: Please select all groups that may be affected.

☐ Everyone in Norfolk

☒ A particular group or cohort of people - please state who they are:

Adults with a learning disability living in Norfolk and their unpaid carer, as well as professionals working with these people as part of providing support for people with a learning disability and their carer to live a good life in Norfolk.

☐ Employees

☒ External organisations

☐ Other - Please state if anyone else will be affected:

Click or tap here to enter text.

5. The numbers of people affected

Tip: Please estimate (as accurately as possible) the overall number of residents, service users and/or employees directly affected by your proposal.

It is estimated that there will be 3541 people with a primary support reason of 'Learning Disability Support' being supported by Adult Social Services in 2023. From Health records, it is reported that in April 2023, there were 6683 adults in Norfolk registered as having a learning disability. Unpaid carers of people with a LD are also to be supported but there are no specific figures at this time, but it is intended that future recording will enable a clearer picture of carers involved to be developed.

There is no specific data about number of people across Norfolk working to support people with a LD but this LD Plan will involve everyone supporting a person with a LD and their carer to live a good life in Norfolk, and will have the opportunity to contribute their ideas in the development of a new LD Plan.

6. The demographic profile of the people affected

Tip: Please estimate the protected characteristics of the people affected:

- Age range
- Sex
- Disability
- Ethnicity/race
- Sexual orientation
- Religion/belief
- Gender reassignment
- Members of the armed forces, their families, or veterans.

For example, "The majority of service users affected will be over the age of 65 and include people with a range of disabilities including…".

The majority of service users will be adults (aged 18 or over) with a moderate to severe learning disability.

Figures indicate that 42% of LD service users are female and 58% male.

96% of service user with a LD report that they are white. Figures for other ethnic groupings can only be recorded as less than 5%.

There is insufficient data to report on reported sexuality, religious belief or gender reassignment for people with a LD.

There is no specific data about members of the armed forces who may have an adult child or carer with a LD but it is hoped that information about support as part of the new LD Plan will be made widely known across Norfolk.

7. Evidence gathering

Tip: This section considers what will happen if the proposal goes ahead.

Please tick all the statements that apply.

If the proposal goes ahead:

☒ It will help to deliver our Council vision and strategy.

If you cannot tick this, please explain why: Click or tap here to enter text.

☒ Service users will not experience any reductions in the quality, standards, or level of services or benefits they **currently** receive.

If you cannot tick this, please explain why: Click or tap here to enter text.

☒ Service users who currently receive a service or benefit will continue to do so. Something will not be taken away from them which they have previously had access to.

If you cannot tick this, please explain why: Click or tap here to enter text.

☒ No changes are proposed to eligibility criteria for services or benefits.

If you cannot tick this, please explain why: Click or tap here to enter text.

☒ The proposal will not change how service users experience existing services or benefits – e.g., opening hours or travel arrangements.

If you cannot tick this, please explain why: Click or tap here to enter text.

☐ The proposal will not lead to new or increased costs for service users or employees.

If you cannot tick this, please explain why: In developing this new LD Plan, it is not intended that there will be increased costs for service users but if as a result of the consultation, it is agreed that there are to be some agreed ways of making changes to delivery of services, then this could have a cost impact.

☒ There will be no changes to staffing structures or staff terms or conditions.

If you cannot tick this, please explain why: Click or tap here to enter text.

☒ If we consult on the proposal, this will be accessible for disabled people. We will include people with different protected characteristics.

If you cannot tick this, please explain why: Click or tap here to enter text.

8. Potential impact for each protected characteristic

Tip: You've considered what will happen if the proposal goes ahead.

You now need to think about how it could impact specifically on people with protected characteristics – for example:

- Whether it presents an opportunity to promote equality for people with protected characteristics.
- Whether it could unintentionally disadvantage people with protected characteristics.

You might find it helpful to remind yourself about the typical barriers that people with protected characteristics face when accessing services and employment. If so, we've included examples in **Annex 1**.

8.1. People of different ages

- Will the proposal unintentionally disadvantage people of different ages – or will it promote equality and ease of access? It is intended that the development of this new LD Plan for adults with a learning disability and their carer will be made available to all. The proposal is not designed to disadvantage anyone based on age and promotes equal access to all services.

8.2. Disabled people

- Will the proposal unintentionally disadvantage disabled people – or will it promote equality and ease of access? It is intended that the development of this new LD Plan for adults with a learning disability and their carer will be made available to all. The proposal is not designed to disadvantage anyone based on age and promotes equal access to all services.

Tip: If you intend to use physical premises, equipment, furniture, physical or digital information or technology to deliver your proposal, please follow the Council's agreed procedures for implementing this, to ensure that access for disabled people is built into the design. For guidance, email accessibility@norfolk.gov.uk

8.3. People from different ethnic groups

- Will the proposal unintentionally disadvantage people from different ethnic groups – or will it promote equality and ease of access? It is intended that the development of this new LD Plan for adults with a learning disability and their carer will be made available to all.. The proposal is not designed to disadvantage anyone based on age and promotes equal access to all services.

8.4. People with different sexual orientations

- Will the proposal unintentionally disadvantage people with different sexual orientations – or will it promote equality and ease of access? It is intended that the development of this new LD Plan for adults with a learning disability and their carer will be made available to all.. The proposal is not designed to disadvantage anyone based on age and promotes equal access to all services.

8.5. Women and men

- Will the proposal unintentionally disadvantage women or men – or will it promote equality and ease of access? It is intended that the development of this new LD Plan for adults with a learning disability and their carer will be made available to all. The proposal is not designed to disadvantage anyone based on age and promotes equal access to all services.

8.6. Non-binary, gender-fluid and transgender people

- Will the proposal unintentionally disadvantage non-binary, gender fluid or transgender people – or will it promote equality and ease of access? . It is intended that the development of this new LD Plan for adults with a learning disability and their carer will be made available to all. The proposal is not designed to disadvantage anyone based on age and promotes equal access to all services.

8.7. People with different religions and beliefs

- Will the proposal unintentionally disadvantage people with different religions and beliefs – or will it promote equality and ease of access? It is intended that the development of this new LD Plan for adults with a learning disability and their carer will be made available to all. The proposal is not designed to disadvantage anyone based on age and promotes equal access to all services.

8.8. People from the armed forces, their families, and veterans

- Will the proposal unintentionally disadvantage people from the armed forces, their families, and veterans, or will it promote equality and ease of access? It is intended that the development of this new LD Plan for adults with a learning disability and their carer will be made available to all. The proposal is not designed to disadvantage anyone based on age and promotes equal access to all services.

9. Additional information

Tip: You can use this section to provide any other relevant information. Click or tap here to enter text.

10. Mitigating actions / reasonable adjustments

Tip: If your assessment identified that the proposal could disadvantage people with a protected characteristic, you must consider whether it is possible to mitigate this via an action or reasonable adjustment.

If so, you must record this here.

We have included some actions as a suggestion – delete if not appropriate.

No.	Action	Lead	Date (dd/mm/yy)

11. Conclusion

This proposal is assessed to have the following impact:

☒ **Positive** impact on people with protected characteristics.

☐ **Detrimental** impact on people with protected characteristics that can be mitigated.

☐ **Detrimental** impact on people with protected characteristics that cannot be fully mitigated.

☐ **Positive and detrimental** impacts on people with protected characteristics.

☐ **No impacts** on people with protected characteristics.

12. Advice for the decision-maker responsible for this proposal

Tip: Before making a final decision on the proposal, the decision-maker must:

- Note their duty to give due regard to the Public Sector Equality Duty.
- Give a 'proper and conscientious focus' to this assessment, 'with rigour and an open mind', before deciding whether the proposal should go ahead.
- This means assessing the extent of any detrimental impact and the ways in which this could be eliminated or mitigated before approving the adoption of the proposal.

The proposal can still go ahead even if there are detrimental impacts. as long as the decision maker has:

- Given due regard to equality and the findings of this assessment.
- Taken reasonable steps to mitigate detrimental impact.
- Confirmed that the impact is lawful and a proportionate means of achieving a legitimate aim.

- **Please explain here** (if applicable) why it may be necessary to go ahead with the proposal, even if it could have a detrimental impact on some people: Click or tap here to enter text or mark as not applicable.

13. Evidence used to inform this assessment

Tip: You need to record the evidence you used to inform this assessment.

Select all that apply:

☒ Norfolk population data (provide links to any population data you draw upon, e.g. Norfolk's Story):

Information has been gathered from POPPI, PANSI and from the Market position statement for Norfolk Care.

☒ Data about existing or future service users - please state:

Predictions are taken from the Market position statement for Norfolk Care

☐ Data about the workforce - please state:

Click or tap here to enter text.

☒ Legislation - please state:

Care Act 2014

National Disability Strategy 2021

Building the Right Support updated August 2022

Transitional Integrated Care Strategy and Joint health and Wellbeing strategy

NHS Long Term Plan – Learning Disability & Autism 2019

☒ National/local research - please state:

Norfolk and Waveney Integrated Care strategy

https://www.scie.org.uk/dementia/living-with-dementia/learning-disabilities/

☒ Consultation (Tip: Please provide details of any consultation)

Remember - if a proposal constitutes a change to an existing service or benefit or a removal of an existing service or benefit those affected may have a 'legitimate expectation' to be consulted.

Information from Ethical Framework consultation led by Curators of Change will be used to inform the LD Plan. Information from the consultation 'Conversations Matter' to ask people what Adult Social care means to them will be used to inform what is written into the new LD Plan.

☐ Consultancy - please state:

Click or tap here to enter text.

☒ Advice from in-house/external experts - please state:

As part of developing the new LD Plan, providers supporting people with a learning disability will be involved as part of drawing on their expert support in helping to consult with people with a LD for their views. This will include consulting with the older young people's forum (aged 14 – 25 years with a LD) Disability Real Action Group of Norfolk, Opening Doors and the Making it Real Board throughout the process to develop a new LD Plan.

☐ Other - please state:

Click or tap here to enter text.

14. Administrative information

Tip: You can update this assessment at any time to inform service planning and commissioning.

Author (name and job title): Amanda Johnson, Adult Services Business Lead – Working Age Adults

Norfolk County Council

Decision-maker (e.g., Full Council, a committee, elected member, working group or officer with delegated responsibility): Craig Chalmers, Director Community Social Work, Adult Services & Lorna Bright, Assistant Director of Integrated Operations (Mental Health and Learning Disabilities)

EqIA start date: 03/04/2023

Contact further information: Amanda.johnson@norfolk.gov.uk

IN TRAN communication for all

If you need this document in large print, audio, Braille, alternative format or in a different language please contact Click or tap here to enter text.on Click or tap here to enter text.or Click or tap here to enter text. (Text relay)

15. Annex 1

Examples of common barriers that people with protected characteristics may face when accessing services or employment:

People of different ages

Older and younger people may experience discrimination or negative beliefs that restrict their professional or social opportunities.

Both older and younger people are likely to be on lower incomes.

Older age is associated with lower use of digital technology and an increased likelihood of disability or long-term limiting health conditions.

Disabled people

Disabled people face barriers to physical environments, information, and communication (as sometimes do people with other protected characteristics).

The nature of these barriers varies tremendously depending upon the nature of someone's disability. It is important to carefully consider the barriers faced by people with physical or mobility impairments; people who are blind or D/deaf; people with learning disabilities; people who are neurodiverse; people with mental health issues or people with a combination of impairments or long-term health conditions.

Disabled people are more likely to experience reduced lifelong outcomes compared to non-disabled people in relation to education, employment, health and housing and barriers to social, sport, leisure, and transport opportunities.

Disabled people may be under-represented in some services; public life; the workforce and participation. They may be more likely to be on a lower income, experience discrimination, hate incidents and social isolation.

People from different ethnic groups

People from some ethnic minority groups (which includes Gypsies, Roma, and Travellers) experience reduced lifelong outcomes compared to White British people and they may be less likely to do well in education, employment and health, and experience barriers in housing, sport, and leisure opportunities.

People from some ethnic minority groups may be under-represented in some services; public life; the workforce; participation; or over-represented (e.g., in criminal justice). They may be more likely to be on a lower income, experience hate incidents and cultural stereotyping.

People from some ethnic groups (for example Gypsies and Travellers) may have low literacy skills or may not access public sector websites.

People with different sexual orientations

Consider how you will provide welcoming spaces for people of all sexual orientations.

Some public services assume that heterosexuality is the 'norm'. For example, heterosexual couples are usually presented in marketing materials but rarely lesbian or gay couples.

People with different sexual orientations may experience barriers to some services and workforce opportunities, discrimination and hate incidents.

Women and men

Women and men experience different lifelong outcomes - e.g., they may have different experiences or be treated differently in education, employment, health, housing, social, sport and leisure opportunities.

Women may experience different life stages to men – e.g., pregnancy, maternity, menopause which can impact them in many ways. Women and men may have different experiences of caring or parenting.

Women and men may be under or over-represented in some services; public life; the workforce, consultation, and participation. They may experience sex discrimination or barriers to accessing support services.

Non-binary, gender-fluid and transgender people

Consider how you will provide welcoming spaces that recognise gender diversity (unless you are categorised as a separate or single-sex service).

Check whether your business systems can record a person's sex if the person does not identify as 'female' or 'male', and whether you can meet the needs of non-binary, gender-fluid and trans people.

People who are non-binary, gender fluid or trans may be under-represented in public life and participation. They may experience barriers to some services and workforce opportunities, discrimination and hate incidents.

Remember that some transgender people do not identify as 'trans' – they may identify as 'female', 'male' or non-binary.

People with different religions and beliefs

Consider how you will provide welcoming spaces for people with different religions and beliefs.

This includes being aware of prayer times, festivals, and cultural practices, where this is appropriate.

“Belief” can refer to an individual’s philosophical beliefs where these are genuinely held and fundamentally shape the way a person chooses to live their life - for example ethical veganism may be a protected belief.

Measures to promote inclusion for people with different beliefs should not impact on the rights of others – e.g., the rights of women or gay people.

People with different religions or beliefs may face barriers to some services; public life; participation and workforce opportunities. They may experience discrimination and hate incidents.

People from the armed forces, their families, and veterans

People from the armed forces, whether serving, their spouse, partner, family, or a veteran, experience a range of barriers to accessing public services – due to the unique obligations and sacrifices of their role.

This includes being regularly posted to different locations; separation; service law and rights; unfamiliarity with civilian life; hours of work and stress.

Endorsing the new Norfolk Adults Learning Disability Plan 2023 - 2028

06 March 2024

Lorna Bright, Assistant Director of Integrated Operations, Mental Health and Learning Disabilities, Adult Social Services

Norfolk County Council

NORFOLK LEARNING DISABILITY PARTNERSHIP

NHS Norfolk and Waveney Integrated Care Board

Process taken to develop the new LD Plan

- Previous Adults Learning Disability Strategy was from 2018 – 2022.
- A new Norfolk Adults Learning Disability Plan (formerly known as ‘Strategy’) has been developed by the Norfolk Adults LD Partnership, which includes NCC and Norfolk and Waveney ICB and all those providers they work with.
- There has been a range of engagement, consultation, co-production and co-design with people with a learning disability, their parents and carers and professionals and providers.
- Over 8 months from April 2023 – November 2023 more than 361 people shared their ideas and these have been used to develop the new LD plan.
- More than 201 people with a learning disability (56% of the total) contributed to this plan.

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NORFOLK LEARNING DISABILITY PARTNERSHIP

NHS Norfolk and Waveney Integrated Care Board

Checking the new plan

- Engagement with people across Norfolk and at the LD Partnership Locality meetings to check suggested wording of the Draft easy read LD Plan.
- Using all the feedback received, a final version of the easy read LD Plan was drawn up and shared. This was signed off by the Norfolk Adults Learning Disability Partnership Board on 29 November 2023.
- People co-designed the range of ways they would like to use in sharing ongoing feedback on whether they feel the plan is working or not.

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NORFOLK LEARNING DISABILITY PARTNERSHIP

NHS Norfolk and Waveney Integrated Care Board

Monitoring the success of the plan

- Every 6 months the Norfolk Adults LD Partnership Board will draw all the feedback into a report to share with the Norfolk & Waveney LD & Autism Programme Board.
- Alongside the easy read LD Plan, a more detailed LD Delivery Plan has been developed outlining the specific actions that will be taken by NCC, ICB and the organizations they work with.
- The LD Delivery plan includes details about how ‘success’ will be measured and the commitment to 6-monthly reporting.
- The Norfolk & Waveney LD & Autism Programme Board will be responsible for checking whether the LD Plan is working or will provide updates that will be shared with the Norfolk Adults LD Partnership Board and partners.

Norfolk County Council

NORFOLK LEARNING DISABILITY PARTNERSHIP

NHS Norfolk and Waveney Integrated Care Board

Full sign off process (1)

- Norfolk & Waveney LD & Autism Programme Board - 23 Nov 2023
- NCC LD, Mental Health and Autism Steering Group - 28 Nov 2023
- Norfolk Adults Learning Disability Partnership Board - 29 Nov 2023
- ICB Quality & Safety Committee - 7 Dec 2023
- NCC Directorate Leadership Team - 7 Dec 2023
- Presentation to NCC ELT & Informal Cabinet - 4 January 2024

Norfolk County Council

NORFOLK LEARNING DISABILITY PARTNERSHIP

NHS Norfolk and Waveney Integrated Care Board

Full sign off process (2)

- ICB Public Board - 23 January 2024
- Health & Wellbeing Board & Integrated Care Partnership - 6 March 2024
- NCC Cabinet - March 2024

Norfolk County Council

NORFOLK LEARNING DISABILITY PARTNERSHIP

NHS Norfolk and Waveney Integrated Care Board

Report title: Norfolk and Waveney Health Inequalities Strategic Framework for Action

Date of meeting: 06 March 2024

Sponsor (ICP member): Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney Integrated Care Board

Reason for the Report

Addressing health inequalities is a priority for our system. This paper asks the ICP to endorse the Health Inequalities Strategic Framework for Action and to commit to supporting its implementation.

Report summary

The Norfolk and Waveney ICS Health Inequalities Strategic Framework for Action has been developed with extensive input from stakeholders and those with lived experience of health inequalities. The Framework sets out the actions we want to take as a system to tackle health inequalities, as shaped by our 'Health Inequalities Conversation'. It lays out what we need to do to strengthen our foundation to create the conditions for success, as well as how we might create better building blocks for health related to three key areas; Living and Working Conditions, Lifestyle Factors and Healthcare Inequalities.

Recommendations

The ICP is asked to:

a) Endorse the Norfolk and Waveney ICS Health Inequalities Strategic Framework for Action.
b) Commit to supporting the implementation of the Framework, providing leadership and advocacy as required.
c) Receive regular updates of progress and delivery and provide oversight as required.

1. Background

1.1 The Health Inequalities Strategic Framework for Action has been developed through extensive engagement, through a 'Health Inequalities Conversation' with stakeholders and people and communities from across the Norfolk and Waveney system, which started in July 2023.

1.2 The initial engagement gave a strong steer that a Strategic Framework for Action should be produced; that a broad scope and ICS wide ambition was required. A set of design principles were developed, which were endorsed by the ICP in November and these principles have guided the further development of this Strategic Framework for Action.

1.3 Our Health Inequalities Conversation has reached all parts of the system and has included conversations with the eight Health and Wellbeing Partnerships, the five Place Boards, numerous VCSE led forums, as well as focused engagement with our ICS organisations. The Community Voices programme, which works with trusted communicators in our VCSE sector, has asked some of our most vulnerable and underserved communities what matters to them, and we have engaged with people with lived experience. For more information about Community Voices visit the improving lives together website.

1.4 The Framework sets out a clear definition of health inequalities; what they are and who they most effect. We have developed a clear understanding of our 'Core20plus' communities in line with the NHS England Core20plus5 health inequalities improvement frameworks and have created a data summary that highlights the specific issues that our Norfolk & Waveney residents face. Go to NHS England to learn more about The Core20plus5 frameworks.

1.5 As a system we have shaped a high-level vision, a set of guiding principles and our 'building blocks' for action – creating clarity of purpose and a sense of shared ambition.

1.6 **Our Vision:** We will come together to tackle unfair and avoidable differences in health outcomes. We will do this by listening to communities, prioritising prevention, and taking action together, making health inequalities everybody's business.

1.7 **Our Guiding Principles**

Everyone needs something, some people need more.

Enabling communities to have a voice is key and requires creativity and persistence.

We will work as close to people and communities as possible.

Our approach must be personalised to ensure the right action at the right time for each individual.

We will ensure accessible services for those in greatest need.

We know we can make a difference and this is a long term commitment.

We will take a lifecourse approach, considering the role of families in our action.

Leading for change requires shared responsibility, collaboration and enduring focus.

We will understand who is accessing our services and support, who isn't and why, in order to act.

Recognising the building blocks for good health and wellbeing are not just in health services.

Building fairer services means supporting change in our organisations.

2. Our Priority Areas for Action

2.1 The organisations involved in the development of this document have agreed the following four building blocks for action (shown below in diagram 1). Firstly, we have to build the foundations and create the **conditions for success**. This will prepare us to act on the agreed building blocks for good health: **living and working conditions**, **lifestyle factors** and **health & care services**. As this is a long-term commitment, our actions may change and respond to need.

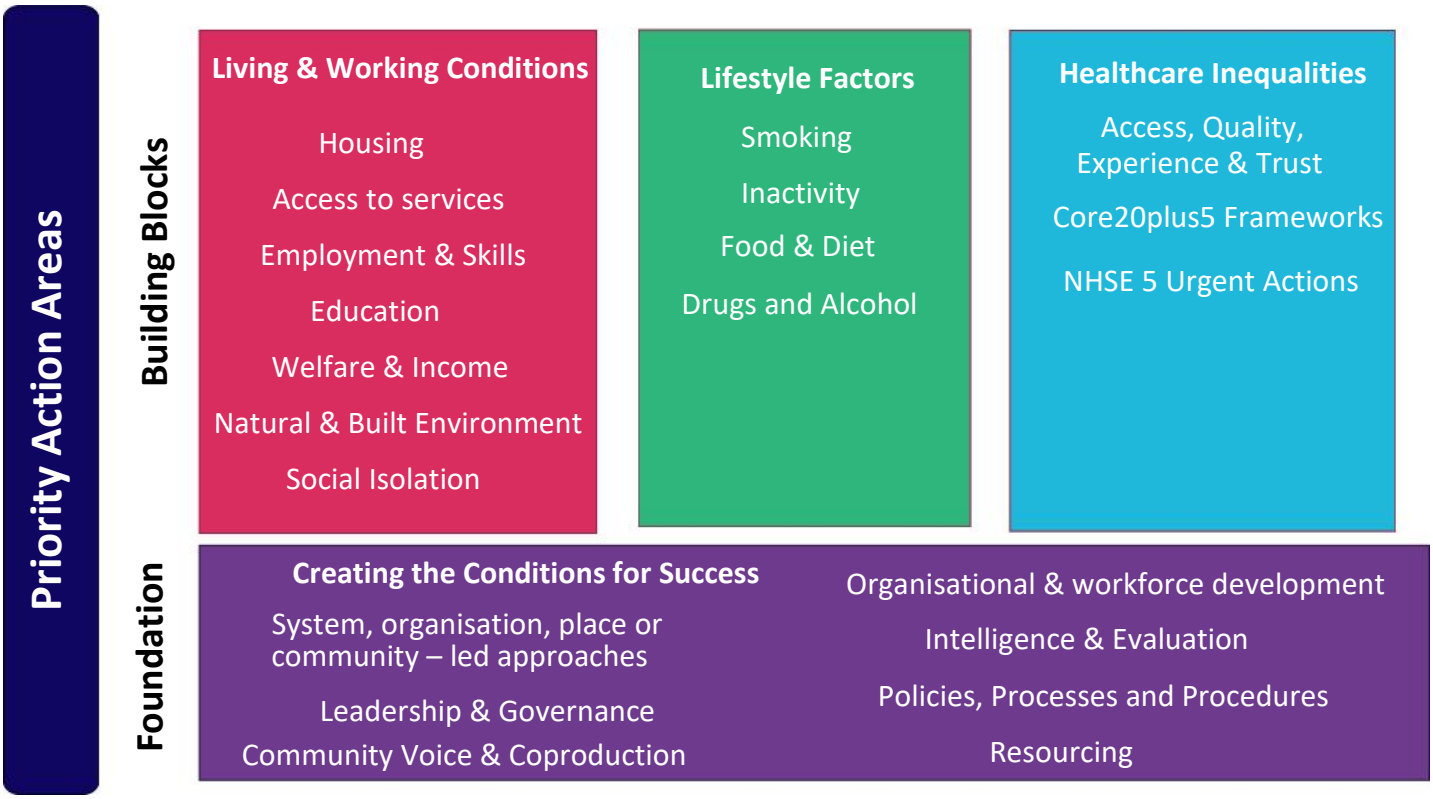

Diagram 1 – Priority action areas

2.2 **Call to Action:** The Framework will act as a catalyst for change; it includes a clear call to action to come together and take collaborative, as well as organisational level action. It also includes actions that can support and empower communities to take action themselves.

2.3 There is a clear 'ask' in the Framework for each organisation in our Integrated Care System to take action to strengthen our foundation, so that we may together create the conditions for success. These actions include considerations around community voice and coproduction, taking intelligence & data led action, and ensuring we have the policies, processes and procedures in place to tackle health inequalities in everything that we do.

2.4 The system was very clear in its feedback – we need coordinated action, clear lines of accountability, and strong leadership. Our actions around leadership and governance are key.

2.5 The Framework also includes 10 initial actions for our first 12 months. These will need to be further developed over time, with a clear requirement to review this action plan annually. We need to create clear coordinated plans for each of our building blocks which build on our existing assets and 'join up' existing work.

2.6 We are commitment to distributing leadership across our ICS organisations through the identification of Senior Responsible Officers for each of our building blocks and creating a 'team' across Norfolk and Waveney that can strengthen future iterations.

2.7 In summary the Framework requires a whole-system commitment, we must continue our Health Inequalities Conversation, and drive further action.

Officer Contact

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

Name: Shelley Ames Tel: 01603 595857 Email: shelley.ames@nhs.net

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Improving lives **together**
Norfolk and Waveney Integrated Care System

Norfolk and Waveney Integrated Care System

Health Inequalities Strategic Framework for Action

2024 - 2034

Forewords

TBC

Introduction

Right now, some people are dying a decade younger than they should. Lives are being cut short because of where someone lives and works, how they are treated and because they might not be able to access services.

This framework for action is designed to change that, to help individuals, families, communities and organisations tackle these issues across the life-course. Nationally, and locally, we know where and what the causes are, but no one organisation can address it alone. That is why this framework will try and map actions and develop tools and commitments so we can act **together** now.

Many people who are passionate about making a difference have contributed to the ideas and information presented within this framework. Our Health Inequalities Conversations have taken place across Norfolk & Waveney and have helped to shape this framework.

There are many people and organisations in Norfolk & Waveney who are working to address health inequalities every day. Action around health inequalities is not new, but the whole Integrated Care System coming together under a common purpose and framework is.

The spotlight on those individuals and communities who have been most affected during the pandemic has meant that we all want to do things differently. Now is the time to act, the creation of our Integrated Care System, and the national drive for change has contributed to the urgency and determination to come together with a common vision, language and goals.

We are focused on our **'building blocks'** for good health, alongside how we strengthen our foundation to **create the conditions for success.**

This is a ten-year framework, which contains within it it a requirement to create annual action plans that are to be reviewed every year. Our initial actions detailed in this framework are the **first steps** towards a whole-system approach, and will be valid for our first 12 months of implementation.

Norfolk and Waveney Vision

We will come together to tackle unfair and avoidable differences in health outcomes. We will do this by listening to communities, prioritising prevention, and taking action together, making health inequalities everybody's business.

What are health inequalities?

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing. The effects of inequality are multiplied for those who have more than one type of disadvantage. (Kings Fund)

Inequalities of what?

This can involve differences in outcomes and in known contributing factors to health:

- **Health status** e.g. life expectancy and prevalence of health conditions
- **Access to care** and non-clinical services e.g. availability or waiting times for treatments, take-up of services, access to information
- **Quality and experience of care**, e.g. levels of patient satisfaction, feeling involved
- **Behavioural risks** to health, e.g. smoking rates
- **Mental wellbeing** and exposure to stressors and adversities (or protective factors)
- **Social economic and environmental conditions** that are 'wider determinants' of health e.g. housing quality, community life, discrimination

Inequalities between who?

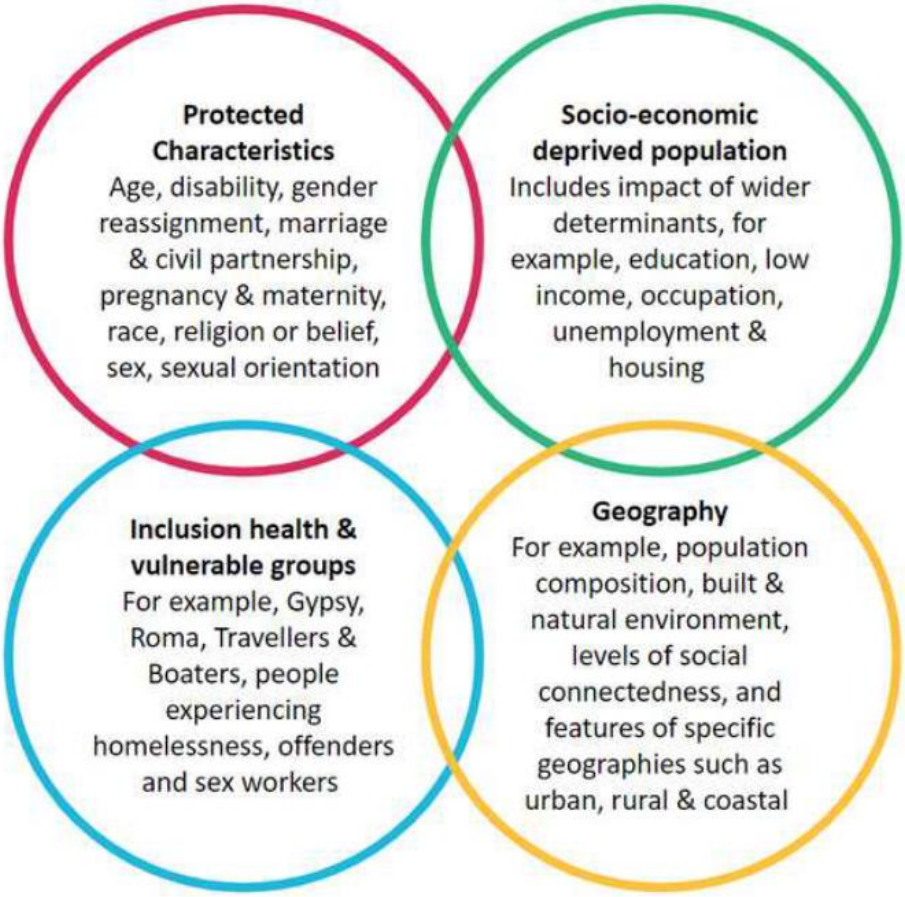


Figure 1:

Keeping healthier for longer

There are lots of studies that show us that where we live and work influence our behaviour, as does how we spend our time and who we spend it with. The chart below is a good starting point for understanding all the factors that go into make up our health and decisions we make about our health, as well as those things we can't influence on our own.

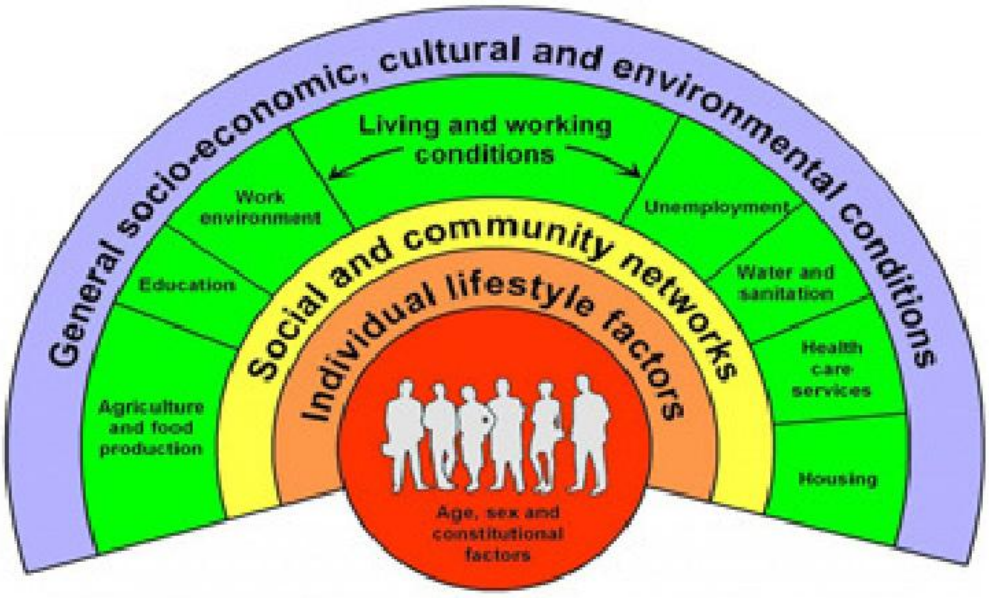


Figure 2: Dahlgren and Whitehead (1991)

Key areas that impact the health and wellbeing of our most vulnerable residents include good work, healthy communities and places, having the best start in life, discrimination and its outcomes, and environmental sustainability (Marmot, 2024).

In the Norfolk and Waveney area, there has been an emphasis on place-based approaches, and the need to address the socio-economic factors and geography outlined in the chart above (Figure 1). These are described locally as **Living and Working Conditions.**

All of us can make a difference to our own health and wellbeing by making good, healthy choices, but sometimes this is not easy to do, especially when faced with a disadvantage because of where you live or if you face discrimination. We have described this as **Lifestyle Factors.**

And of course, when we need help, being able to access services early, and quickly, the same as anyone else with similar issues, but recognising the way in which the services is delivered might need to be different. For example, a person with autism accessing mental health services, someone with a mental health condition accessing stop smoking services, or someone attending a hospital appointment when English is not their first language. We describe this as **Healthcare Inequalities.**

Why are we doing this?

Health equity means everyone should be able to reach their full potential for health and well-being, with fair and just opportunity to do so. Right now, we know this is not happening as some people are dying earlier than we would expect.

The map below shows that people are dying much earlier in some parts of Norfolk & Waveney than others, for reasons that can be prevented. The difference in average life expectancy between residents in one place compared to another is the kind of gap we want to close.

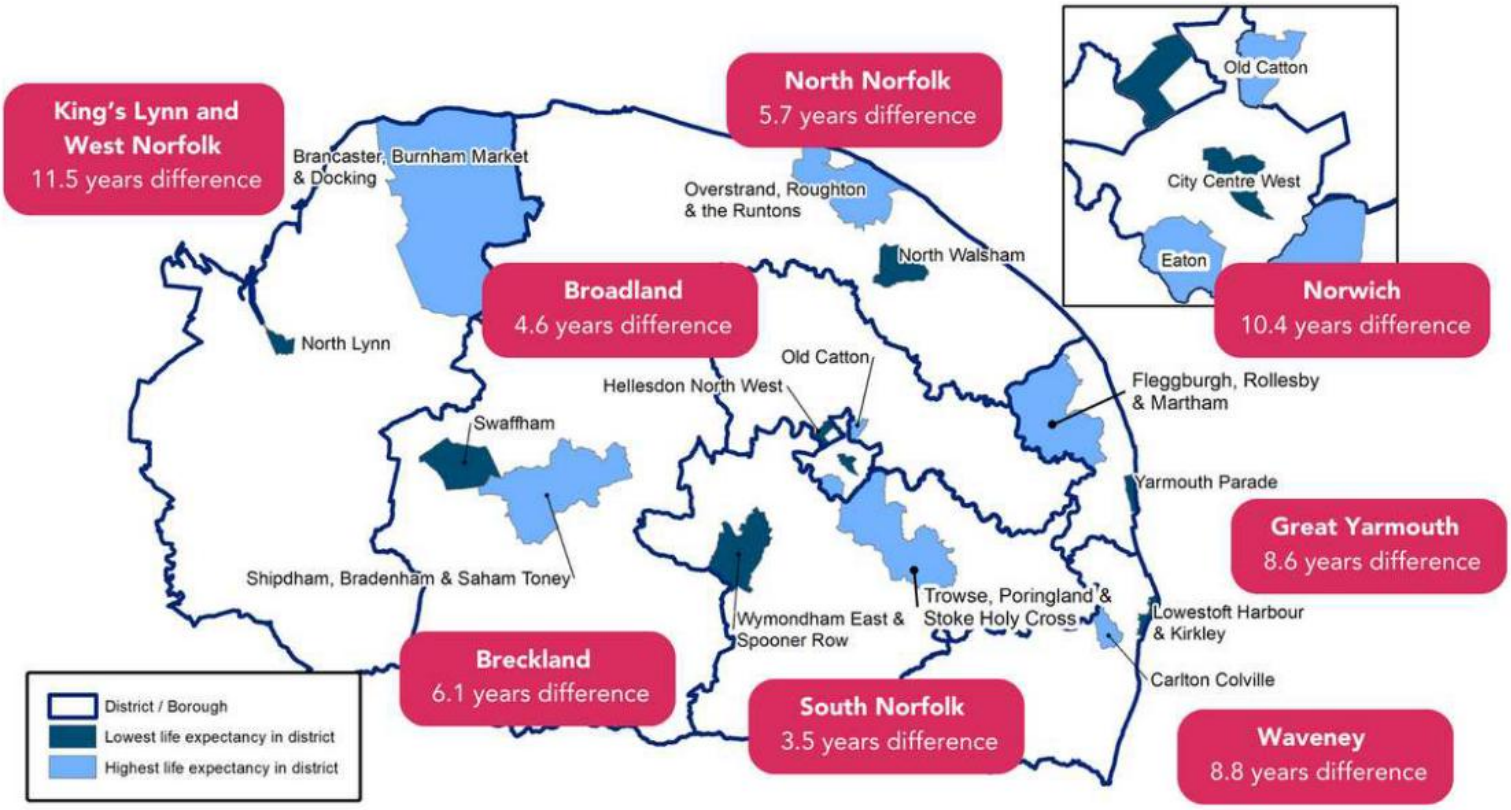


Figure 3:

Across Norfolk & Waveney differences in life expectancy can be seen in each district footprint. There is a 11.9 year age gap between the lowest life expectancy in Norfolk and Waveney (72.2 years as seen in North Lynn & Yarmouth Parade) and the highest (84.1 years seen in Eaton).

This gap in life expectancy is even bigger for some groups, such as those who are homeless, or with a learning disability.

Figure 4:

Norfolk insight is our local data hub where anyone can look online at local data about the population of Norfolk and Waveney. We know who lives in poor health, who dies earlier from preventable illnesses, who has worse health outcomes, where they live and much of the time, why they have worse outcomes.

We know that people are dying earlier from preventable illnesses in some communities, with around half (men) to a third (women) of these due to circulatory diseases and cancer in Norfolk.

You can find more data relating to health inequalities by clicking here.

We have also been speaking to our communities that experience inequalities to better understand the barriers and build a rich picture to help close the health gap between groups.

Who will we reach?

Although we have a lot of data telling us about the different experiences in our communities, we also want to make sure that we are listening, and that people are able to speak for themselves. We have asked people directly, what the issues are that affect them the most.

We have targeted these conversations towards the groups that experience the greatest differences in health outcomes, working with our trusted communicators in voluntary & charitable sector groups through our Community Voices programme.

Community Voices
Using your feedback to improve care

We asked our communities what matters to them in relation to their health and wellbeing. In summary these conversations highlight the importance of consideration of the environment in which our residents live and work, alongside those factors that influence their health behaviours and their ability to access services.
The below highligts some of what we have heard and more information can be found in our summary reports here.

"Living in poor housing adds to (my) health issues and stress"

"Gp has told them they must quit (smoking) due to heart condition. Has tried vapes and tablets (champix) . Finds current living condition very stressful and feels that quitting now would be a huge stress 'on top of everything'..... Has anti social neighbours and black mould caused by an issue with leak in flat above. Doesn't feel in 'right place mentally' to quit"

"Some residents have concerns they are treated differently due to being a migrant or having a language barrier. Many report a lack of trust in the NHS, ofen stemming from miscommunications or feeling unheard"

[recently left prison] he has not been able to sort his benefits for the last 5 months and is living on a very limited budget for food which is also playing a big part in his illness [diabetes] and feels he cannot afford to spend what little money he has on a nutritious diet that he needs to try and keep healthy"

Our Community Voices conversations highlight why action should not be limited to health services alone. The the causes of disease begin long before someone sees a health professional as outlined below. This image clearly shows the '**building blocks'** for good health.

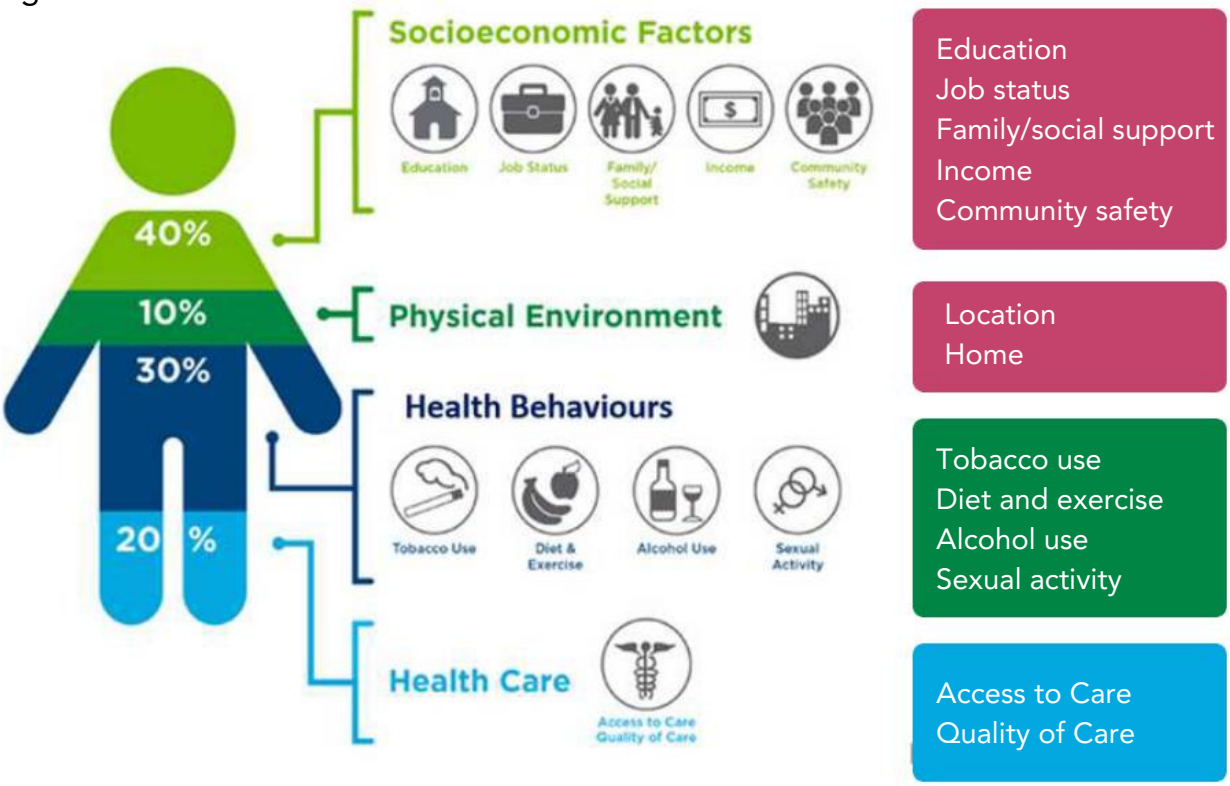


Figure 5: Determinants of health

The NHS has identified the communities and groups we should focus on as the 'Core20plus' communities. These are the people living in the most deprived areas and vulnerable people in the local area, who are referred to as the 'plus groups'. Our most deprived 'Core20' communities are highlighted in the map below.

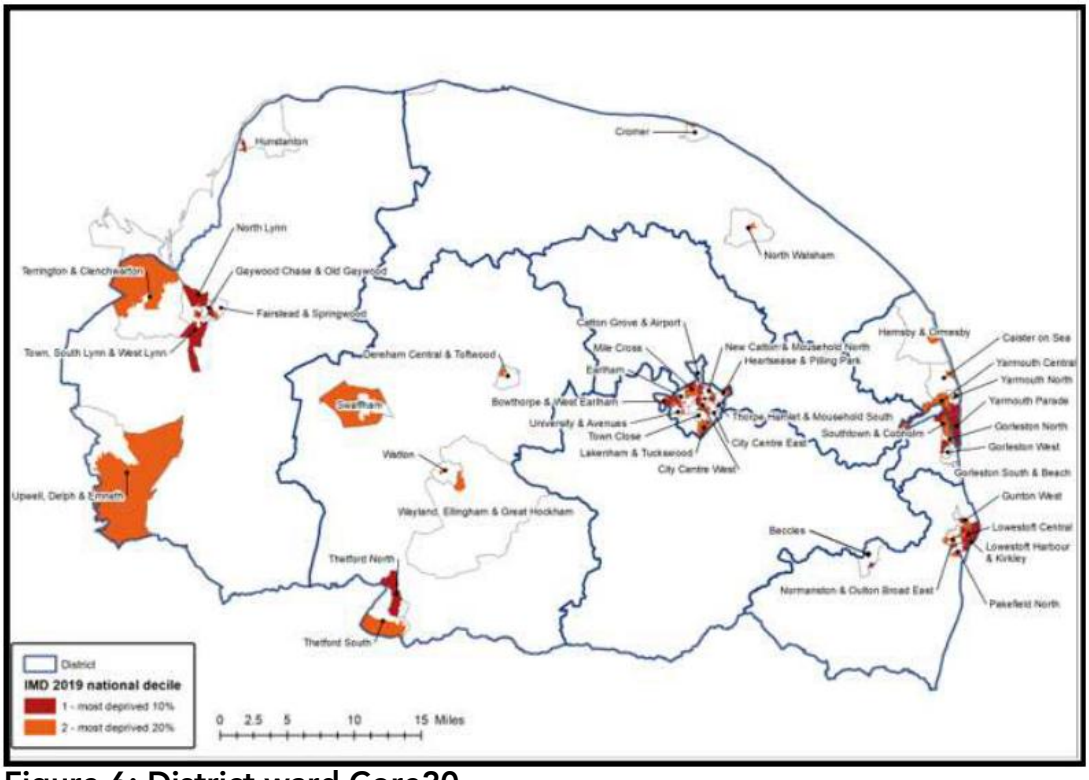


Figure 6: District ward Core20

The Norfolk & Waveney 'plus' groups have been locally defined and agreed. These are:

- Ethnic minority communities
- Inclusion health groups
  - People experiencing homelessness
  - Drug & alchohol dependence
  - Vulnerable migrants
  - Gypsy, Roma and Traveller communities
  - Sex workers
  - People in contact with the justice system
  - Victims of modern slavery
- People with a learning disability and autistic people
- People living in coastal and rural communities
- Young carers and looked after children
- Armed forces community

We have produced some fact sheets which give more information about each of our plus groups, which you can find here.

Health services have a clear call to action outlined via the Core20plus5 health equality improvement frameworks, which map where the inequalities are nationally, and what the NHS should focus on locally. The frameworks also include 5 clinical priority areas, and there is a framework for adults and a framework for children and young people. You can find out more information here.

What difference will we make?

Residents who face the worst health outcomes will:

- Be able to access the right services more easily and get the right support to improve their health and wellbeing.
- Have more say about services, especially feedback on whether they are working well.
- Live longer, healthier, happier lives.

Organisations involved in improving the health of residents will:

- All organisations in Norfolk and Waveney commit to working together more effectively to tackle the causes of health inequalities.
- Have a common language and purpose and commit to improving outcomes for residents experiencing inequalities.
- Recognise and respond to risk for specific groups, with good quality information and understanding of need and be supported to enable this.
- Detect and manage need early, targeting resources based on preventing further ill health.
- Increase their effectiveness through a healthy and diverse workforce.
- Improve understanding of the cost of existing health inequalities for all organisations.

Existing commitments

Our organisations and leadership are not new to trying to prevent unfair and avoidable differences in experiences and early deaths from preventable illness. Listed below are the ICS strategies and approaches that include commitments relating to health inequalities. This framework will help to deliver them and a summary of their existing objectives can be found here.

Our Guiding Principles

Health Inequalities Conversation

Through our Health Inequalities Conversation we have developed the following 10 guiding principles that we ask our partner organisations to adopt. These are guidelines for decision making.

Everyone needs something, some people need more.

Enabling communities to have a voice is key and requires creativity and persistence.

We will work as close to people and communities as possible.

Our approach must be personalised to ensure the right action at the right time for the right individual.

We will ensure accessible services for those in greatest need.

We know we can make a difference, and this is a long-term commitment.

We will take an approach that includes consideration for families and all stages of life

Leading for change requires shared responsibility and enduring focus.

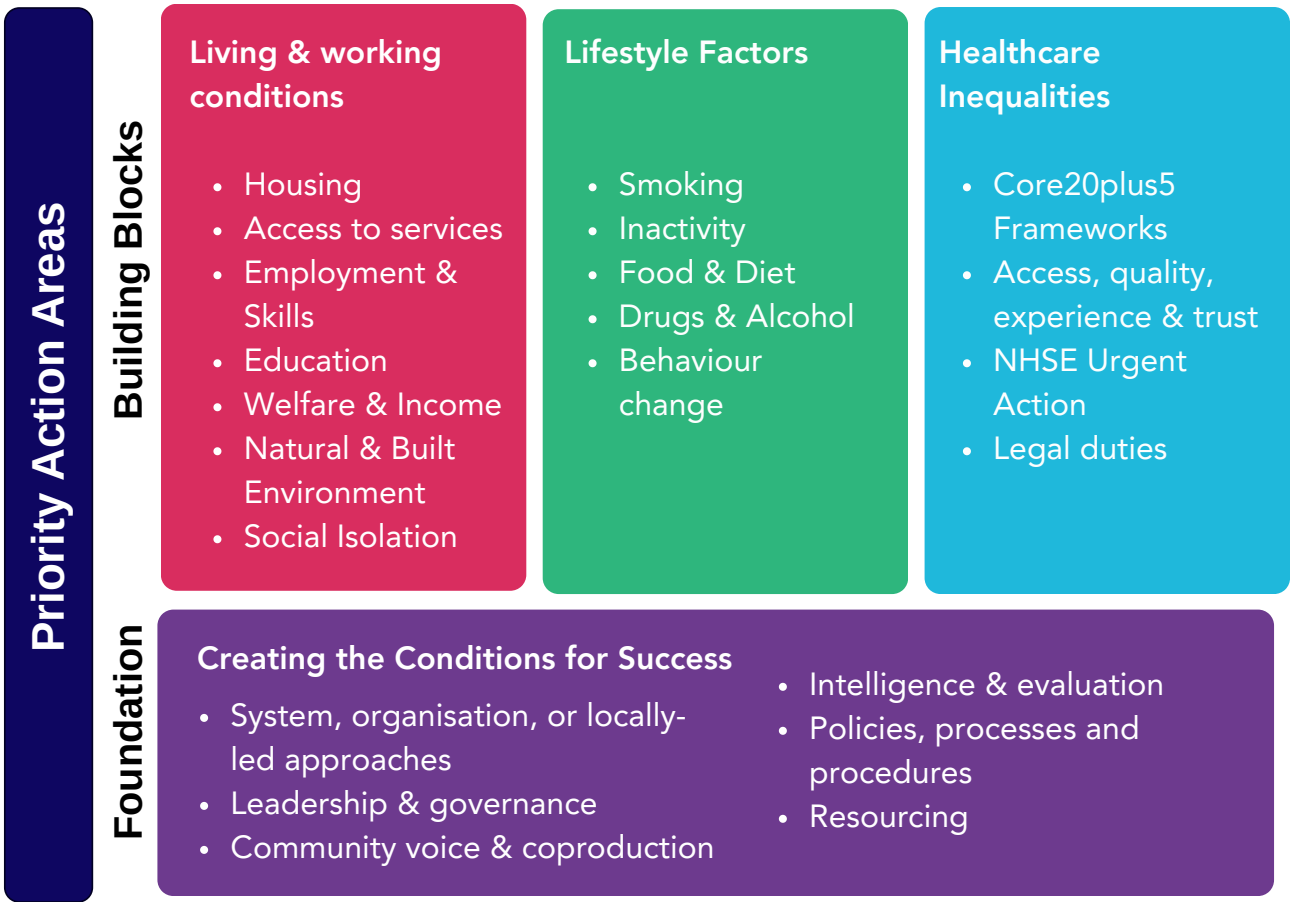
We will understand who is accessing our services, who isn't and why in order to act.

Recognising the building blocks for good health & wellbeing are not just in health services.

Building fairer services means supporting change in our organisations.

Our priority areas for action

Through our Health Inequalities Conversation we have determined our priority areas for action, as described below. We refer to these as our **'building blocks'** and our **'foundation'.**



Living and working conditions

The health outcomes of a population depend on the level and quality of education, living in an adequate house, being able to work, and access to quality health and social care services. These are part of the wider social and economic circumstances that can determine an individual's health throughout their life. The same factors have significant effects on health inequalities (Marmot, 2010). These factors are often linked. For example, a person who is unemployed is more likely to live in poorer housing conditions and may not have access to affordable fresh and healthy food or get out and about in green spaces.

Tackling health inequalities requires a local shift in expenditure patterns to address some of the underlying causes of inequality. Resources should go where there is need, to ensure equal health outcomes (The King's Fund, 2022).

Lifestyle factors

The choices we make in living our lives impact our health and wellbeing. The impact of smoking, choosing unhealthy foods to eat, not getting enough exercise, and drinking alcohol are known as behavioural risk factors. These are a major challenge for health and social care for all residents, not only those communities that experience inequalities in outcomes.

These factors increase our chances of developing chronic conditions like heart disease, cancer or diabetes and can lead to early death. Health inequalities increase the risk of becoming ill and living in poor health among some groups in society and can be seen and measured as a result.

Health and care services

Health and care services are there to maintain and improve our health. The original focus of the NHS was the diagnosis and treatment of disease. Now it plays more of a part in both preventing ill health and improving the physical and mental health of the population.

Health and care services are structured to meet everyone's need which at times makes it difficult for some people to get the service they need. This can be due to examples like services not being available, adjustments not being made for disability, people having challenges being understood because of language barriers, or discrimination.

The NHS has legal duties relating to health inequalities, and there are 5 Urgent Actions that are identified in NHS operational planning guidance, which will require a partnership approach to implement. More information about these duties to address health inequalities can be found here.

HOLD FOR CASE STUDIES

Creating the Conditions for Success

This framework for action is ambitious. We have to work together building on our successes so far, sharing our knowledge, tools and resources to drive change. If we are going to make a difference to health outcomes, so people have a fairer chance to live longer and healthier lives, we have to change the way we work within our organisations and together.

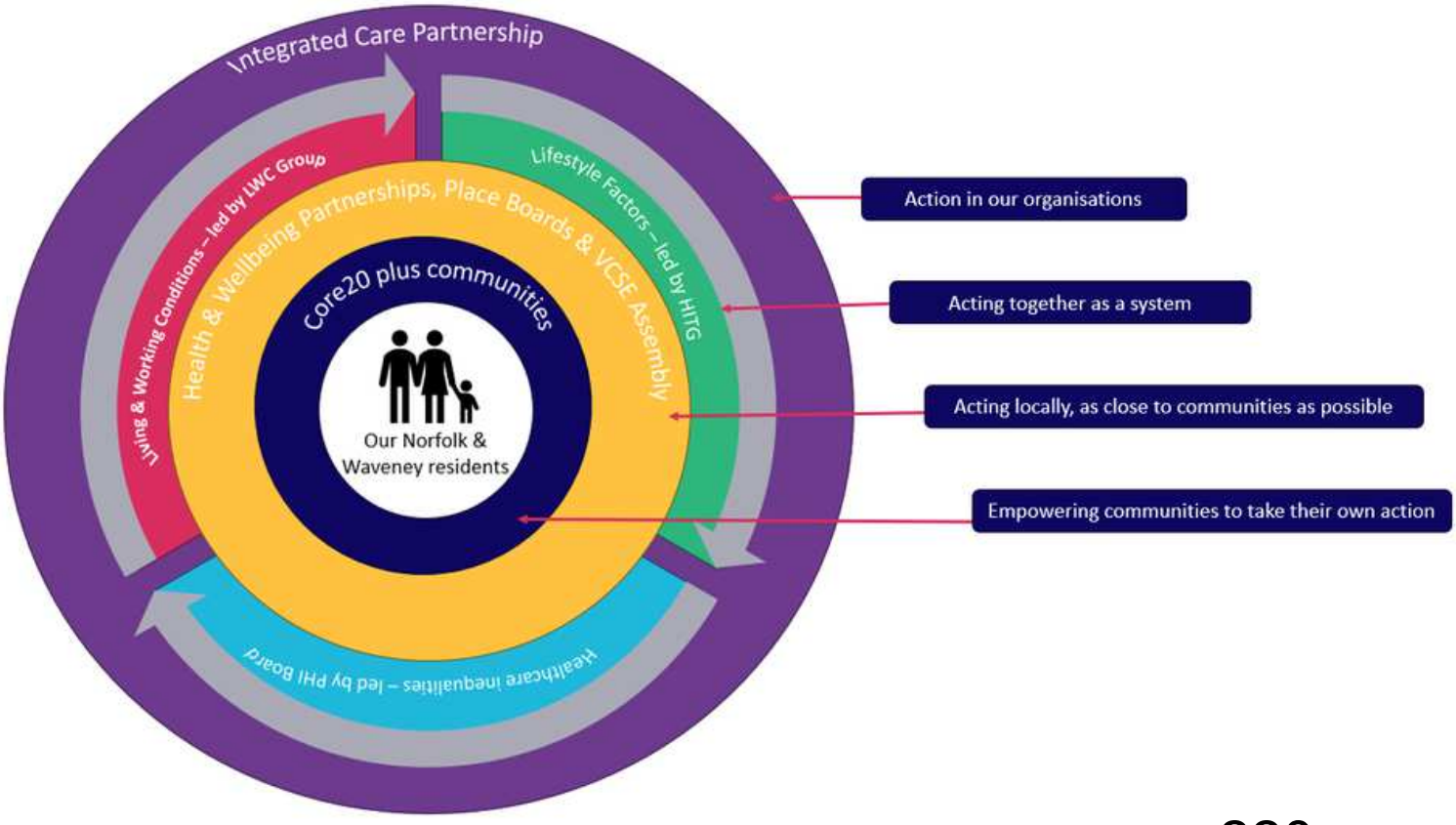
Navigating our different duties, relationships, structures and priorities is going to be difficult. However, this is the chance to work more closely with communities, understanding better how we can do differently, and leading more effectively.

Leadership & Governance

We recommend a leadership and governance structure for health inequalities that maximises our existing resources and expertise and responds to the benefits of working locally.

This proposed structure enables us to share, learn and scale what works and understand what doesn't. This is about what we can do together and all parts of our Integrated Care System have a role to play - this includes our district and county councils, Voluntary Community & Social Enterprise (VCSE sector) and our health services.

Our Norfolk & Waveney Integrated Care Partnership brings together health and social care providers, local government, the VCSE sector and other partners. It will provide ensure the Health Inequalities Framework is delivered.



Action in within our organisations

Our organisations already make a huge difference to the wellbeing of people living in Norfolk and Waveney right now. Closing the gap so that everyone has a fair chance; stopping the early deaths of vulnerable people, will mean doing some things differently. Organisations involved have a number of ways to make this happen, for example:

- By embedding these guiding principles in their organisational action plans and ways of working
- As 'anchor institutions' working locally to lead by example as an employer and estate owner, as well as through buying power.
- Through good quality equality impact assessments, complaints procedures or by embedding a requirement for social value in contracts.
- Through sharing good practice and intelligence to inform action
- Through a commitment to actively listening to people, especially the most vulnerable
- Through robust data collection and sharing

This isn't everything we can do, and we have outlined below what some of this might look like. UCL Partners, working alongside NHS organisations, have produced a useful toolkit that you can find here, which helps anchor organisations understand 'how strong is your anchor' currently.

Acting as close to communities as possible

Organisations often come together around a 'place'. This might be a few streets, a neighbourhood, a council footprint or a health system boundary. There are ways in which people in communities and organisations can plan their place together, that helps identify where the greatest need is, and what the best approach is for that place.

Place-based partnerships are an important vehicle for tackling health inequalities. They bring together organisations at a local level, including district councils, VCSE organisations and health and care services, to enable greater understanding, connectivity and collaboration.

Place-based partnerships will be supported to close the gaps between groups, through the update and production of tools and guides. Place-based structures will play a key role in developing the action plans for each of the building blocks, with the **Health & Wellbeing Partnerships** coordinating action relating to Living & Working Conditions and Lifestyle Factors, and Place Boards coordinating action relating to Healthcare Inequalities and Creating the Conditions for Success.

Empowering communities

The Voluntary, Community & Social Enterprise (VCSE) sector also plays a crucial role in addressing health inequalities. Collaborating with the VCSE sector allows for new solutions to local health issues, they are rooted in communities and have established relationships with residents meaning they can act as 'trusted communicators' and have a sound understanding of community need. They can offer creative and cost-effective approaches and connect with people that experience the greatest health disadvantage.

In summary, collaboration with the VCSE sector is a powerful tool for transforming health inequalities. promoting community wellbeing and ensuring equitable access to healthcare.

As such it is vital that the VCSE sector are integrated into all parts of our governance as an **equal partner** and that they are empowered where possible to provide a leadership role.

In support of our work to address health inequalities we will commit to the development of a VCSE partnering work programme, as well as the continued development of a VCSE Assembly that complements our local VCSE infrastructure arrangements and existing thematic forums.

Acting together as a 'system'

The word system has different meaning for different people. Simply put it means organisations coming together to tackle a common goal, considering the desired outcome rather than individual organisational interests.

We need to better coordinate our action to tackle health inequalities as a 'whole system' , so that we can join up and coordinate our existing work, share best practice, scale what works and understand better what doesn't.

Our proposed structure recommends 3 groups all of which are to be representative of our Integrated Care System, that will drive further action relating to our building blocks:

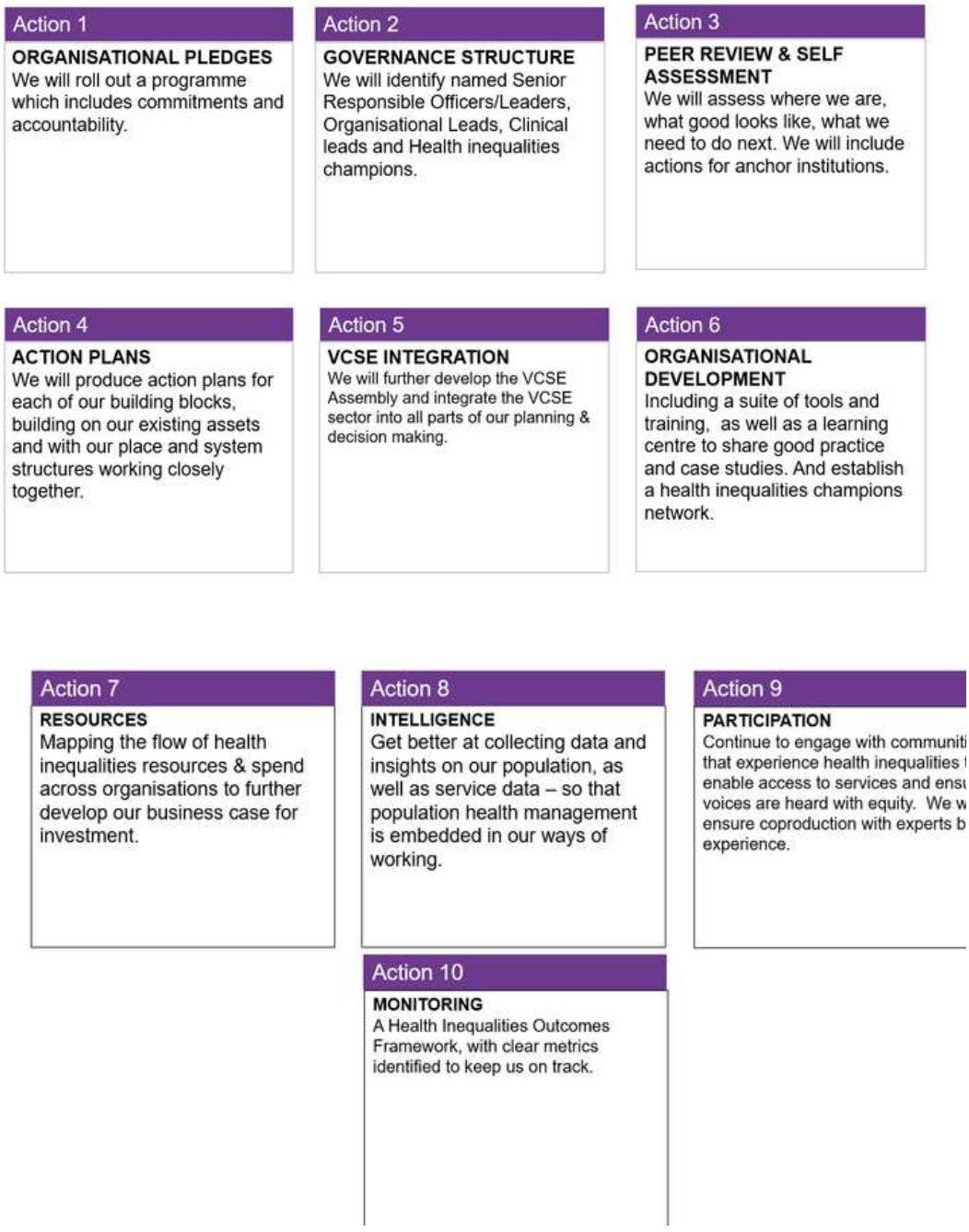
- Living & Working Conditions Group to drive action relating to Living and Working conditions - Chaired by TBC
- Health Improvement Transformation Group to drive action relating to Lifestyle Factors - Chaired by the SRO for Prevention
- Population Health & Inequalities Board to drive action relating to Healthcare Inequalities and the tools required to create the conditions for success - Chaired by the SRO for Healthcare Inequalities

Summary of key actions

We have set out here what actions we think need to take place first so that people across all organisations are confident they can tackle local health inequalities. These are based on our Health Inequalities Conversations - what we need to do to make this commitment happen.

We plan to take these **10** actions in the first **12** months of implementation, by April 1st 2025.

The ICS Health Inequalities Oversight Group will be responsible for making sure they happen, with responsible organisations for each action to be agreed. More detailed action planning is available separately.



Action over time

Short term actions (year 1)

- Focus on our foundation – improving our ways of working to create the conditions for success
- Strengthen our leadership, governance and partnership working
- Understand our baseline - map and coordinate existing activity and identify gaps
- Clarifying the actions required around our building blocks to further our impact

Medium term actions (2-5 years)

- Implementing our action plans, and understanding our impact
- Organisations taking action utilising the tools provided
- Aligning the action between our building blocks - creating a Health Equity focus
- Measurable differences in our ways of working – improvements on our baseline

Long term actions (5 – 10 years)

- Tackling health inequalities part of our 'business as usual' via a confident and competent workforce
- Demonstrable impact on the metrics within our outcomes framework

Improving lives **together**
Norfolk and Waveney Integrated Care System

Appendix

Hold for Outcome metrics for each building block

Suggested actions for our building blocks

It is now up to the system to come together to build on existing activity and take coordinated action around our building blocks. During our engagement we identified a number of potential actions, some of which are provided below as examples.
For a more detailed report about what we heard during our Health Inequalities Conversation please go to xxxxx.

Living & Working Conditions

Lifestyle Factors

Healthcare Inequalities


Action plan template

Health Inequalities Conversation

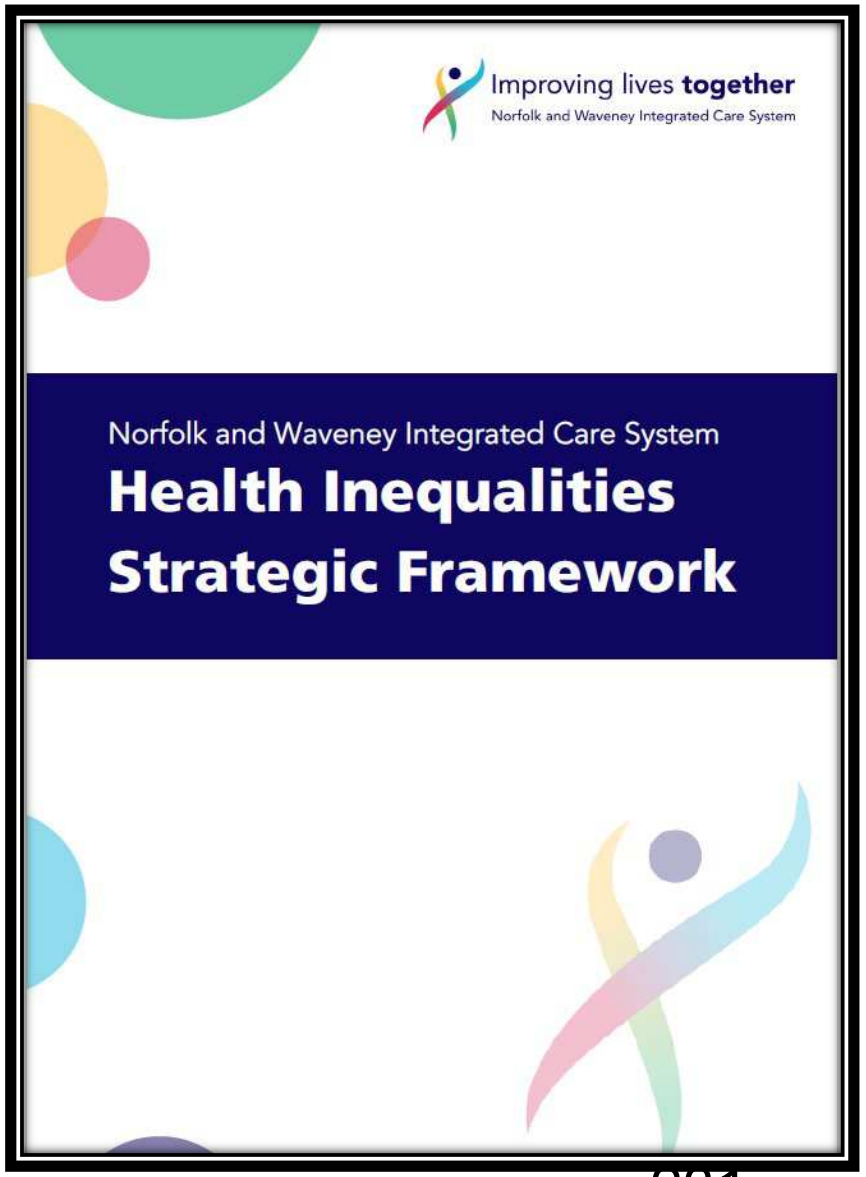
Improving lives together
Norfolk and Waveney Integrated Care System

Tackling Health Inequalities: A Strategic Framework for Action

Mark Burgis, Executive Director of Patients and Communities, NHS Norfolk and Waveney Integrated Care Board
Tracy Williams, Clinical Lead for Health Inequalities & Inclusion Health, NHS Norfolk and Waveney Integrated Care Board

Introduction

- This Framework responds to the Joint Forward Plan objective to develop a Health Inequalities Strategy by April 1st 2024.
- Designed through a significant engagement process across our local system, and by reviewing best practice from other systems.
- Over 100 organisations engaged, including all Place Boards, Health & Wellbeing Partnerships, VCSE forums and governance structures.
- Driven by a multi-agency taskforce, with significant input from Public Health colleagues.
- It is designed to be our **first step** in a whole system approach, to lay a strong foundation for the future.
- Going to ICP on 6th March 2024 for endorsement.



Vision

We will come together to address unfair and avoidable differences in health outcomes. We will do this by listening to communities, prioritising prevention, and taking action together, making health inequalities everybody's business.

Our Guiding Principles

- Everyone needs something, some people need more.
- Enabling communities to have a voice is key and requires creativity and persistence.
- We will work as close to people and communities as possible.
- Our approach must be personalised to ensure the right action at the right time for each individual.
- We will ensure accessible services for those in greatest need.
- We know we can make a difference, and this is a long-term commitment.
- We will take an approach that includes consideration for families and all stages of life.
- Leading for change requires shared responsibility, collaboration and enduring focus.
- We will understand who is accessing our services & support, who isn't and why in order to act.
- Recognising the building blocks for good health & wellbeing are not just in health services.
- Building fairer services means supporting change in our organisations.

Priority Action Areas

Building Blocks

Living & working conditions

Housing

Access to services

Employment & Skills

Education

Welfare & Income

Natural & Built Environment

Social Isolation

Lifestyle Factors

Smoking

Inactivity

Food & Diet

Drugs and Alcohol

Healthcare Inequalities

Access, Quality, Experience & Trust

Core20plus5 Frameworks

NHSE 5 Urgent Actions

Legal duties

Foundation

Creating the Conditions for Success

System, organisation, place or community-led approaches

Leadership & Governance

Community Voice & Coproduction

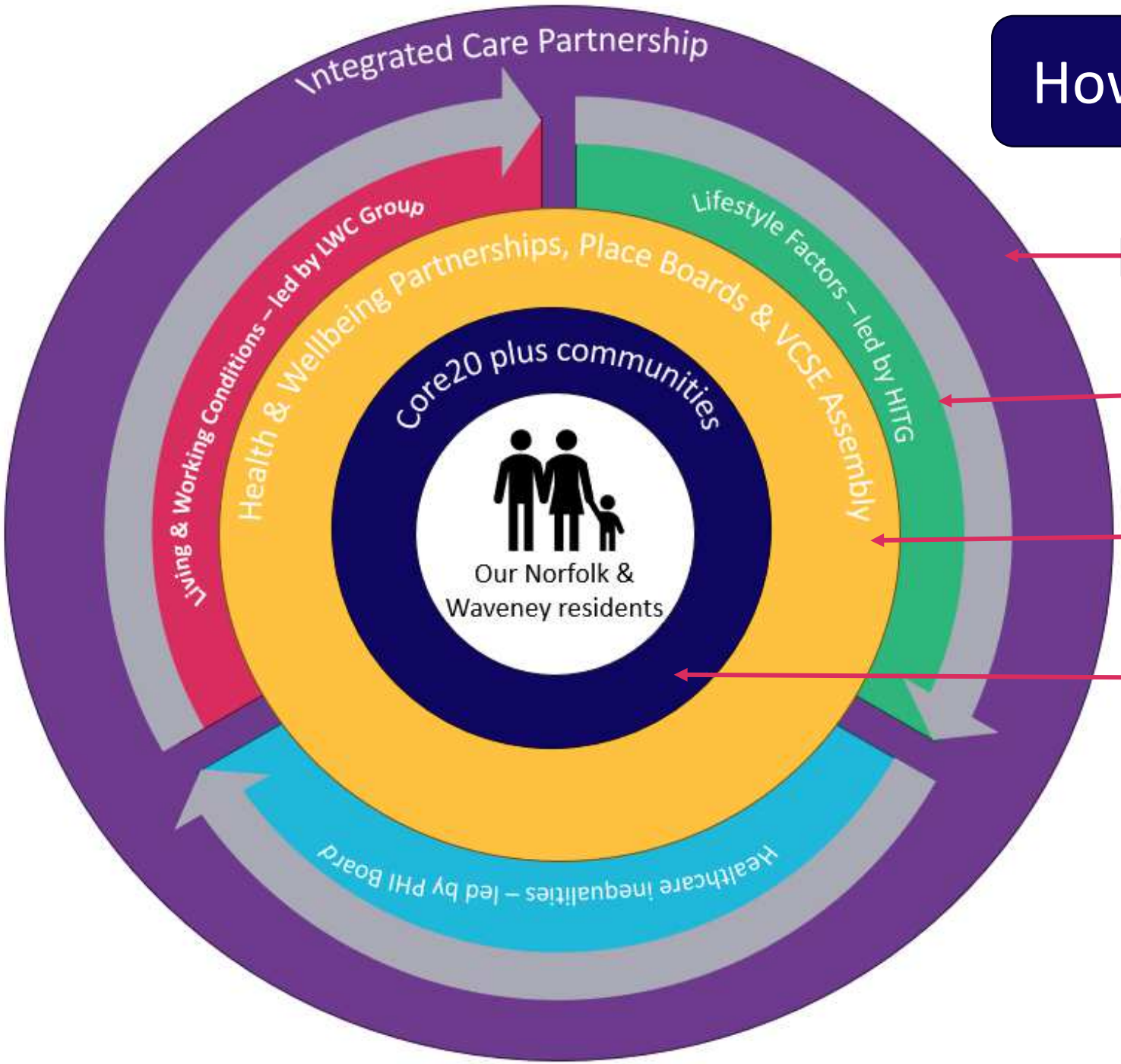
Organisational & workforce development

Intelligence & Evaluation

Policies, Processes and Procedures

Resourcing

How will we organise ourselves?



Action in our organisations

Acting together as a system

Acting locally, as close to communities as possible

Empowering communities to take their own action

Action 1

ORGANISATIONAL PLEDGES

We will roll out a programme which includes commitments and accountability.

Action 2

GOVERNANCE STRUCTURE

We will identify named Senior Responsible Officers/Leaders, Organisational Leads, Clinical leads and Health inequalities champions.

Action 3

PEER REVIEW & SELF ASSESSMENT

We will assess where we are, what good looks like, what we need to do next. We will include actions for anchor institutions.

Action 4

ACTION PLANS

We will produce action plans for each of our building blocks, building on our existing assets and with our place and system structures working closely together.

Action 5

VCSE INTEGRATION

We will further develop the VCSE Assembly and integrate the VCSE sector into all parts of our planning & decision making.

Action 6

ORGANISATIONAL DEVELOPMENT

Including a suite of tools and training, as well as a learning centre to share good practice and case studies. And establish a health inequalities champions network.

Action 7

RESOURCES

Mapping the flow of health inequalities resources & spend across organisations to further develop our business case for investment.

Action 8

INTELLIGENCE

Get better at collecting data and insights on our population, as well as service data – so that population health management is embedded in our ways of working.

Action 9

PARTICIPATION

Continue to engage with communities that experience health inequalities to enable access to services and ensure voices are heard with equity. We will ensure coproduction with experts by experience.

Action 10

MONITORING

A Health Inequalities Outcomes Framework, with clear metrics identified to keep us on track.

Call to action

Recommendations:

The ICP is asked to:

- Endorse the Norfolk & Waveney ICS Health Inequalities Strategic Framework for Action.
- Support implementation, providing leadership and advocacy as required.
- Receive regular updates of progress and delivery and provide oversight as required.

Item No: 7

Report title: Committing to the Hewitt Review recommendations

Date of meeting: 06 March 2024

Sponsor (ICP member): Councillor Kim Carsok, South Norfolk Portfolio Holder for Healthy & Active Lifestyles, South Norfolk District Council

Reason for the Report

The Broadland and South Norfolk Health & Wellbeing Partnerships (HWPs) welcomed the Hewitt Review recommendations as reflecting the principles by which they have worked over the last year. However, they were disappointed with the lack of national support. A Statement of Commitment was created for both Partnerships and brought to the Integrated Care Partnership (ICP) for their endorsement and support, a version of which has since been considered by all HWPs. To profile the work the HWPs have done to drive each Integrated Care System (ICS) priority and to address health inequality locally. It is advised the ICP recognises HWPs as a strategic asset and capitalises on this opportunity for delivering shared objectives, addressing health inequalities, and shifting towards prevention.

Report summary

This report explores recommendations made in the Hewitt Review around shifting the focus to promoting health and prevention from illness, delivering on the promise of systems, and resetting approaches to finance and embed change. It demonstrates how the HWPs are well-positioned to enact them, supported through their contribution to ICS priorities and aims since their formation. The report recommends the ICS utilise HWPs to deliver shared objectives, address health inequalities, and continue to lead the shift towards prevention.

Recommendations

The ICP is asked to:

a) Endorse and sign-off the Statement of Commitments to the Hewitt Review, consider committing to them as an ICP, and ensure progress is tracked.
b) Recognise Health and Wellbeing Partnerships as key and strategic anchors to the ICPs shared objectives of addressing health inequalities and a shift towards prevention.
c) Consider our model of distributed leadership and how resource can be dispersed to support place activity.

1. Background

1.1 The ‘Hewitt Review: an independent review of integrated care systems’ was published in April 2023. The South Norfolk and Broadland HWPs were unsatisfied by the lack of commitment and endorsement by national bodies. The strong relationships, transparency, and principles the HWPs have established mean they are ready to demonstrate full commitment to the Review’s recommendations.

1.2 Statement of Commitments were signed by the Broadland, South Norfolk (see appendix 3) North Norfolk, Great Yarmouth and Breckland HWPs, with other partnerships considering their position (see attached papers).

1.3 The HWPs were set up in 2022 to focus on prevention, addressing health inequalities, and utilising partners’ expertise in the wider determinants of health. Varying place by place they

include participation and commitment from local leaders from across the full spectrum of local public services and the VCSE.

2. Embedding the Hewitt Review Recommendations

2.1 **The review lists 6 Priorities:**

- collaboration within and between systems and national bodies,
- a limited number of shared priorities,
- allowing local leaders the space and time to lead,
- the right support,
- balancing freedom with accountability,
- enabling access to timely, transparent and high-quality data.

2.2 These principles resonate with the work the HWPs have been doing since their formation. There are three sections of the review where the ICP could harness the progress the HWPs have made so far and utilise them to deliver shared outcomes:

2.3 *From focusing on illness to promoting health*

2.3.1 In this section, the review calls for a shift of focus upstream to prevention. To do so, a baseline of current investment in prevention within each ICS is required, including the health inequalities funding. Once this is known, the HWPs should be utilised to facilitate the shift to prevention. The HWPs have formed mature partnerships of locally-focused system leaders that contribute to the wider determinants of health. Their leadership and outcomes over the last year have demonstrated optimal positioning to be trusted with delivering ICS-wide aims such as the impending Health Inequalities Strategic Framework. This would require courageous leadership from the ICP.

2.3.2 The review also encourages taking every opportunity to refocus clinical pathways towards prevention. Working across all sectors, the HWPs have managed to foster trust between health, voluntary, and government organisations for better system and individual outcomes, whilst reducing inefficiencies. The resources and expertise of VCSEs and district councils are essential for shifting clinical pathways towards prevention. The HWPs can therefore utilise their existing resources and relationships with their residents/clients/patients to work with NHS organisations to ensure clinical pathways are focused towards prevention.

2.3.3 Data is mentioned as a tool to enable ICSs to connect multiple sources. This is key in order to shift to prevention. There have been multiple examples of HWPs using data to identify local cohorts of residents in need of support, working alongside both physical and mental health providers to proactively target need and provide localised and community-based solutions (see appendix).

2.4 *Delivering on the promise of systems*

2.4.1 The Statement of Commitments show the HWPs' full support for Hewitt's recommendation of ICSs locally co-developed priorities and targets being treated with equal weight to national targets. The HWPs have delivered enhanced outcomes for individuals when priorities are locally set and delivered on, using a multi-disciplinary lens. If funding streams allowed HWPs the freedom to determine this more often, they could deliver programmes of work that have impressive cross-system outcomes.

2.4.2 The Review also states that ICS leaders should challenge themselves and expect to be challenged around working together to use existing resources as effectively as possible. Projects the HWPs have carried out have effectively increased efficiency in the system by reducing duplication and increasing collaborative and integrative working (e.g. District

Direct, Active NoW, HWP joint-funded posts, Lily, etc.). Having the HWPs are a unique asset to Norfolk & Waveney and should be utilised further.

2.5 *Resetting our approach to finance to embed change*

2.5.1 The Health & Wellbeing Partnerships have received small yearly or two yearly investment from Public Health and the Better Care Fund through Adult Social Care. Matched to other locally available sources of finance, the HWPs have achieved greater integration, enhanced outcomes for individuals and populations, and worked towards a reduction in health inequalities. However, the limited and non-recurring funding prevent them being able to plan ahead and deliver long-term preventative programmes and system change. The review recommends ending small in-year funding pots, to ensure greater financial freedom. The variety of projects and resource invested in has demonstrated the strength and creativity of the HWPs and their ability to start to make real system change. This opportunity should be taken by the ICP to invest and trust in as a delivery mechanism and engine room for innovation.

2.5.2 The review also recommends pooling budgets to allow local leaders to make holistic decisions about how best to allocate resources across health and care systems. The strong relationships, trust and transparency, and collaborative way of working the HWPs promote means they're well positioned to deliver system-wide goals with pooled budgets. Their unique range of expertise and relationships with their patients/clients/residents is a powerful asset to the system.

2.6 How have the Health & Wellbeing Partnerships been working towards reducing health inequalities, addressing wider determinants of health, and focusing on prevention?

2.6.1 Since their formation, the eight HWPs have delivered locally Health and Wellbeing Strategies which have guided programmes of work with short funding pots spanning an impressive range of areas including physical activity, driving integration, workforce development, empowering resilient communities, and working with migrant communities (see slide pack for all themes). These are projects decided upon mutually across partners, utilising local intelligence and data to determine priorities. Examples are shown in Appendix 2. Themes are consistent across Health & Wellbeing Partnerships, but schemes tailored to their locality's needs. This demonstrates the maturity of this level of place-based partnerships.

2.7 How has investment in these projects contributed to delivering the ICS Strategy?

2.7.1 A number of projects across the Health & Wellbeing Partnerships have contributed to the ICS's four priorities: driving integration, prioritising prevention, addressing inequalities, enabling resilient communities. This is demonstrated in Appendix 1. All projects fit under multiple themes but have been coded into threads based on their main focus. The size of the boxes give an approximate representation of the number of projects within each thread. These all come under the umbrella of addressing and reducing health inequalities.

2.7.2 The strong relationships built in the Health & Wellbeing Partnerships and the projects and outcomes delivered to progress work in a variety of different themes further demonstrates their optimal positioning to be trusted with shared ICP outcomes.

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

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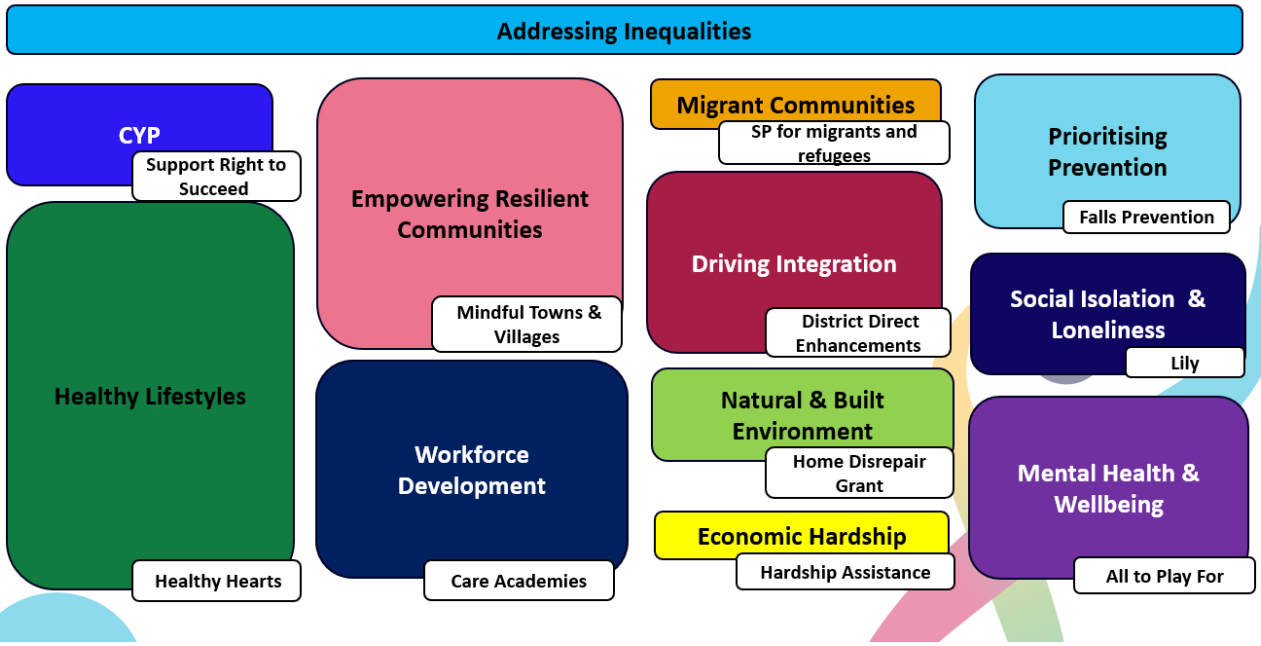
If you need this report in large print, audio, Braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Common threads - Examples

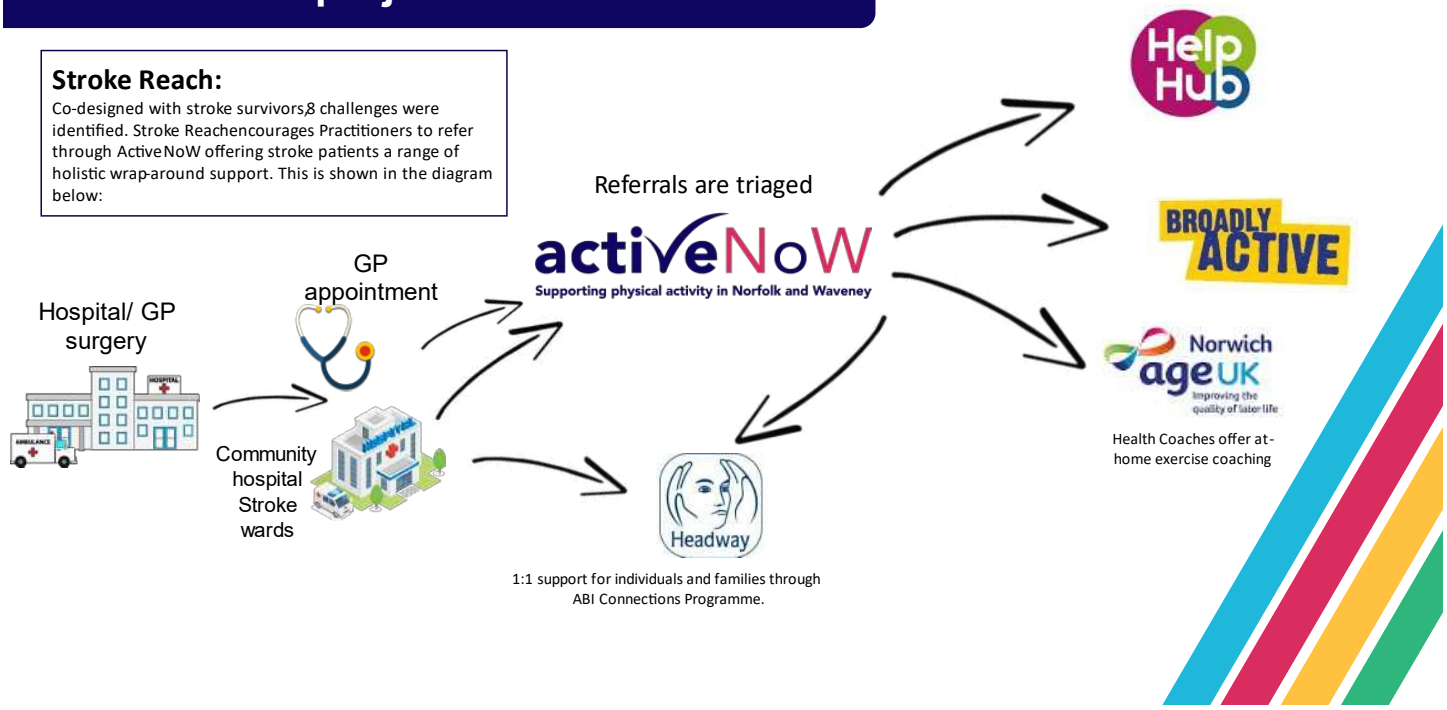


Item No: 7, APPENDIX 2: Project examples

A) Stroke Reach Project

Stroke Reach project

Stroke Reach:
Co-designed with stroke survivors,8 challenges were identified. Stroke Reachencourages Practitioners to refer through ActiveNoW offering stroke patients a range of holistic wrap-around support. This is shown in the diagram below:



B) Warm Homes

Warm Homes

The pilot aimed to answer the following question:***could keeping people warm and well at home reduce need for health services?***

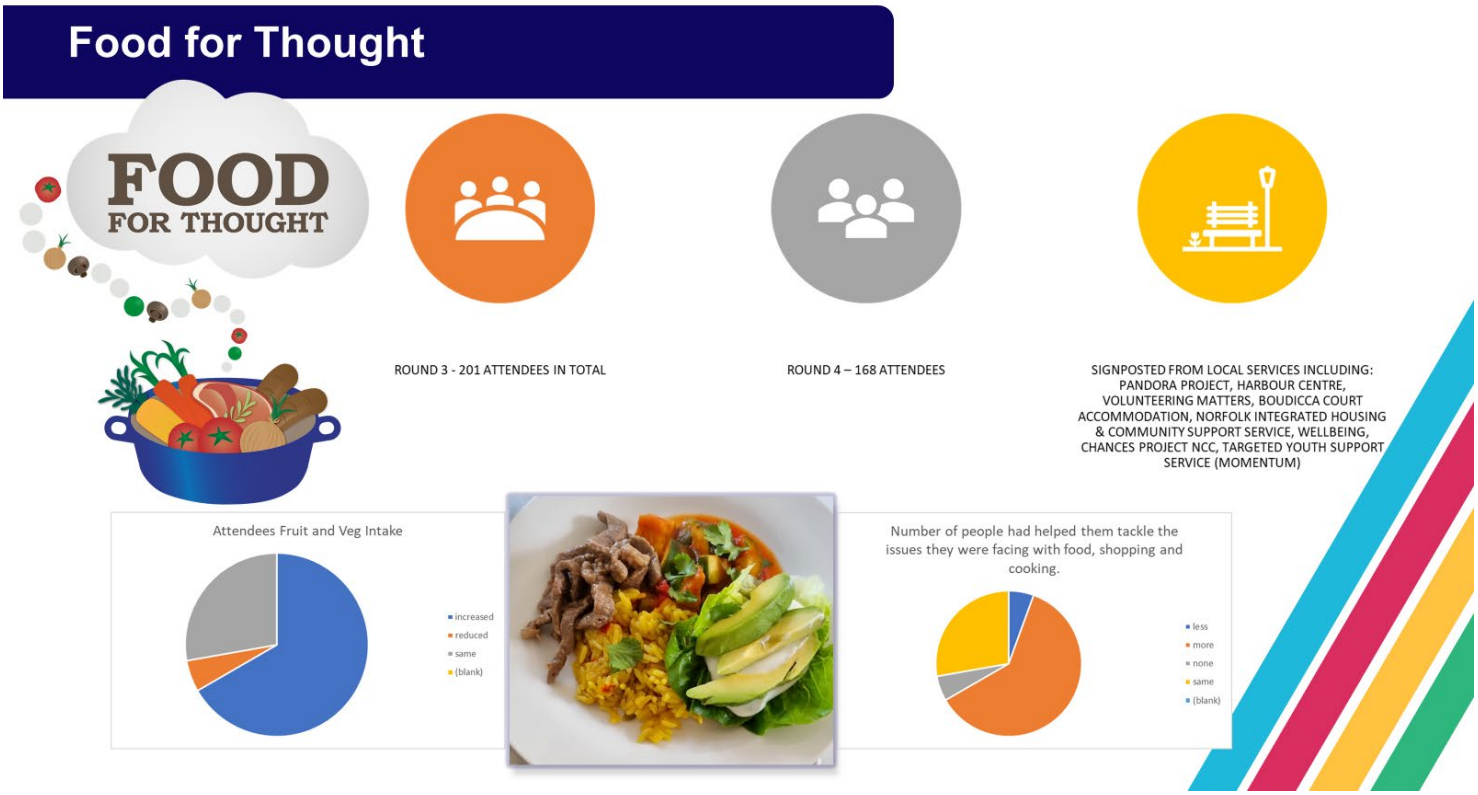
Design Principles
- Connect data about health and welfare to see the person-centred bigger picture
- Use existing conditions to help understand vulnerability to welfare issues and potential admissions
- Understand the impacts of the wider determinants of health e.g. fuel poverty and housing

Identified Cohort
- 65+ in Great Yarmouth and Waveney
- Risk of fuel poverty and cold homes
- Chronic respiratory condition
- Hospital admission in the past 3 -6 months

= 353 people

Received a letter with support info → **Received a call from Protect Now with script** → **Those with further need referred to Districts** → **Districts made contact and explored options** → **All wider support options covered including cash payments, housing support and referrals to other services = 18 households**

C) Food for Thought



South Norfolk Health and Wellbeing Partnership's

Statement of Commitment to the Hewitt Review recommendations

Intended for: The Health and Wellbeing Board/Integrated Care Partnership

As a wide variety of organisations positioned across South Norfolk, we were grateful for the opportunity to contribute to Patricia Hewitt's Independent Review of Integrated Care Systems. We firmly believe Integrated Care Systems do represent the best opportunity in a generation for transforming our health and care system, and we intend to cultivate this in our patch.

This statement of commitment is to demonstrate South Norfolk Health and Wellbeing Partnership's dedication to drive towards a preventive system that operates in an integrated way. By approaching the integrated care system as an adjective, instead of accepting it as a noun, we hope to meet this goal.

The Partnership is dedicated to delivering prevention guided by a set of principles including being bold, confident, and transparent, using intelligence and evidence to set priorities, working collaboratively and proactively, embracing trust, and innovating, testing, and reviewing regularly. These principles are echoed in the Hewitt Review as necessary facilitators for change.

We recognise the Hewitt Review recommendations and Matthew Taylor's advice in his NHS ConfedExpo speech requires everyone taking responsibility. Therefore, the following shows our public commitment to achieving these in our patch and encouraging others to do so too. We will:

Drive a shift of focus upstream:

- ✓ Identify those who have the drive to make a real difference and give them headspace to look upstream of the immediate pressures we face in our district. We will increase capacity for this by investing in dedicated resource to drive their ideas. This demonstration of trust and space intends to facilitate their innovation, and support the recommendation of allowing local leaders the space and time to lead.
- ✓ Ensure all our investments using Health and Wellbeing Partnership funding go towards prevention, and working with our Place Boards, Public Health, local VCSEs, and community, we will get a better understanding of where we can have the most impact. We have already invested in a programme of preventative activities over the last year including providing wrap-around support for individuals experiencing a stroke, delivering free mental health and wellbeing awareness training to local community groups and businesses to build an available group of people in local communities who can support each other, and delivering Care Academies to support recruitment and training of care staff.
- ✓ Use our data and intelligence to innovatively work to identify where we can have the biggest impact in prevention. We are currently exploring a Proactive Interventions project seeking to transform the approach to supporting residents to proactive, targeted, preventative support. It uses sophisticated holistic data analysis to predict support requirements, running falls pilots currently.
- ✓ Build on existing relationships in our communities to design and create prevention activities which are right for them. We will also strive to connect with those who are less well known to us through co-production activities specifically in our Resilient and Healthy Communities Priority Delivery Group.

- ✓ Work with our communities to empower them to manage their own health, building on the Mindful Towns and Villages model to ensure our communities are best supported to work together sustainably for better individual outcomes.

Work locally, proving subsidiarity works:

- ✓ Use our collective intelligence, experience, and data to inform our priorities and our focus areas. Our Health and Wellbeing Strategy was the result of extensive engagement with our partners and their networks sharing collective intelligence to inform our current priority areas: mental health and wellbeing, access and prevention, resilient and healthy communities, all underpinned by Covid-19 recovery and hardship support. We will continue to work closely with Public Health to be evidence-led as this is one of our agreed Partnership Principles.
- ✓ Take accountability of enacting the relevant Hewitt Review recommendations at our local level, ensuring our priorities are informed by our people, environment, communities, and local economy. We have impressive buy-in from key players across our patch of the Integrated Care System, we are harnessing their enthusiasm through their leadership of each Priority Delivery Group.
- ✓ We will lobby national government and NHS England to hold our local priorities and targets with equal weight to national targets.
- ✓ Learn from others and share transparently. We do not operate in competition with other parts of the Norfolk and Waveney system and are always eager to share and learn. A National Peer Review would give Integrated Care Systems the chance to share learnings and best practice formally. We support this recommendation and will explore the possibility of a local peer review whilst encouraging a national one.

Encourage funding that enables change:

- ✓ Shift resource into our communities by building on our existing relationships. We will do this by working with our partners, our community groups, and our populations to understand where resource is most efficiently utilised.
- ✓ Ensure the entirety of our spend is on prevention, and we will encourage other organisations to increase their spend on this agenda and lobby the government and NHS England to increase theirs.
- ✓ Continue to lobby the government for longer-term funding to enable us to meet the ambitions we have for our populations. To achieve true prevention longer term funding is required. The ambitions of the Partnership exceed the confining timeframes set by funding pots, therefore we will actively seek opportunities to lobby on this issue.

We will hold ourselves to account for each of these commitments and will measure progress against them in a years' time.

Signed: The South Norfolk Health and Wellbeing Partnership

Committing to the Hewitt Review recommendations

Jamie Sutterby

Director, South Norfolk and Broadland District Councils

Improving lives **together**
Norfolk and Waveney Integrated Care System

Hewitt Review: 6 principles

1. Collaboration within and between systems and national bodies.
2. A limited number of shared priorities.
3. Allowing local leaders the space and time to lead.
4. The right support.
5. Balancing freedom with accountability.
6. Enabling access to timely, transparent and high-quality data.

4 main aims of ICS

1. To improve outcomes in population health and healthcare.
2. To tackle inequalities in outcomes experience and access.
3. To enhance productivity and value for money.
4. To help the NHS support broader social and economic development.

From focusing on illness to promoting health

- ✓ Increasing resources **must** be committed to prevention.
- ✓ The share of total NHS budgets at ICS level going towards prevention should increase by at least 1% over next 5 years.
- ✓ Take every opportunity to refocus clinical pathways towards prevention.
- ✓ Enable ICSs to connect data from multiple sources to enable a shift to prevention.

Delivering on the promise of systems

- ✓ Locally co-developed priorities/targets should be given equal weight to national targets and span health and social care.
- ✓ Data collection should increasingly include outcomes rather than mainly focusing on inputs and processes.
- ✓ A national peer review should be developed to share best practice across ICSs.
- ✓ ICS leaders should challenge themselves and expect to be challenged- to work together to use existing resources as effectively as possible.

Resetting our approach to finance to embed change

- ✓ Ending (where possible) small in-year funding pots.
- ✓ Giving systems more flexibility to determine allocations for services and appropriate payment mechanisms within their own boundaries.
- ✓ Work towards pooling budgets to allow local leaders to make holistic decisions about how best to allocate resources across health and care systems.

Improving lives together
Norfolk and Waveney Integrated Care System

Addressing Inequalities

CYP

Support Right to Succeed

Healthy Lifestyles

Healthy Hearts

Empowering Resilient Communities

Mindful Towns & Villages

Workforce Development

Care Academies

Migrant Communities

SP for migrants and refugees

Driving Integration

District Direct Enhancements

Natural & Built Environment

Home Disrepair Grant

Economic Hardship

Hardship Assistance

Prioritising Prevention

Falls Prevention

Social Isolation & Loneliness

Lily

Mental Health & Wellbeing

All to Play For

Improving lives **together**

Norfolk and Waveney Integrated Care System

PRIORITIES

Driving Integration

- Shadowing Programme
- Community Hub Activity
- Social Prescribers in Secondary Care
- Active NoW
- Locality Infrastructure Coordinator
- MECC training
- District Direct Enhancements
- Stroke Reach

Prioritising Prevention

- Falls Prevention
- Develop & support use of green spaces and physical activity
- Community Connectors
- Healthier North Walsham
- Lily
- Proactive Interventions
- Community Health Workers

Addressing inequalities

- Charles Burrell Centre enhanced training
- Living Well Programme
- Power to Change Programme
- Age Friendly Community
- SPs for migrants and refugees
- Safe Habitable Homes
- Extension of Help Through Crisis

Enabling resilient communities

- Community Network
- Our Day Out
- Healthy Hearts
- Community Voices
- PitStop
- Mobile Hub
- World Café training
- Pace of Mind
- Mindful Towns & Villages

Improving lives together
Norfolk and Waveney Integrated Care System

The ICP is asked to:

a) Endorse and sign-off the Statement of Commitments to the Hewitt Review, and consider committing to them as an ICP, and ensure progress is tracked.

b) Recognise Health and Wellbeing Partnership as key and strategic anchors to the ICPs shared objectives of addressing health inequality and a shift towards prevention.

c) Consider our model of distributed leadership and how resource can be dispersed to support place activity.

Report title: Cancer, Public Health key indicators for Norfolk and Waveney

Date of meeting: 06 March 2024

Sponsor (ICP member): Stuart Lines, Director of Public Health, Norfolk County Council

Reason for the Report

The Integrated Care Partnership (ICP) Chair has asked Public Health to provide reports on a number of health conditions, so that the ICP can work together to improve the health of the population. It has been agreed that these reports will cover four major heath conditions: Cardiovascular Disease (June 2023), Respiratory conditions (September 2023), Mental Health (November 2023) and Cancer (March 2024). This is fourth in the series, focusing on Cancer.

Report summary

Across England, cancer incidence (new cases each year) rose slightly through the 2000s, but this trend stopped around 2013. Norfolk and Waveney picture has remained similar to that seen nationally. In the same period rate of people dying from cancer has decreased. Overall, mortality rates for cancers are lower in Norfolk & Waveney compared to England. However, early deaths (those under 75) are higher than expected in the more deprived areas.

Cancer survival rates have improved in the past decade and are in line with the England average. However, patients from more deprived communities are more likely to have cancer diagnosed at a later stage and have lower survival rates.

Studies have shown that 38% of cancer cases are preventable and that smoking is the largest single preventable cause of cancer, accounting for 15% of cases. And as deprivation increases the proportion of people with higher risk health behaviour also increases.

Recommendations

The ICP is asked to:

a) Note the data and information relating to Cancer for people living in Norfolk and Waveney for use in their strategic and operational planning and note there is additional information contained within the Norfolk Joint Strategic Needs Assessment (JSNA).

1. Background

1.1 Previous analysis has shown that cancer diagnosis in Norfolk and Waveney is a key driver of health inequalities and places a significant demand on the health and care system. This also results in unwarranted variation in the survival rates across our population.

2. Key indicators

2.1 Cancer Incidence in Norfolk & Waveney

2.1.1 Incidence is the number of new cases diagnosed every year.

2.1.2 Cancer incidence rose slightly through the 2000s across Norfolk and Waveney (also in England), but this trend stopped around 2013, and is now decreasing slightly.

2.1.3 In Norfolk & Waveney there are between 6,500 and 7,400 new cases of cancer identified annually (6,584 in 2020 – this could be due to Covid effect, patients not able to be seen by GPs and then subsequent referral to hospitals during and around lockdown period.)

2.1.4 The most common types of cancer diagnosed in Norfolk and Waveney:

- prostate cancer (males)
- breast cancer (females)
- lung cancer
- colorectal cancer

Every year there are around 1,000 new cases of prostate cancer and breast cancer, and more than 800 new cases of lung cancer and colorectal cancer.

2.2 Cancer Deaths

2.2.1 Whilst the overall incidence rate of cancer has increased, the rate of people dying from cancer has decreased due to advances in earlier diagnosis, prompt treatments.

2.2.2 In Norfolk & Waveney there were 3,226 deaths from cancer in 2020. These account for around a quarter of all deaths in the area.

2.2.3 40% of cancer deaths occur below the age of 75, and 10% below the age of 60.

2.2.4 Main causes of cancer deaths in N&W

- Males – lung, prostate and colorectal cancers
- Females – lung, breast and colorectal cancers

2.2.5 Across Norfolk and Waveney early deaths (those under 75) are higher than expected in the more deprived areas. There is an excess of 50 deaths out of a total of more than 200 deaths per year in the most deprived 20% of people under the age of 75.

2.3 Cancer Survival

2.3.1 In Norfolk & Waveney

- 74% of people diagnosed with cancer survive more than one year after diagnosis and
- 56% survive more than five years.

2.3.2 Cancer survival rates have improved in the past decade due to advances in earlier diagnosis, prompt treatments at early stages of cancer, and are in line with the England average.

2.4 Health Inequalities in Cancer

2.4.1 Patients from more deprived communities are more likely to have cancer diagnosed at a later stage and have lower survival rates.

2.4.2 People from more deprived communities are less likely to recognise symptoms, less likely to attend screening and are more likely to report barriers to seeking help. For more information on socio-economic deprivation and cancer in the UK go to cancerresearchuk.org to read the Cancer in the UK 2020 report.

2.4.3 Studies have shown that 38% of cancer cases are preventable and that smoking is the largest single preventable cause of cancer, accounting for 15% of cases.

2.4.4 As deprivation increases the proportion of people with higher risk health behaviour also increases, e.g. smoking, alcohol, healthy eating and excess weight.

3. Further Information on Cancer in Norfolk and Waveney

3.1 Norfolk Insight is a locality-focused information system providing data and analysis for neighbourhoods in Norfolk and Waveney. There are a range of documents gathered on the Norfolk Insights website that provide further detail regarding cancer:

Officer Contact

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

Name: Dr Abhijit Bagade Tel: 07825851227 Email: abhijit.bagade@norfolk.gov.uk

Cancer
Key indicators for Norfolk and Waveney

ICP meeting
06 March 2024

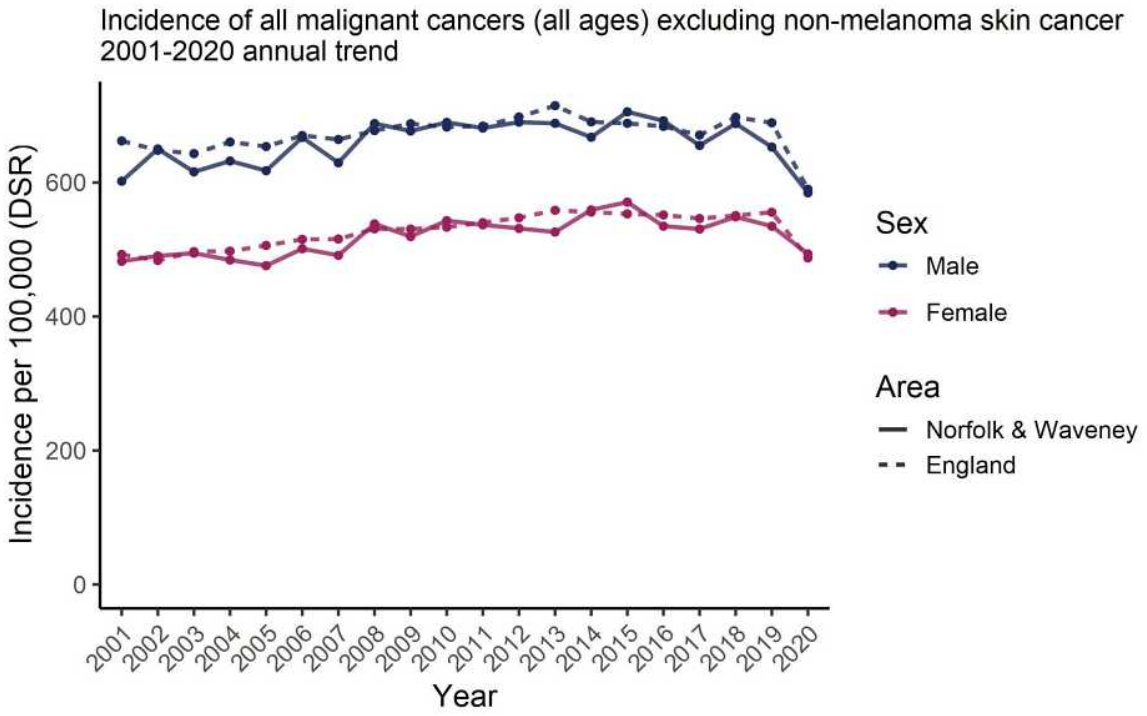
Suzanne Meredith, Deputy director of Public Health,
Norfolk County Council

Acknowledgements:
Dr Abhijit Bagade, Josh Robotham, Dr Tim Winters, Public Health

Norfolk County Council

Cancer Incidence (new cases) in Norfolk & Waveney

- Cancer incidence rose slightly through the 2000s across Norfolk and Waveney (also in England), but this trend stopped around 2013.
- In Norfolk & Waveney there are between 6,500 and 7,400 new cases of cancer identified annually (6,584 in 2020 – Covid effect?).
- The most common types of cancer: prostate cancer (males), breast cancer (females), lung cancer and colorectal cancer.
- New cases every year:
  - Around 1,000 cases of prostate cancer and breast cancer,
  - more than 800 cases of lung cancer and colorectal cancer.



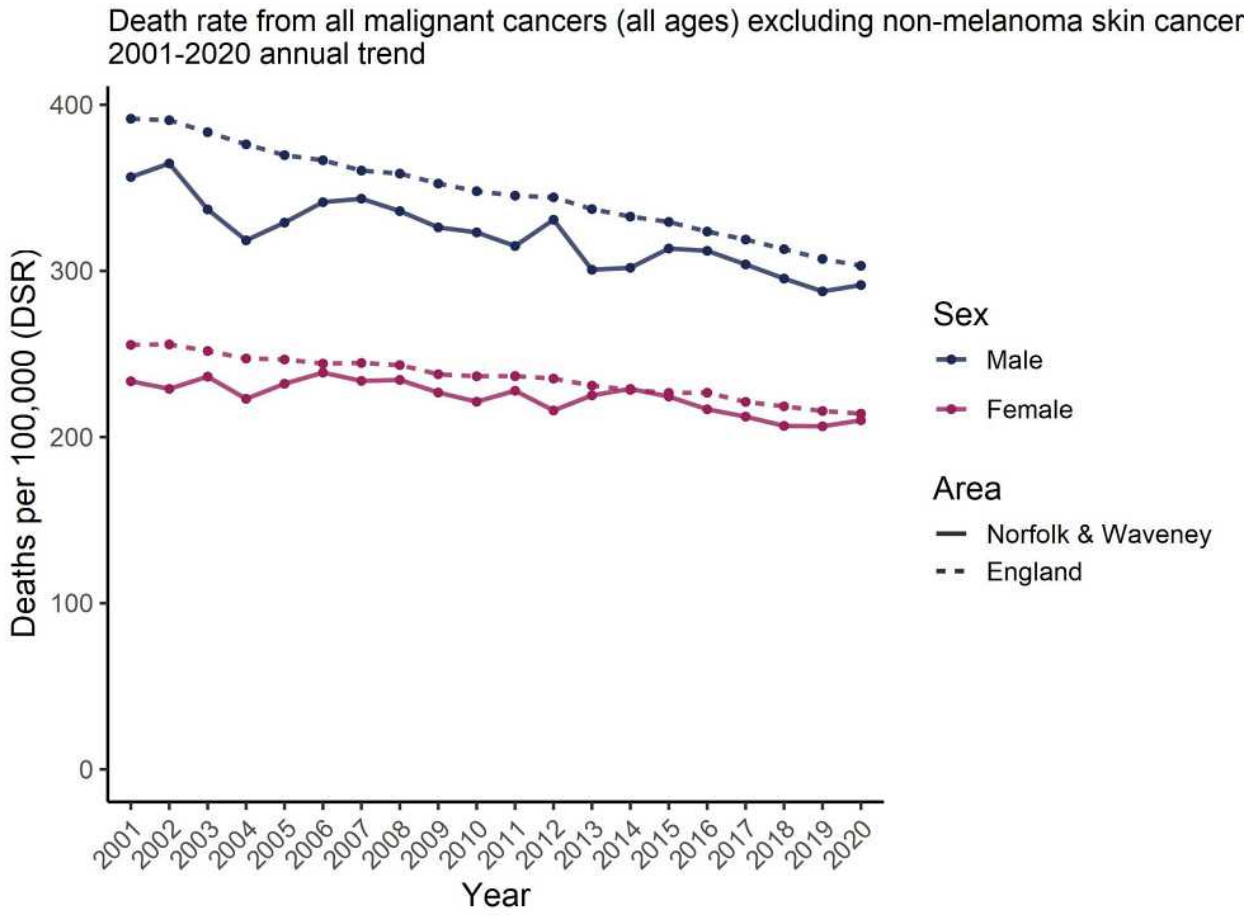
Norfolk County Council

Cancer deaths

- Whilst the overall incidence rate of cancer has increased, the rate of people dying from cancer has decreased.
- In Norfolk & Waveney there were 3,226 deaths from cancer in 2020. These account for around a quarter of all deaths in the area.
- 40% of cancer deaths occur below the age of 75, and 10% below the age of 60.
- Overall, mortality rates for cancers are lower in Norfolk & Waveney compared to England.

Main causes of cancer deaths in N&W:

- Males – lung, prostate and colorectal cancers.
- Females – lung, breast and colorectal cancers.

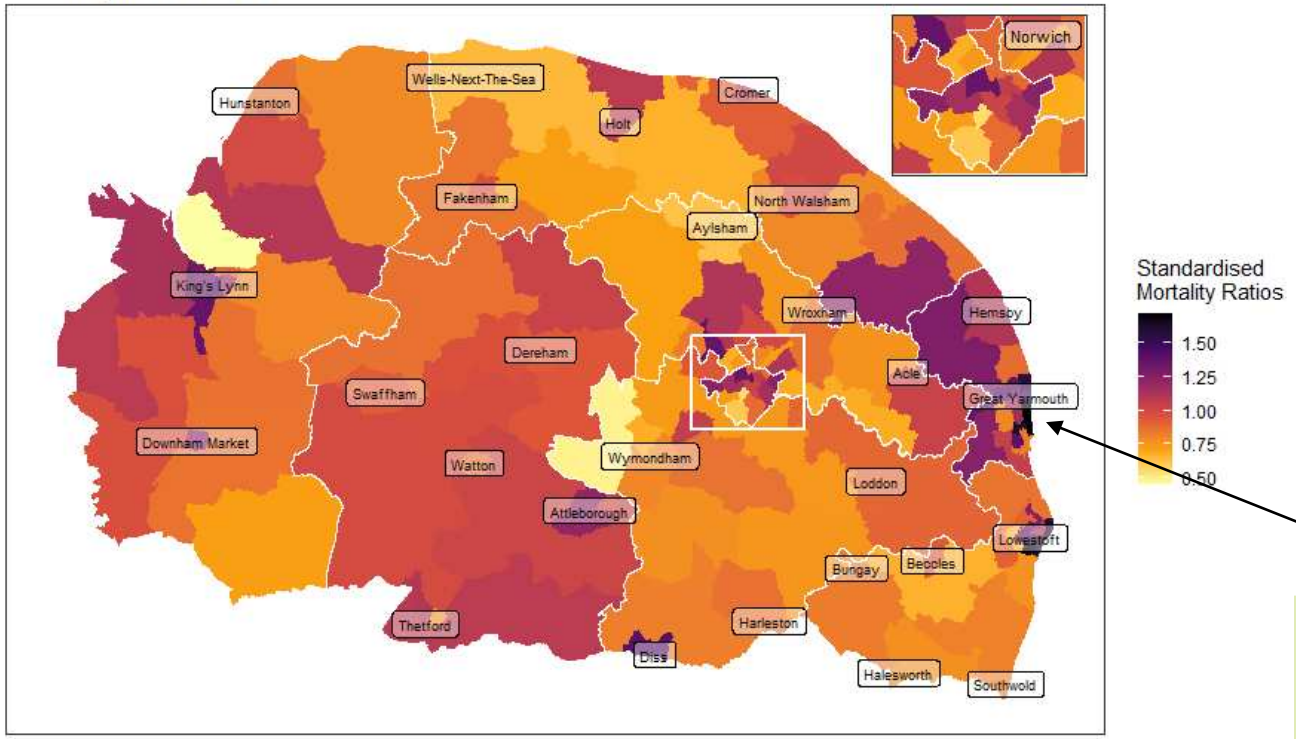


Norfolk County Council

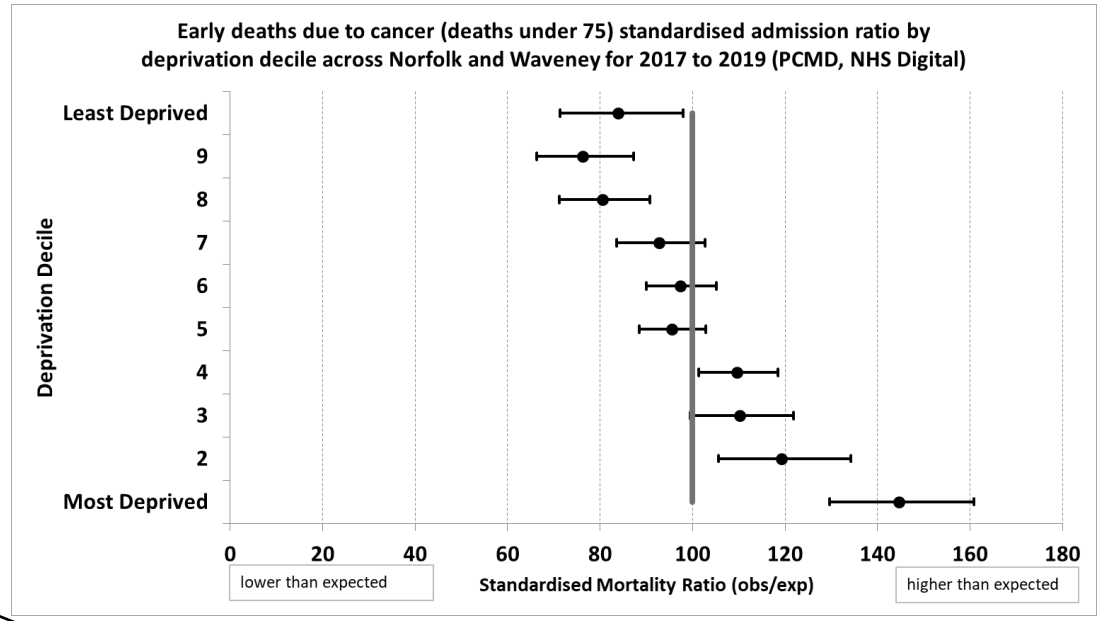
Early Cancer deaths (those under 75)

- Across Norfolk and Waveney early deaths (those under 75) are higher than expected in the more deprived areas. For the most deprived 20% of areas this excess is about 50 per year.

Standardised Mortality Ratios for under 75s for all cancers across Norfolk and Waveney in 2020 - 2022



Source: NHS Digital Primary Care Mortality Database

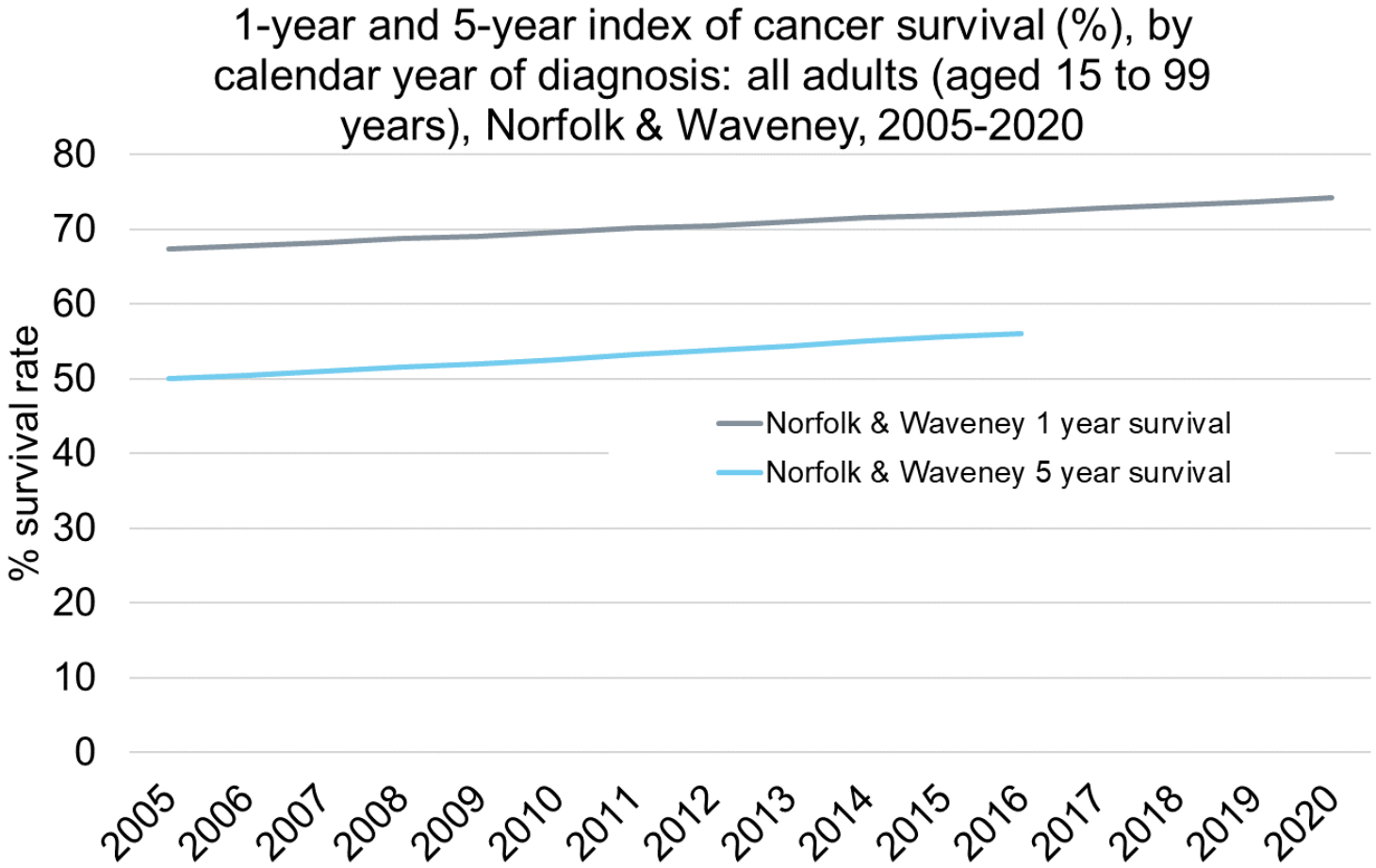


Darker colours indicate higher than expected rates – these are generally associated with the more deprived areas.

Cancer survival

- In Norfolk & Waveney, 74% of people diagnosed with cancer survive more than one year after diagnosis and 56% survive more than five years.

- Cancer survival rates have improved in the past decade and are in line with the England average.



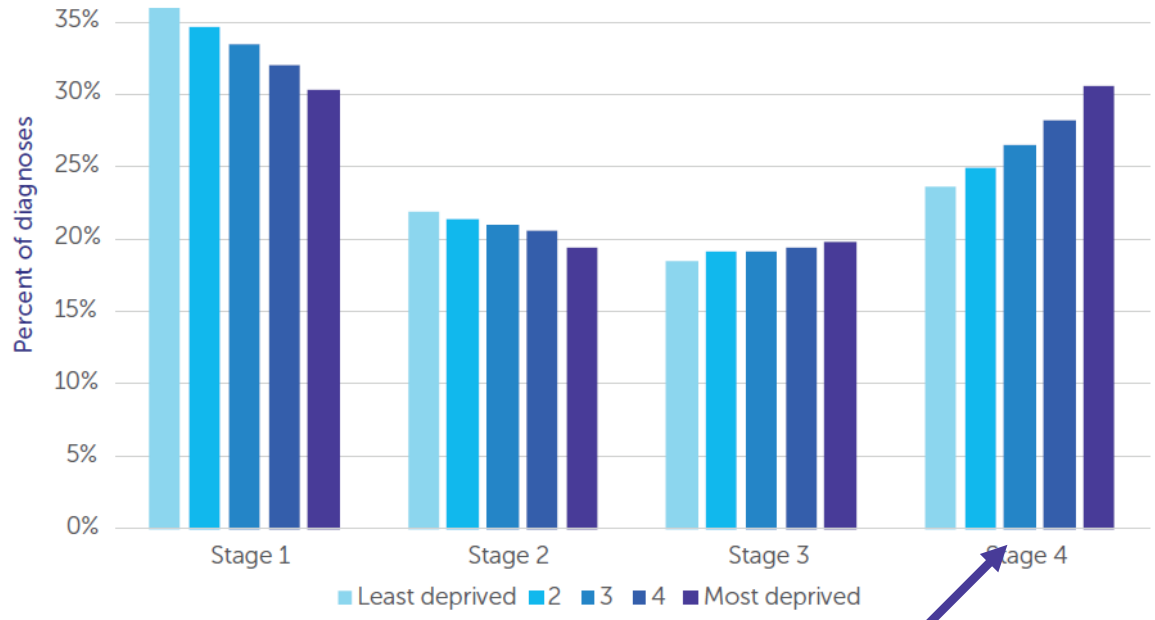
Norfolk County Council

Cancer – inequalities

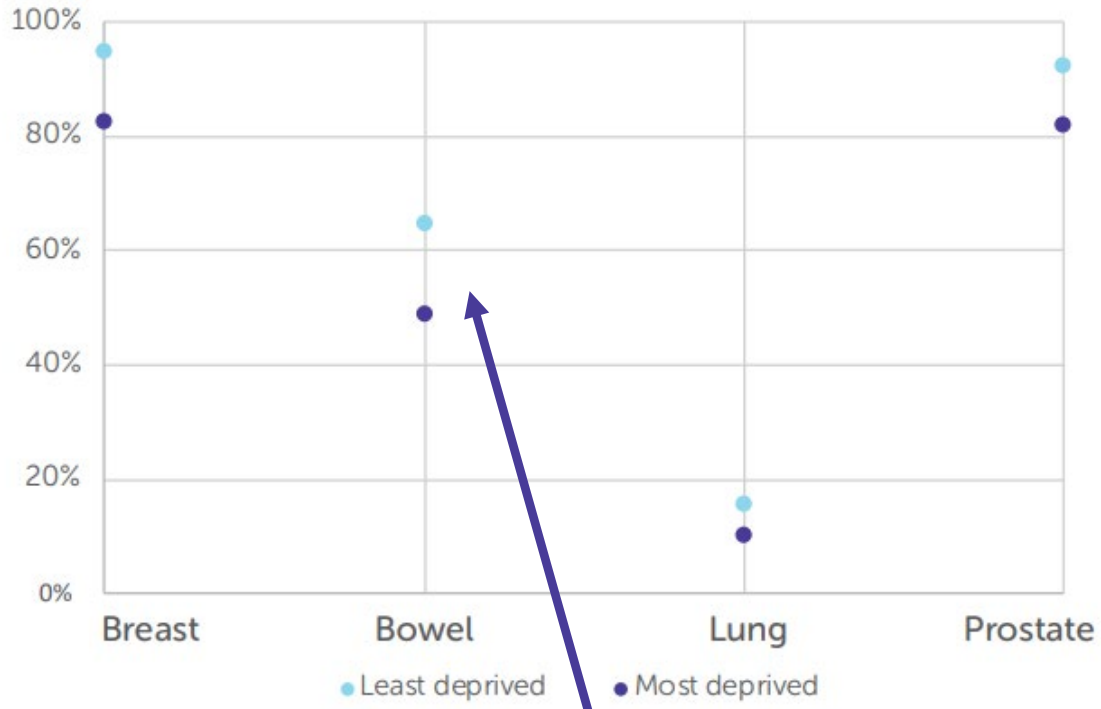
Please note this important slide

- Patients from more deprived communities are more likely to have cancer diagnosed at a later stage and have lower survival rates.

Proportion of patients diagnosed at each stage by deprivation quintile, England, 2014-2018



Five year cancer survival (net) by socio-economic deprivation, Wales, 2012-2016



Stage 4 diagnoses higher in the more deprived communities

Net survival lower in the more deprived communities

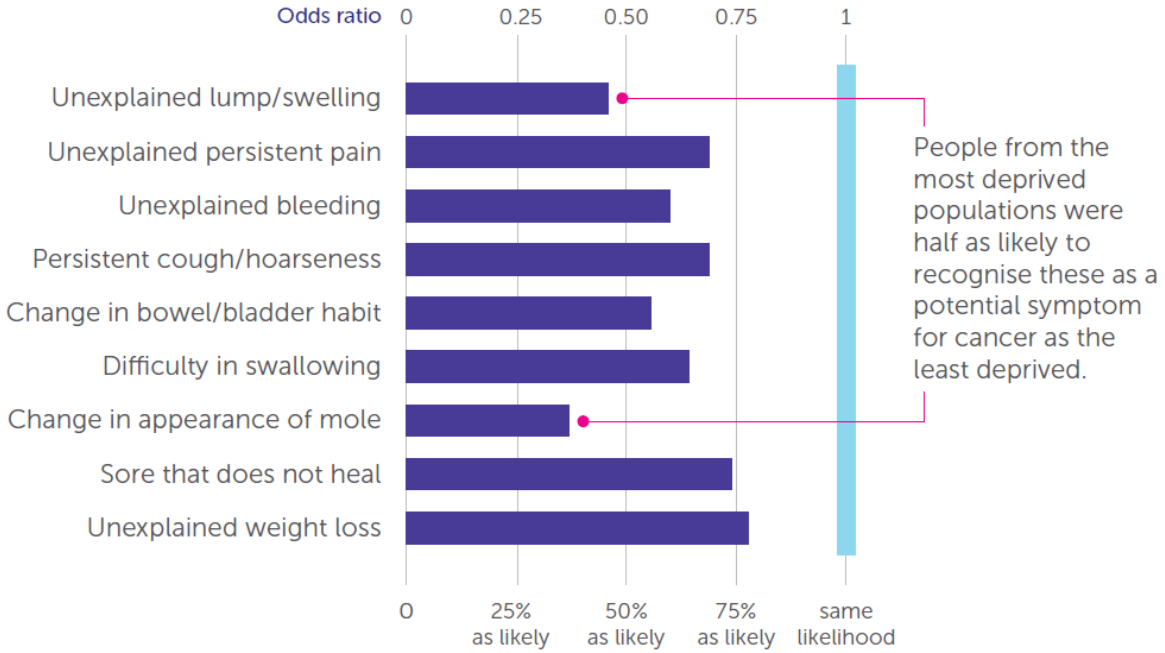
https://www.cancerresearchuk.org/sites/default/files/cancer_inequalities_in_the_uk.pdf

Cancer survival – inequalities

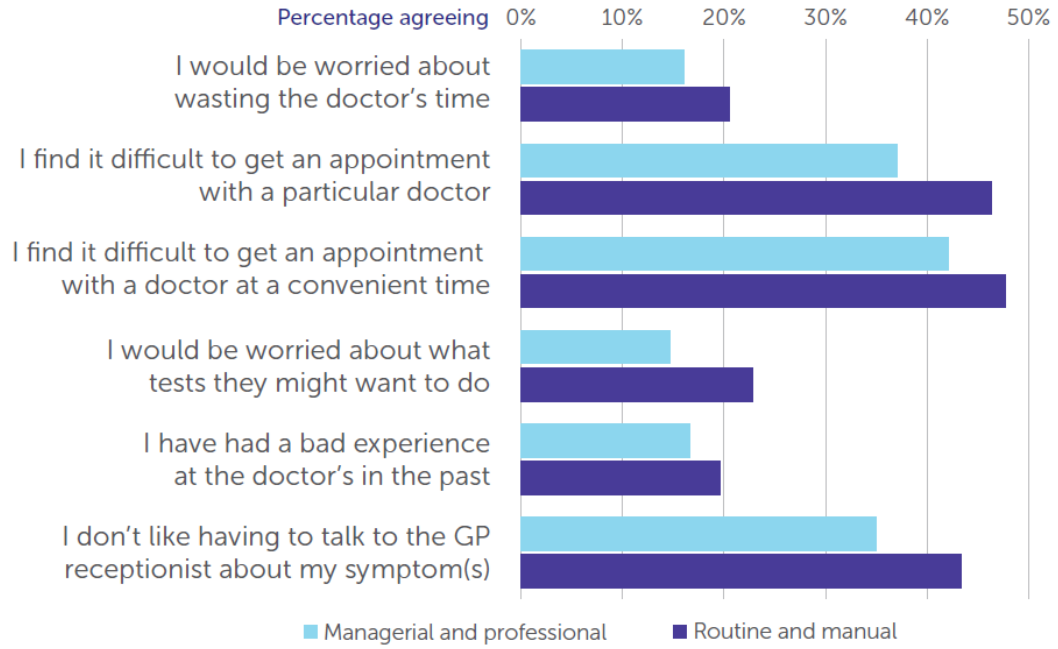
Please note this important slide

- People from more deprived communities are less likely to recognise symptoms, less likely to attend screening and are more likely to report barriers to seeking help.

Recognition of cancer symptoms, most deprived compared to least deprived, England, 2009-2011



Proportion citing barriers to help-seeking by occupation group, Great Britain, 2014



Less likely to recognise symptoms

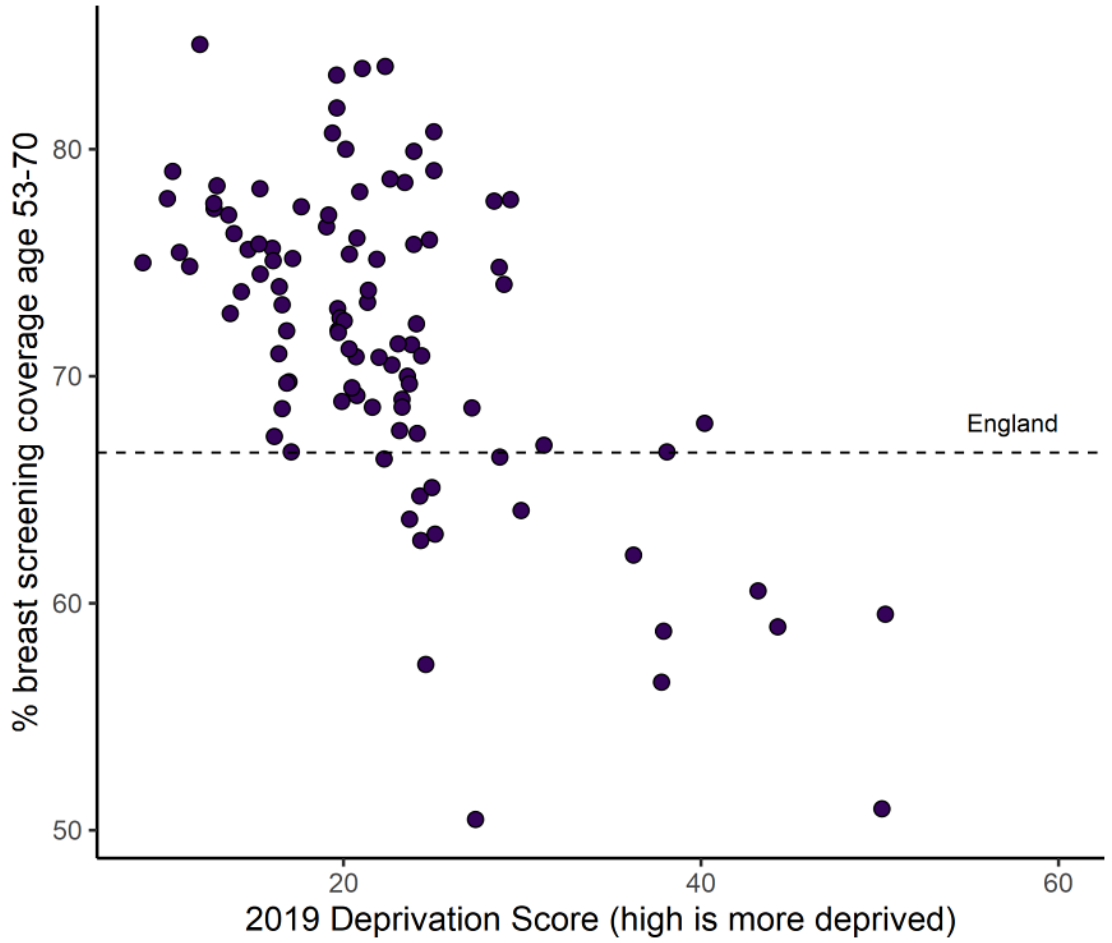
More likely to report barriers

https://www.cancerresearchuk.org/sites/default/files/cancer_inequalities_in_the_uk.pdf

Cancer screening

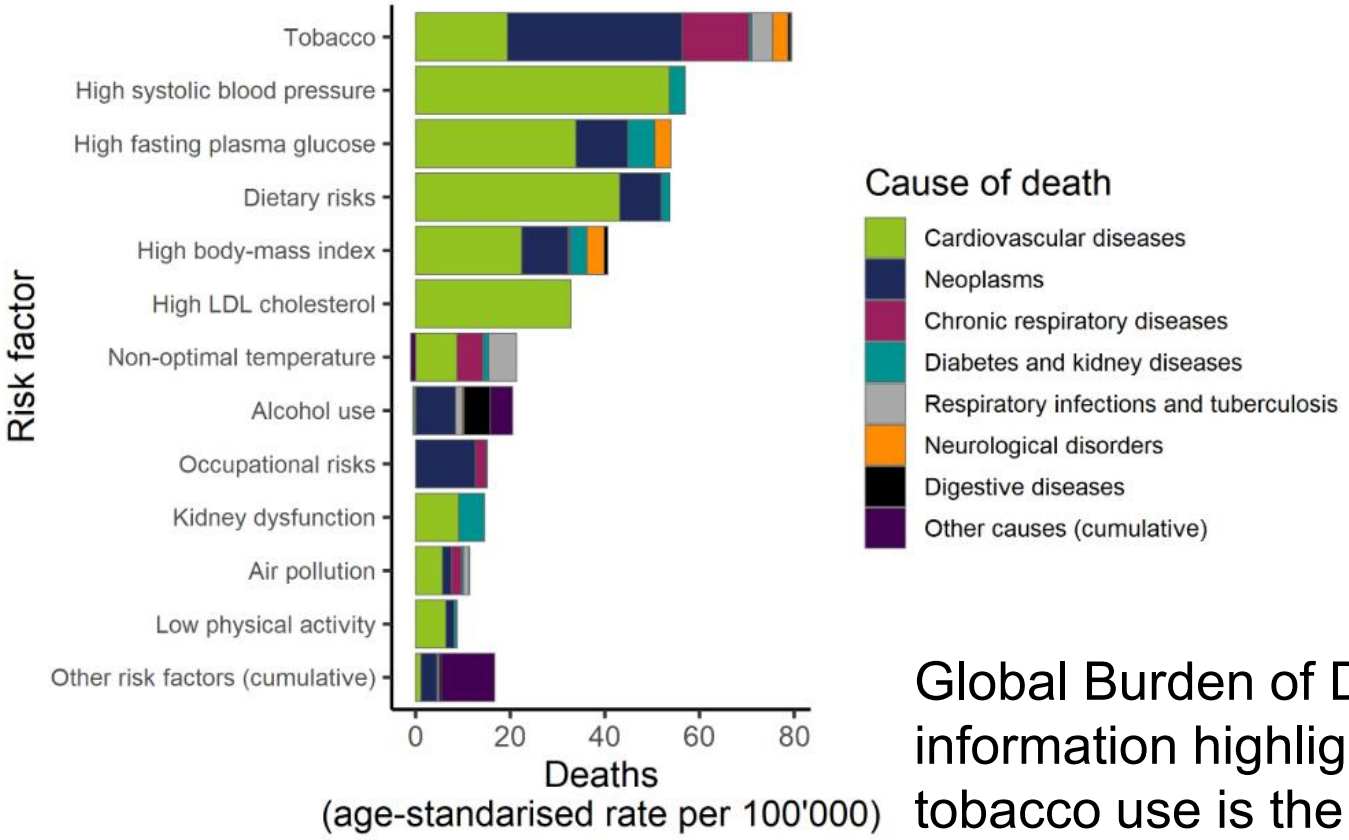
- **Breast cancer** screening in Norfolk and Waveney is good relative to the rest of the country. More than 70% of eligible women aged 53-70 have had a breast screening in 2022/23, higher than the England average of 67%.
- The situation is similar for **cervical and bowel cancer screening**, uptake is good compared to the England average.
- However, there are inequalities in uptake across the screening programmes.
- For example, GP practices with more deprived populations have lower breast cancer screening coverage rates (right).

Breast screening coverage: aged 53 to 70 years old, Norfolk and Waveney GP Practices, 2022-23.



Risk factors

- Risk factors for cancer broadly fall into three categories: genetic/hereditary, environmental, and lifestyle/behaviour risks.
- Previous work has shown 38% of cancer cases are preventable and that smoking is the largest single preventable cause of cancer, accounting for 15% of cases.



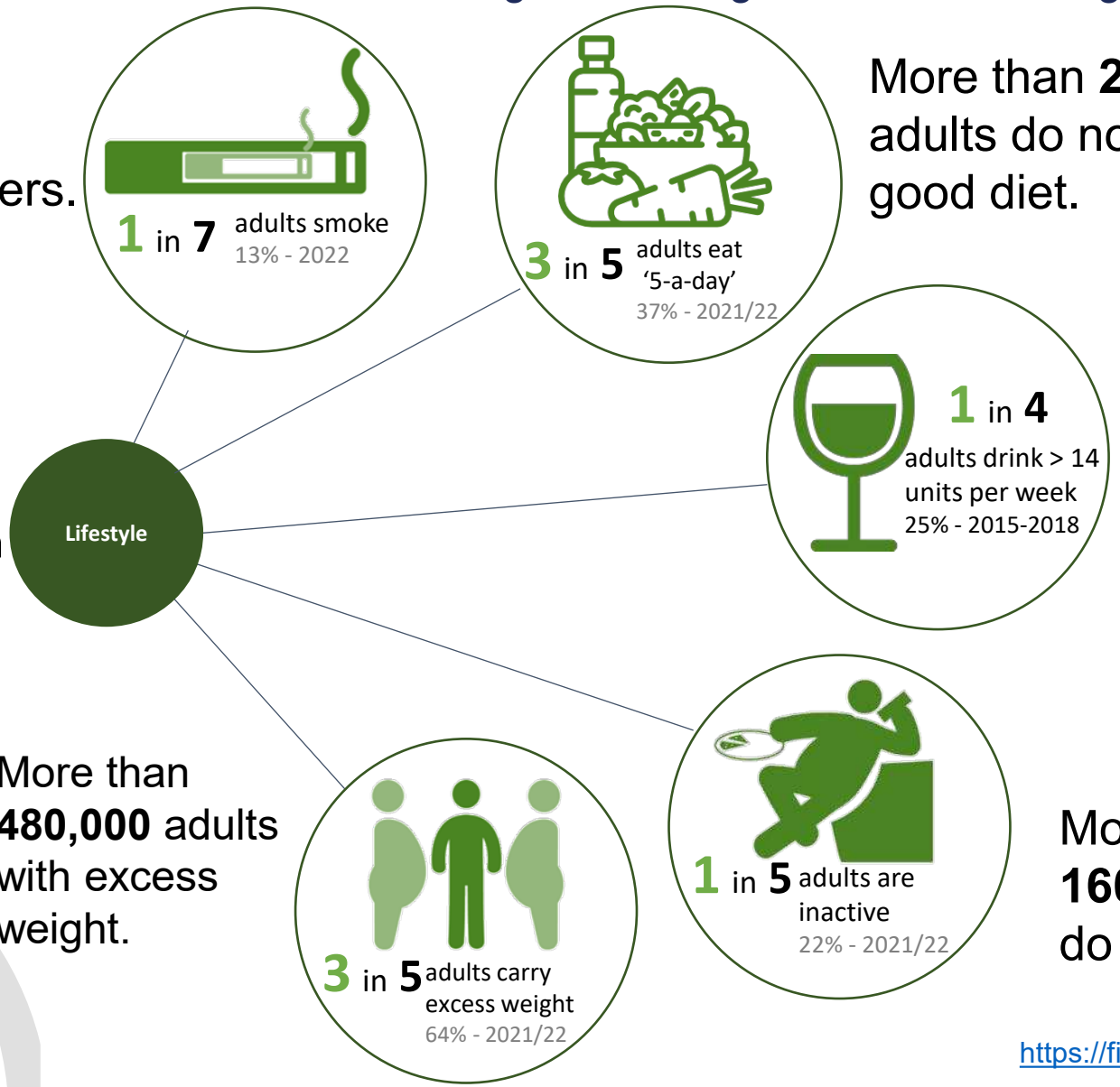
Global Burden of Disease information highlights that tobacco use is the largest contributor to deaths in Norfolk: https://www.healthdata.org/gbd/2019

Risk factors:

- Lifestyle
  - Alcohol
  - Excess weight
  - Diet (processed food, lack of fibre etc.)
  - Smoking
  - Physical Activity
- Infection agents (e.g. HPV)
- Environmental and occupational
  - Asbestos
  - Other environmental exposure
  - Sunlight
  - Radiation

Risk factors

- For lifestyle factors that increase cancer risk in Norfolk, smoking prevalence, overweight adults, inactivity and alcohol consumption rates are similar to the England average, and those eating 5-a-day is significantly better:



https://fingertips.phe.org.uk/

Norfolk County Council

Officer Contact:

If you have any questions about matters contained in this presentation,

please get in touch with:

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Tel: 07825 851227

Email: abhijit.bagade@norfolk.gov.uk / abhijit.bagade@nhs.net

Further detailed information is available on the Norfolk Insight website:
https://www.norfolkinsight.org.uk/jsna/healthcare-evaluation/

Norfolk County Council

Item No: 9

Report title: Driving Integration through system wide training opportunities

Date of meeting: 06 March 2024

Sponsor (ICP member): Debbie Bartlett, Executive Director of Adult Social Services, Norfolk County Council

Reason for the Report

We are seeking Integrated Care Partnership acknowledgement for the current approach to system wide training, organisation, and delivery and to recognise the opportunities for future partnership development and oversight through the People Board. This report builds on the ICP development session on the 31 January 2024 at which ICP members discussed considerations in creating effective system training, education, and leadership. Direct feedback received from the ICP development session is also included in this report in Appendix 1.

Report summary

Historically there has been joint Learning and Development (L&D) and Education organised/delivered across Health and Social care to meet needs identified for specific target groups and partners, with some limited involvement of the voluntary sector.

This report shares examples of current activities and highlights further opportunities for us to learn together and from each other. It covers:

- Current joint L&D/Education activity and opportunities for increasing system wide activity.
- How we can identify future system wide activity and where we should focus.
- Challenges to overcome e.g. funding sources.

Recommendations

The ICP is asked to endorse:

a) The oversight of the Learning and Development workstreams in the ICS through the Norfolk and Waveney system People Board.

b) The principle that clinical education/training opportunities are expanded collaboratively across the system where a new need is identified e.g. delegated health interventions, to enhance joined-up care across the system.

c) Use ongoing development of delegated Healthcare training and implementation of Oliver McGowan Mandatory to build principles of joint training and share knowledge to improve our understanding of effective partnership delivery over the next year.

d) Development and delivery of a system training transformation programme over the next three years including:

   1.) The development of a system “skills passport”

   2.) A systemwide approach to leadership and management development which is a key enabler of a “One Workforce” approach

   3.)The development of an approach to pooling training resources including all ICS partners.

e) Longer term exploration of a system wide Learning Management platform (recognising the data governance, financial and organisational challenges that this would entail as we mature as a system).

1. Background

1.1 Norfolk and Waveney Integrated Care System (ICS) has a good history of co-operation in relation to delivering joint training. As we move to more integrated service delivery this becomes increasingly important.

1.2 Professionals/employees in partner organisations need a shared understanding of:

- Practice
- Processes/responsibilities across partners
- How we engage with service users/patients

2. Joint Learning, Leadership and Development/Education

2.1 **Current activities:** The activities below are just some of those that are currently delivered across the ICS.

2.1.1 **Safeguarding Adults/Mental Capacity Act Training:** This is offered by Norfolk County Council (NCC) to its own employees, the private care sector, and voluntary organisations in Norfolk. It offers a suite of 12 Safeguarding courses and 5 Mental Capacity Act Courses, funded by NCC with a small charge for delegates from partner organisations.

2.1.2 **Safeguarding Children Partnership offer:** The Partnership delivers over 25 tutor-led courses, covering a wide range of safeguarding and practice topics. The offer is part funded by three statutory partners, with charges for attendance depending on employer status.

2.1.3 **Training for Family Hub Workers:** NCC is organising training for Family Hub Workers and the wider workforce e.g. midwives, school staff, school and community teams, voluntary services e.g. Homestart. It covers a variety of topics e.g., Solihull approach, Parents as Early Education Partners, Infant feeding, Perinatal mental health. The work is part project funded, with some single agency funding.

2.1.4 **Education and Training Opportunities for Health and Social Care Staff:** The Clinical Education Team (Norfolk & Waveney ICB) organise multiple short courses e.g. suicide awareness, dementia awareness, dressings; 1 hour bite-size sessions; placement visits. These are funded through collaboration across the ICS.

2.1.5 **East of England Leadership and Development Offers:** In addition to the NHS leadership programmes, the NHS East of England Academy offers the following for senior leaders/managers:

- **Inclusion, Equality and Diversity Training :** Go to leadershipacademy.nhs.uk to read more about Inclusion, Equality and Diversity Training.
- **Coaching and Mentoring:** For more information on Coaching and Mentoring go to leadershipacademy.nhs.uk,
- **Leadership Development and Wellbeing resources:** Go to leadershipacademy.nhs.uk to read more about Leadership Development and Wellbeing resources.
- **Introduction to Leadership & management:** Go to leadershipacademy.nhs.uk to read more about Introduction to Leadership and Management.
- **Influencing skills:** Go to leadershipacademy.nhs.uk to read more about Influencing skills training.

2.1.6 **Apprenticeships:** NCC have put in place a procurement framework that can be accessed by NHS and other public sector organisations in Norfolk and Suffolk. There is also a portal that allows NHS organisations to share their levy with other providers in the system. In the future, joint training needs analysis/delivery of apprenticeships could be achieved.

2.1.7 **Care Support Worker Development Programme:** This development programme aims to retain care support workers. The first programme launched in November 2023. It delivers online workshops on confidence, communication and record keeping, empowerment, understanding of learning disabilities and autism, mental health and wellbeing, coaching skills, and personal development. Early lessons are that partnership working can develop and deliver a programme that is relevant to the cross-system workforce that aims to address a shared challenge.

2.1.8 **The Health and Care Academy:** The Health and Care Academy was established by the James Paget University Hospital (JPUH) in 2018 to attract young people in years 12 and 13 into the sector. It helped this cohort to understand the roles that exist and the opportunities/pathways they can follow. This project has linked to schools and sixth forms to identify young people interested in exploring health and social care careers. The academy is now a systemwide project supporting all of Norfolk and Waveney. 367 participants have been involved since 2020. It is currently being extended to work with year 10 students. The updated design is looking at a model that uses technology to show all options/ roles available. It will focus on those where there are significant vacancies.

2.1.9 **A systemwide approach to leadership development**: In 2023 the ICS engaged Newton Europe to undertake a diagnostic of opportunities to improve HR productivity across the ICS. One of four “Upscaling HR” initiatives is the development of a systemwide approach to leadership and management development. This is a key enabler of a “One Workforce” ICS approach and deliverables include developing a standard catalogue of development programmes tailored to different management and leadership levels. This will include identifying where bespoke training is required for specific staff groups or organisations.

2.2 Future opportunities for joint training and development

2.2.1 **Oliver McGowan Mandatory Training (OMMT)**
OMMT is the preferred and recommended training package to support registered providers to meet the legal training requirement for Learning Disabilities and Autism. Oversight is through the ICS LD&A Board. The ICB is coordinating a plan with stakeholders to consider the most appropriate approach to ensuring the standards in the code of practice are met. The model of delivery is complex and requires a significant level of resourcing. It falls into two tiers with eLearning and trainer trios. We have investment from NHS England to pump prime roll-out. A sustainable model will need partner or employer investment ongoing.

2.2.2 **Delegated Healthcare Interventions:** In care settings, care workers may be asked to conduct healthcare interventions that are usually undertaken by a regulated healthcare professional. Ensuring this is done safely is paramount, and a Delegated Healthcare Interventions Framework has been developed. A task and finish group of commissioners across health and social care, including those involved in care market skills development, are determining how the framework can be used. This involves overcoming the challenges of access to, and the cost of, training for care workers; understanding what the activities are; ensuring training is available and that providers and healthcare professionals are aware of the offer.

2.2.3 **Skills Passport:** Nationally the NHS has been piloting with junior doctors a skills passport for the transfer of information across multiple NHS providers. The Government Care Workforce pathway says that Adult Social Care will introduce a digital skills passport by spring 2025 to improve portability of training between care and adult social care employers. Opportunities should be explored to how these two programmes may be aligned to create a universal systems skills passport enabling the development of a portable portfolio of skills

attained both through learning programmes and practical experience within a range of health and care services.

2.3 How we can identify future joint activity and where we should focus

2.3.1 We believe opportunities for future system collaboration fall into the following areas:

- New legal/statutory requirements that span the system e.g. Oliver McGowan Mandatory Training
- Meeting increasingly complex care needs e.g., delegated healthcare interventions.
- Joint board development work
- Shared challenges e.g., retention (Scope for Growth)
- In-person events - to improve collaboration and understanding across the partnership
- Forums for conversations to identify joint work areas e.g., Care Certificate, further levy sharing – joint identification of future use, senior talent pools, digital learning, joint delivery platform for running programmes.
- The sharing of workforce strategies between partners, to provide opportunities to harmonise and coordinate efforts.
- Opportunities to further develop and collaborate on system leadership offers.

2.3.2 We suggest that the best current forum to ensure that oversight and cooperation of this work is through the ICS People Board, whilst acknowledging that not all system partners are represented at the People Board (e.g., district councils).

2.4 **Challenges to overcome:** We acknowledge there are challenges to more effective joint working for example:

- Differences in language used in healthcare and social care.
- Organisational policies and practices.
- Requirements of specific/specialist training based on role and profession.
- Perceptions of parity between NHS and social care, and the voluntary sector.
- Funding complexities.
- No shared Learning Management System (to provide data for mandatory courses).
- Data sharing agreements.
- Advertising across organisations.
- Using manual workarounds to add 'external delegates' to internal courses.
- How we work with Higher Education – particularly in leadership and management.
- The challenge of changing the pressurized culture prevalent across all partners to create a culture which supports and empathises the importance of training and development as a prerequisite for success in an employee's role, not a hindrance.

2.5 Next steps and recommendations

2.5.1 The ICS L&D/Education Community will continue to explore joint initiatives wherever appropriate.

We highlight the need for continued oversight of the L&D workstreams in the ICS through the People Board.

We propose that the initial focus as an ICS is on:

- Delegated healthcare training to upskill the care market - this is already part of the ICS quality programme workstream.
- Oliver McGowan Mandatory Training - this has already started as a joint project.
- The work taking place to upscale NHS HR services to support development of a systemwide approach to leadership.

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2.5.2 We also request that the ICP consider the following:

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- Development and delivery of a specific system training transformation programme to support a mature system conversation around leadership and training opportunities for all partners, including the voluntary sector. This should look at initiatives such as a “system skills” passport, joint approaches to system leadership and the pooling of resources including finances.

- The exploration of procurement of a systemwide learning platform (recognising the financial and organisational challenges that this would entail)

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

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Considerations in Creating Effective System Training, Education and Leadership

Scale :
27,000+ wte health staff
27,000+ wte in NCC/ASC market
4000+ registered charities in VCSE

Mandatory training vs Education vs leadership

Delivery methods - In person versus online, eLearning versus tutor led

Size and shape of organisations – NHS versus SMEs/national companies in care sector

Language e.g. “patients” in a healthcare setting, “service user” in a social care setting

Appropriately skilled people to offer training e.g. experts by experience

- workforce capacity to prioritise training
- Communication of system offer

- Professional role requirements
- Statutory body regulations

- IT access and functionality
- Data protection and information sharing

- Transferability of training across sectors
- Assessment of competencies

- Governance arrangements, policies and procedures - where when and who?

- Finances
- Joint funding?

"How do you plan to contribute to the enhancement of ICS system training and skills development in the future?"

Summary of Themes from Workshop

•**The need for an ICS Workforce Strategy: h**ow to make the strategy visible to leaders, how to collaborate and share good practices across organisations, how to identify and address the training and skills needs, and how to develop and retain the ICS workforce.

•**Training and skills:** The workshop emphasizes the need for clear and shared training approaches across the ICS, and the need to develop joint initiatives such as a skills framework, a training needs analysis and joint training opportunities. common idea that emerges from the themes is the need for a training passport that allows the workforce to have transferable skills and qualifications across the system.

•**Leadership:** The workshop suggests leadership development and culture are important for the ICS, and proposes ideas such as a local leadership academy, a system leadership value, and Schwartz rounds.

Funding and branding: The workshop highlighted the possibility of approaching the private sector for funding opportunities, and the need for a consistent and positive branding of the ICS and its roles.

•**Collaboration and integration:** The workshop highlights the benefits and challenges of collaboration and integration across the ICS, such as breaking barriers, sharing good practices, pooling resources, co-locating staff, and supporting the voluntary sector, how to engage with the private sector, the local schools, the communities, and the voluntary care sector for potential outreach, and support opportunities.

•**Retention and succession planning:** The workshop identifies the need for retaining and developing the existing and future workforce, and suggests strategies such as talent spotting, personal development, internal workforce market, positive image, and outreach to schools and communities.

•**Existing initiatives:** some examples of existing or potential initiatives that align with the themes, such as the Queen Elizabeth Hospital and schools project, the CERA social care online platform, the Schwartz rounds, and exploring a Norfolk graduate scheme.

All Comments from Workshop

•how we make our ICS workforce strategy visible to us as leaders
•Queen Elizabeth Hospital-working with local schools
•being clear on what training and skills are needed
•how can we share good practise
•How we view skills and training at the place level
•Shared training open up more learning and development, particularity mandatory and in person you be shared between parties
•leadership - bring back leadership programme leadership Academy at a local level
•debate about whether you do this across organisations or you have a set of principles delivered in an individual
•How we approach approaching private sector for potential funding opportunities
•training passport - training that applies in all parts of the ICS
•Should be
•Focused on personal development talent spotting and developing potential
•Joint and shared training for system leaders training needs analysis
•focus on retention and succession planning
•Set up on internal workforce market across the system
•Aware of what communities need from us as system providers
•continue to enable HR and Comms leads across Norfolk and Waveney to meet and collaborate
•be aware of what funded training and which role/post needs training to deliver health and social care related outreach community support reply
•how do we nurture good culture/leadership – the health and WB is a good opportunity to do this
•routes for People/residents into health and social care jobs grow our own; volunteering employability life skills etcetera
•Need positive image/brand to promote health and social care job roles EG born in Norfolk made in the NHS
•we need to sell the vision
•training for future workforce new role/AI/new clinical development/passport
•Agree common gaps and target these first
•prioritise cross organisational training
•start small

•create capacity for change
•training on things I.e. safeguarding which many organisations need
•leadership training together
•offer a percentage of spaces to system colleagues
•training apps
•shadowing each others roles
•ICS induction
•human library (EG borrow a social worker)
•secondment to a partner organisation
•skills passport
•job family apprenticeships - cohort of apprentices who spend time in several ICS organisations
•Norfolk graduate scheme
•colocation of staff
•shift culture on mandatory training to personal career development
•long term workforce planning train now for roles we struggle to recruit
•Use nearly learned skills to train others in organisation
•System leadership value prioritise release time
•Neighbourhood level conversations
•health and well-being board facilitating conversations
•link with tier 3
•flex the workforce
•volunteering opportunities within the system
•provide other opportunity to train and develop
•Integration collaboration share information
•CERA - social care online platform AI benefits terms and conditions built in CPD
•2 way process - VCSE - more engagement and support needed
•Train the trainer
•Create capacity to change
•Collaboration between further education higher education COWA
•passport skills elearning
•educational and skills framework
•transferable skills mutual recognition
•pooling training
•do fewer things better
•future needs
•Schwartz rounds - non hierarchical safe space to describe experiences
•ICS workforce strategy
•Benefits retention and reduced sickness levels
•QEH and schools project

•agreed principles agreed core syllabus
•Understanding core themes
•mapping skills to recognised qualifications
•shared ownership of the challenges
•breakdown of barriers that stop us joining up
•training needs analysis to deliver agreed priorities
•joint training opportunity blended and face to face (connections)
•Challenges of siloed training budget
•change the narrative system not organisational
•language (patient/ service user/citizen)
•leaders drive the training agenda
•training passport
•create capacity for change
•training on things I.e. safeguarding which many organisations need
•leadership training together
•offer a percentage of spaces to system colleagues
•training apps
•Branding unrecognised
•cross functional perspective managing multidisciplinary teams opportunity of common training
•see the workforce as a collective resource
•breaking barriers
•able to take longer term perspective
•trusted assessor
•knowing who to call
•ability to support voluntary care sector
•economies of scale
•better mixing across organisations
•agreed principles agreed core syllabus
•Understanding core themes
•mapping skills to recognised qualifications
•shared ownership of the challenges
•breakdown of barriers that stop us joining up
•training needs analysis to deliver agreed priorities
•joint training opportunity blended and face to face (connections)
•Challenges of siloed training budget
•change the narrative system not organisational
•language (patient/ service user/citizen)
•leaders drive the training agenda
•training passport

Driving Integration through joint learning and Development Opportunities

Improving lives **together**
Norfolk and Waveney Integrated Care System

Paul Wardle, Strategic Human Resource Business Partner - Adults, Norfolk County Council

Sharon Crowle, Head of Professional Education, Training and Development, Norfolk and Waveney Integrated Care System (ICS)

For discussion at Norfolk & Waveney Integrated Care Partnership, 6th March 2024

Next Steps & Recommendations

Next Steps

- The development of system wide joint training opportunities between disparate partners is maturing.
- The Integrated Care System (ICS) Learning and Development /Education Community will continue to explore joint initiatives wherever appropriate.

Discussion points

Our current focus as an ICS is on:

- Delegated healthcare training to upskill the care market - this is already part of the ICS quality programme workstream.
- Oliver McGowan Mandatory Training - this has already started as a joint project.
- The ICS upscaling HR programme “Improving Lives Together” which has a key workstream focused on system leadership opportunities.

Next Steps and Recommendations

- There are potentially significant future opportunities to develop system wide training programmes (including the care market and the voluntary sector) but we recognise the significant challenges of joint funding arrangements, incompatible training systems, data sharing agreements and role related training requirements.
- We would ask the ICP to consider development and delivery of a specific system training transformation programme to support a mature system conversation around leadership and training opportunities for all partners, including the voluntary sector. This should look at initiatives such as a digital “system skills” passport, joint approaches to system leadership and the pooling of resources including finances to create a genuine culture of system development.
- The exploration of procurement of a system wide Learning Management System to support a systemwide approach to training is recommended.

Norfolk and Waveney Integrated Care Partnership

Report title: Norfolk & Waveney NHS System Capital Distribution for 2024/2025

Date of meeting: 06 March 2024

Sponsor (ICP member): Tracey Bleakley, Chief Executive, NHS Norfolk & Waveney Integrated Care Board (ICB)

Reason for the Report

The purpose of this report is to inform the Integrated Care Partnership (ICP) of the NHS Norfolk and Waveney System Capital Departmental Expenditure Limit (CDEL) proposal to distribute the system resource to the Norfolk and Waveney organisation for capital infrastructure investment.

Report summary

The report highlights the process and progress made by the NHS in distributing £77.9m of available capital resource (CDEL) for 2024/25. Current proposals for the resource distributed to Norfolk and Waveney NHS organisations based on existing agreements and business cases (e.g. Diagnostic Assessment Centre (DAC), Hellesdon Redevelopment & RAAC remedial works). The proposed distribution of the CDEL resource by organisation is:

- James Paget University Hospital - £14.7m
- Norfolk and Norwich University Hospital - £14.8m
- Queen Elizabeth Hospital - £33.1m
- Norfolk and Suffolk Foundation Trust - £9.1m
- Norfolk Community Health and Care - £4.2m
- Norfolk and Waveney Integrated Care Board - £2.0m
- Total draft distribution of resource - £77.9m

The system has also been provided £10.6m for IFRS 16 (lease accounting standard adoption). This is still subject to discussion as to distribution between organisations.

In addition to system CDEL, system partners have a number of schemes and programmes funded from central NHS programmes. These programmes are agreed at national level and are for specific nationally support infrastructure developments. Once these programmes are approved, N&W ICB has no discretion or ability to redistribute these resources as these are managed at a national level. The “central programme” capital funds for the N&W ICB by programme for 2024/25 are as follows:

- National Hospitals Programme - £13.9m
- Diagnostic Assessment Centres - £35.4m
- Community Diagnostic Centres - £6.8m
- Diagnostic Imaging Capacity - £0.2m
- Elective Recovery/Targeted Investment Fund (TIF) - £5.5m
- Front Line Digitisation - £35.4m
- Urgent & Emergency Care (UEC) Capacity - £0.4m
- Total central programme costs - £99m

The total resource for the N&W ICB for 2024/25 is £187.5m (CDEL of £77.9m, IFRS16 CDEL of £10.6m & Central Programmes of £99m).

Recommendations

The ICP is asked to:

a) Receive and endorse the proposed NHS distribution of the NHS system Capital Departmental Expenditure Limit resource to deliver organisational and system capital plans.

b) Receive and note the sums assigned to the central NHS programmes for 2024/25.

1. Background

1.1 The National Health Service Act 2006, as amended by the Health and Care Act 2022 (the amended 2006 Act) sets out that an Integrated Care Board (ICB) and its partner NHS trusts and foundation trusts:

- Must before the start of each financial year, prepare a plan setting out their planned capital resource use.
- Must publish that plan and give a copy to their Integrated Care Partnership, Health and Wellbeing Board and NHS England.
- May revise the published plan – but if they consider the changes significant, they must re-publish the whole plan; if the changes are not significant, they must publish a document setting out the changes.

1.2 To support ICBs in meeting these requirements of the amended 2006 Act, ICB joint capital resource use plan templates will be issued to systems via the Public Financial Management System (PFMS) ICB portal inboxes.

2. The Norfolk and Waveney 2024/25 Distribution of Capital Resource for Capital Infrastructure

2.1 As per the above, the NHS is required to present its 2024/25 capital plan to the ICP. With regard to the identification, prioritisation and distribution process for investment, this report will only consider the system CDEL allocation. This is because it is only these sums that are for system discretion as to allocation. For central programme funded schemes, once approved N&W ICB has no discretion or ability to redistribute these resources as these are managed at a national level.

2.2 Norfolk and Waveney NHS Provider organisations are all members of the Norfolk and Waveney Strategic Capital Board (SCB). This sub-committee of the NHS ICS Board is where the prioritisation of capital proposals are considered, prioritisations are agreed and capital resource is proposed for distribution to enable the organisational delivery of capital schemes.

2.3 The available capital resources for the Norfolk and Waveney NHS ICS system distribution, as per the NHS planning financial settlements (draft) is £88.5m, £32.2m is specifically identified for the RAAC remedial works at JPUH & QEH, £10.5m is for IFRS 16 and £2m is ringfenced for the ICB re: Primary Care, this leaves £43.7m for SCB to consider for distribution.

2.4 Due to central programme funding constraints, N&W SCB has agreed to contribute system CDEL to two central programmes, these are:

- Hellesdon redevelopment with £3.8m
- The Diagnostic Assessment Centre (DAC) programme with £10.8m.

2.5 The consequence of these agreements mean that only £29.1m of the £43.7m is available for the remaining capital priorities across N&W organisations.

2.6 For 2024/25 the SCB received the prioritised programmes from each NHS organisation. As per the agreed process of the SCB, for the above requests each organisation prioritised their proposals in the categories of:

1) Prior Commitment/already agreed and commenced.
2) Legal/statutory compliance requirements.
3) Care Quality Commission (CQC) compliance "Must Do", where not already identified as a legal/statutory issue.
4) System wide strategic priority schemes.
5) Other “local” schemes.

2.7 Items specifically idented in 1, 2 and 3 are prioritised as first call on the CDEL resource. Items categorised in 4 or 5 are individually assessed and given a score of one to ten (ten high) on three categories with a weighting as per the below:

2.8 **Patient and public safety – 60% Weighting**

- Addressing current high risks relating to one or more of the following areas, which cannot be mitigated through alternative routes at lower cost e.g.
- Clinical safety (not clinical quality), i.e. where there is high risk of patient harm.
- Health and safety of patients, staff and/or visitors.
- Fire safety.
- Cyber security.
- Regulatory instruction in relation to safe patient care, e.g. CQC ‘must do’.

2.9 **Maintaining an acceptable level of service quality – 30% Weighting**

- Addressing current high risks, for existing services, relating to one or more of the following areas, which cannot be mitigated through alternative routes at lower cost.
- Clinical quality which adversely impact patient experience but do not carry high risk of patient harm.
- Service continuity.
- Regulatory instruction in relation to quality of patient care, e.g. CQC ‘should do’.

2.10 **Business case (strategic and financial case) – 10% Weighting**

- A sound case for investment based on strategic fit and financial case.

2.11 Utilising this process all capital scheme proposals are able to be ranked, prioritised and assessed for capital resource funding.

2.12 Due to the limitations of the resource availability a number of iterations were undertaken by the SCB, reviewing and challenging the prioritisations. Also to enable the alignment of CDEL to organisational cash balances that enable the purchase of capital assets and infrastructure, the resource needs to be considered against the proportional %s of organisational depreciation charges. The 2023/2024 proportions of depreciation charges for each organisation are as follows: JPUH 18%, NNUH 30%, QEH 20%, NSFT 18% and NCHC 14%.

2.13 The proposed distribution for each organisation for 2024/25 is shown in the table:

Norfolk and Waveney Capital Plan prioritisation	JPUH	NNUH	QEH	NSFT	NCHC	ICB	Total Funds
System CDEL	£5.2m	£8.7m	£5.7m	£5.3m	£4.2m	£0.0	£29.1m
Diagnostic Assessment Centre (DAC)	£2.3m	£6.1m	£2.4m	£0.0	£0.0	£0.0	£10.8m
Hellesdon	£0.0	£0.0	£0.0	£3.8m	£0.0	£0.0	£3.8m
System CDEL Sub total	£7.5m	£14.8m	£8.1m	£9.1m	£4.2m	£0.0	£43.7m
RAAC remedial works	£7.2m	£0.0	£25m	£0.0	£0.0	£0.0	£32.2m
ICB	£0.0	£0.0	£0.0	£0.0	£0.0	£2m	£2.0
Total cost	£14.7m	£14.8m	£33.1m	£9.1m	£4.2m	£2m	£77.9m

3. 2024/25 Central Programme Funding

3.1 In addition to system CDEL, system partners are able to bid and obtain funding for specific infrastructure funding from “central programmes”. These programmes are agreed at national level and are for specific nationally supported infrastructure developments. The table below shows these central programme capital funds by organisation for 2024/25.

Central Programme Title	JPUH	NNUH	QEH	NSFT	Total Funds
National Hospitals Programme	£12.1	£0.0	£1.8m	£0.0	£13.9m
Diagnostic Assessment Centres	£3.5m	£28.4m	£3.5m	£0.0	£35.4m
Community Diagnostic Centres	£6.8m	£0.0	£0.0	£0.0	£6.8m
Diagnostic Digital Capability Programme	£0.1m	£0.0	£0.1m	£0.0	£0.2m
Diagnostic Imaging Capacity	£0.0	£1.4m	£0.0	£0.0	£1.4m
Elective Recovery/Targeted Investment Fund	£5.5m	£0.0	£0.0	£0.0	£5.5m
Front Line Digitalisation	£7.2m	£18.5m	£9.0m	£0.7m	£35.4m
UEC Capacity	£0.0	£0.0	£0.0	£0.4m	£0.4m
Central Programme Total					£99m

3.2 Once agreed between organisations and the specific national programme team N&W ICB supports the delivery but doesn’t have any ability to redistribute funding to other priorities. The review and monitoring of these programmes at system level is undertaken at the SCB.

3.3 The highest profile of these central programmes is the New Hospitals Building Programme. The James Paget Hospital & Queen Elizabeth Hospitals have been included in the Government’s programme and the plan is for the new hospitals to be built by 2030.

3.4 The Diagnostic Assessment Centre (DAC) is also a significant development in N&W which will increase diagnostic facilities across Norfolk & Waveney. The programme creates three separate centres, adjacent to each of the acute hospital sites. JPUH also has funding to create a Community Diagnostic Centre which is scheduled for completion in 2024/25 and is co-located with the JPUH DAC.

3.5 The Front-Line Digitisation funding across the three acute hospitals is primarily associated with the acute Electronic Programme Record (EPR), which has been developed across acute organisations as an integrated patient records solution. EPR will enhance patient care by empowering clinicians, providing them with the right information at the right time. It will enable integration of acute services across the three trusts and improve the recruitment and retention of skilled healthcare professionals. The scheme spans several years and is expected to be majority funded via the digital national programme funding.

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

Norfolk and Waveney Integrated Care Partnership

Report title: Norfolk and Waveney Integrated Care System Suicide Prevention Strategy 2023-2028

Date of meeting: 06 March 2024

Sponsor (ICP member): Stuart Lines, Director of Public Health, Norfolk County Council

Reason for the Report

The suicide prevention strategy for the ICS is a partnership commitment to act collectively to tackle suicides in the locality. The strategy incorporates action from a range of organisations working in partnership, recognising that suicide is everybody's business. Members are therefore encouraged to review the proposed intentions of partners over the next five years so as to be informed and ready to act.

Report summary

The Norfolk and Waveney ICS Suicide Prevention Strategy 2023-2028 is attached and submitted for the ICP to review. Member representatives are asked to endorse the strategy and reassure themselves that their organisations are actively participating in preventing suicide.

The strategy was developed over 2023 with local organisations attending a face-to-face workshop in the summer, and an online consultation process in the winter, as well as being brought to relevant partnership meetings as appropriate. Experts by experience have also been involved in the development of the strategy both in consultation and as members of partnership meetings.

The national suicide prevention strategy was updated in September 2023, which resulted in the delay of the local strategy to ensure alignment. The strategy encompasses a broad range of actions in many sectors, to increase the effectiveness of interventions and opportunity to prevent suicide.

Recommendations

The ICP is asked to:

a) Endorse the Norfolk and Waveney ICS Suicide Prevention Strategy on behalf of their organisations.
b) Support the commitment to joint actions on suicide prevention.

1. Background

1.1 This is the second Norfolk and Waveney Suicide Prevention Strategy. The partnership is led by Norfolk County Council's Public Health and organisations from across the statutory and voluntary and community sector work together to implement change.

1.2 There is a Suicide Prevention Leadership Group, and a Partnership Group and Information Network are in place, where learning is shared, and actions agreed. Further information is detailed in the proposed strategy attached (see appendix 1).

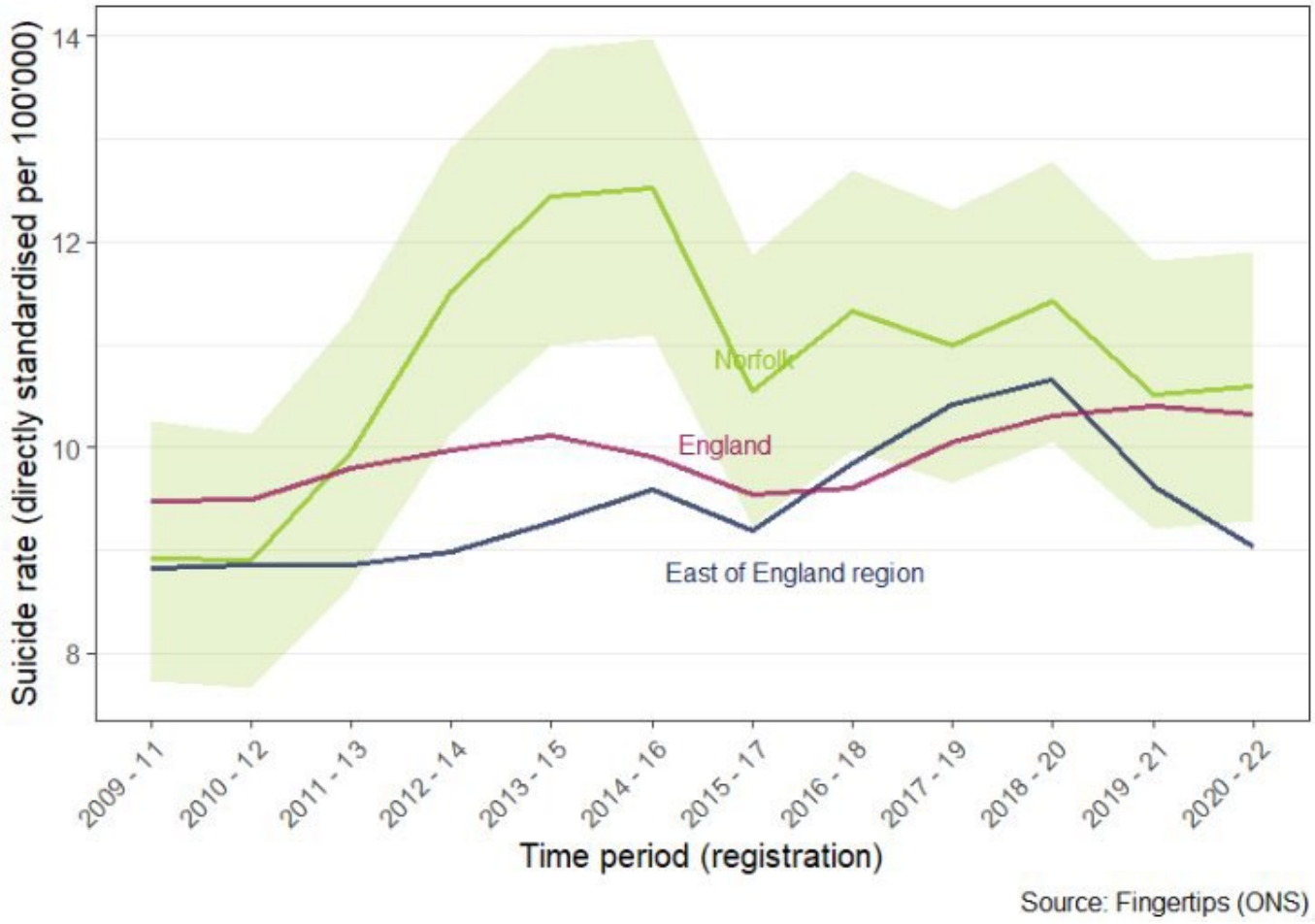
2. Suicide Prevention in Norfolk and Waveney

2.1 Implementation of the previous strategy demonstrated the strength of good partnership working and has built a strong foundation to continue to respond to the tragedy of suicide.

2.2 We have implemented evidence led approaches such as building the capacity of men's wellbeing services, and targetted bereavement support. In addition, processes have over the years, been refined to mean a responsive, mature system is in place. This includes a robust real time surveillance system for suspected suicides, and a comprehensive cluster response protocol.

2.3 We were able to attract £1m of funding over three years from NHS England which ended in 2021/2 which was used to develop services across sectors and importantly, building the capacity of community level support. Since then, we have successfully worked with partners to secure a number of commissioned services.

2.4 Following a favourable LGA peer review in 2022/3, we are confident that robust systems and leadership are in place. Also, rates of suicide have slowed in Norfolk, (see diagram 1 below).



2.5 The chart above taken from ONS (Office of National Statistics) and OHID (Office for Health Improvement and Disparities) data, shows that the rate of suicide in Norfolk has reduced considerably in recent years to 10.6 per 100,000 people from 2020-2022, from a high of 12.5 per 100,000 people in 2014-16, and is now nearer to the national average.

2.6 However, there is still more to do to reduce the number of suicides. Addressing health inequalities in particular are a focus of attention in this next iteration. As is increased use of safety planning tools across organisations. Working closely with our counterparts in Suffolk, we have also begun regular monitoring of suspected suicides in the Waveney area. We are also mindful of the need to strengthen links with partnerships in the county

and ICS that will impact on our own strategy, such as the local Autism Strategy, and Domestic Abuse partnership working.

2.7 Challenges for delivery of the strategy still remain. There are few opportunities for prevention interventions to access funding at the scale required. Some statutory services have reduced capacity to respond to need effectively. However, the partnership continues to strive to reduce the number of local suicides with the resources available.

2.8 The ICP has representative organisations which take an active role in the prevention of suicide, partners are asked to ensure that leadership is robust through affirming commitment to action and endorsing the strategy.

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Norfolk and Waveney Suicide Prevention Strategy Draft 2023 – 2028

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Call Samaritans for free on 116 123, email them at jo@samaritans.org, or visit www.samaritans.org
Or visit this page for more ideas of where you can get support www.norfolk.gov.uk/care-support-and-health/health-and-wellbeing/adults-health/suicide

Introduction

Suicide is not inevitable, and everyone can have a role to play in helping someone else find the breathing space to make a different decision, whether a friend, colleague, family member or neighbour.

People who take their own lives may face several challenges. Offering easily accessed local community support and activities, and the chance at hope, could help someone to pause and reconsider.

The Norfolk and Waveney Integrated Care System Suicide Prevention Strategy 2023-2028 will build on the progress made so far in addressing the risk factors and increasing the protective factors around suicide.

Having reviewed the intelligence and engaged with stakeholders, the key themes identified locally are men's wellbeing, bereavement, self-harm, primary care and autism. There will be a greater emphasis on specific groups that are affected, such as autistic people or men from diverse backgrounds, as well as continuing to build on the existing good practice in relation to surveillance.

The strategy outlined below reviews progress and looks to the next five years. Many factors influence an individual's decision to take their own life. Suicide prevention is everybody's business, which means that actions should not be limited to what takes place in the suicide prevention partnerships. Individuals, communities, workplaces and organisations that serve communities all have a role to play in preventing suicide.

The strategy looks forward five years but is not limited to the actions outlined, these guide partners based on evidence but there is a commitment to remain flexible and responsive to emerging areas of concern and implementing innovation and good practice.

Key principles

- Listen to people in our communities.
- Coproduce plans with experts by experience and partners.
- Remove barriers to action.
- Understand that some challenges are outside our collective control, but that we all have responsibility.
- People can be supported to stay safe in the community, with friends, family, workplaces, and services all with a role to play.

National Picture

We welcome the updated government suicide prevention strategy and have considered it alongside local intelligence, to inform refreshed priorities for the local partnership. The national strategy, published 11th September 2023, will focus on evidence relating to the following key concerns:

Over the next 5 years, priorities for action include:

1. Improving data and evidence to ensure that effective, evidence-informed, and timely interventions continue to be developed and adapted.
2. Tailored, targeted support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.
3. Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.
4. Promoting online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
5. Providing effective crisis support across sectors for those who reach crisis point.
6. Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.
7. Providing effective bereavement support to those affected by suicide.
8. Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

Suicide prevention in England: 5-year cross-sector strategy - GOV.UK (www.gov.uk)

The Norfolk and Waveney ICS (Integrated Care System) suicide prevention strategy will align with the national strategy paying particular attention to where local evidence is strongest.

Summary

Looking back 2016-2023

Since the last strategy was implemented, starting in 2017 there has been considerable progress in working together to tackle suicide prevention in the Norfolk and Waveney integrated care system.

More than £1m was drawn into the local area to tackle suicides, and the partnership was able to **build community capacity**, develop the skills of frontline staff and raise awareness of stigma as a result.

Significantly, Norfolk saw a **slowdown** and **slight decrease** in rates of suicide, with rates now closer to the average in England, bearing in mind the number of deaths before 2016.

Milestones Achieved

Milestone: Deliver a campaign to raise awareness and reduce stigma across the county.	Achieved: The 'I am really not ok campaign' was launched with the strategy alongside resources for individuals, loved ones and professionals so that people could get help and stay safe.
Milestone: Publish guidance which emphasises safety planning and making the environment safe and distribute it online. Updated guidance in 2023	Achieved: Norfolk Suicide Prevention Guidance for Professionals Training Document Interactive 2016 2021.pdf

Milestone: Make a website resource available listing local and national support for people in crisis – putting it all in one easily accessible place.	Achieved: Suicide prevention - Norfolk County Council
Milestone: Make sure that training on suicide prevention is available for professionals in the county.	**Achieved:** almost 600 front line staff from a range of organisations trained in suicide prevention awareness and first aid since 2018. **Achieved**: approximately 200 barbers trained in mental health first aid **Achieved:** nearly 300 people trained in bereavement support in the workplace

What else was achieved

- A partnership between Norfolk County Council Public Health, Norfolk and Suffolk Constabulary and the Coroner's office, with input from Norfolk and Suffolk Foundation Trust (NSFT) the local mental Health trust, set up a **real time surveillance system** to monitor trends and identify potential clusters as early as possible so as to take partnership action. This has been in place since 2019 and has now moved to an automated software system.
- Agencies came together in 2017 and 2018 around world suicide prevention day to share good practice, experiences and hear from people affected by suicide highlighting the importance of **working together.**
- A self-harm data project has been set up, with hospital data analysis underway.
- A task and finish group to tackle concerns around **specific locations**, which although not high frequency, give cause for concern, has led to cooperation between Norwich City Council, the Constabulary, and Norfolk County Council to 'design out' safety concerns.
- A one-year partnership pilot project between NSFT and young people's charity MAP (The Mancroft Advice Project) to tackle self-harm funded by Norfolk County Council Public Health 'RUSH (Rapid Response Pathway)' project. This project has since been commissioned to continue by the Integrated Care Board (ICB).

What is happening for residents right now?

The most recent suicide prevention audit for Norfolk (2022) has demonstrated that similar challenges to previous years remain.

At-a-glance key findings, for Norfolk:	
Suicides in Norfolk are largely consistent with national data regarding rates, cohorts, and personal risk factors.	
Suicide rates are high in Norfolk, but not significantly higher than the England average in the most recent time periods.	
Norwich has consistently had the highest or second highest suicide rates among the Norfolk local authority areas.	
Around three in four individuals who die by suicide are men.	
The risk of suicide is highest in middle-aged and very old men.	
Deprivation is a key factor, as is being born in an EU (European Union) country	
Most suicides occur at home and by hanging.	
Risk Factors:	**Protective Factors:**

○ Unemployment ○ Living alone ○ Relationship breakdown ○ Addiction ○ Poor Physical Health ○ Bereavement ○ Adverse Childhood Experiences ○ **The most common predictor of suicides is attempts made.**	○ Access to work ○ Financial security ○ Good quality relationships ○ Good physical wellbeing ○ Pain management if experiencing physical health challenges. ○ Support networks to manage life challenges.

Proposed Key Milestones

National milestones are highlighted in bold:

- Rates of suicide continue to slow down and are further reduced:
  - **Reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner.**
- Residents are made aware of local support and are better connected to their communities.
- Primary care staff, particularly general practice, have clear pathways to support people diagnosed with depression and low mood who are prescribed anti-depressants, towards wellbeing initiatives alongside medication.
- Frontline staff across sectors are aware of pathways into support, whether community or primary care.
- The number of unexpected deaths reported by the local mental health trust goes down.
- **Improve support for people who have self-harmed.**
- **Improve support for people bereaved by suicide.**

Governance

In January 2023, the LGA (Local Government Association) completed a review of the Suicide Prevention Partnerships in place. Stakeholders were interviewed, and it was concluded that the existing structures in place were robust and should remain as they are. The governance structure can be accessed separately alongside this strategy.

- The Suicide Prevention Leadership group will monitor progress against the milestones outlined.
- The Suicide Prevention Partnership group will be responsible for implementation of the framework for action.
- The Suicide Prevention Information Network will share good practice, learning and innovative solutions to ensure the partnership is well informed and our approach robust.

Below is a framework for action – timescales and milestones will be agreed with partner organisations involved in the delivery of the agreed actions in greater detail and with assigned responsibilities with a programme management approach. It is intended that a 'live' programme plan will assign tasks, monitor progress and respond flexibly to challenges with

oversight from the Suicide Prevention Partnership Group. What is outlined below is the overarching ambition of the partnership.

A framework for action

Improving data and evidence to ensure that effective, evidence-informed, and timely interventions continue to be developed and adapted.

Norfolk and Waveney have robust systems in place which provide timely data for immediate action, as well as robust data for targeted local action. We commit to the following:

Actions

- Continue with real time suicide surveillance (RTSS) using automated software, in order to monitor risks and highlight concerns for partnership action, including working with Suffolk County Council to ensure parity in Norfolk and Waveney data.
- Continue to produce suicide audits every two years to inform long term activities and areas for partnership action.
- Continue the Self Harm Data Pilot Project with NSFT and local hospitals.
- Produce a Self-Harm data report informed by the above project.
- Evaluate the impact of services.
- Local organisations will liaise with regional and national colleagues on the roll out of the National Suicide Surveillance System as outlined in the national strategy.

Tailored, targeted support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.

Locally the evidence available highlights the priority groups below should have additional consideration as the highest risk groups:

- **Children and young people who self-harm**
- **People who have made known previous suicide attempts.**
- **People who have had wellbeing contact with primary and secondary care services.**
- **Autistic people**
- **People who are lonely**
- **Men who have experienced relationship breakdown**
- **Older men with long-term limiting physical health conditions**
- **Men from diverse backgrounds**

This reflects most of those groups prioritised in the national strategy, highlighted above in bold.

Actions

Children and Young People

- Support Norfolk's Higher Education and Further Education settings to promote wellbeing and where appropriate join the University Mental Health Charter and become Suicide Safer Universities.
- Enable schools to address bullying and support mental health.

Self-Harm and previous suicide attempts

- Self-harm training and policy for schools and community
- Targeted approaches for those groups identified in the local Self-Harm data report.
    - Pathways into appropriate support for those discharged from hospital
    - Review of existing support services for most vulnerable groups

People who have had contact with primary and secondary care services

- NSFT strategy and action plan
- NSFT will deliver a carers pack for families and carers supporting loved ones.
- Ensure primary care pathways for people with common mental health disorders adheres to NICE guidance and monitor processes for those people who are prescribed anti-depressants.
- Review how pain management pathways consider mental wellbeing i.e., depression/anxiety screening/responses for patients with long term physical conditions.

Relationship breakdown

- Strengthen pathways into relationship support via community and voluntary sector services.
- Tailored relationship advice services to underserved groups.

Men and Social Isolation

- Target loneliness initiatives at men and younger cohorts
- Continue to strengthen community interventions which target men such as Menscraft, or 12th Man.

Autistic People

The Norfolk All Age Autism Strategy will factor in suicide reduction and endeavor to address the key concerns identified both in the national Suicide Prevention Strategy, and in local feedback as:

- Undiagnosed or late diagnosed Autism may be preventable risk factors for suicides.
- Following national guidance on accessible mental health services for autistic people.
- Learning from the Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) programme to identify areas for improvement to prevent suicides.

Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.

Nationally the following population risk factors have been identified:

- physical illness
- financial difficulty and economic adversity
- harmful gambling
- substance misuse
- domestic abuse
- social isolation and loneliness

These are almost identical to the local risk factors identified.

Actions

- Partner agencies continue to provide physical activity initiatives to improve mental wellbeing.
- Partners work together to ensure that there are addiction service pathways into wellbeing services.
- Partners continue to provide Information, Advice and Guidance support to address challenges such as debt and housing.

Domestic Abuse

The following are local Domestic Homicide Review recommendations agreed by partners in the Domestic Abuse and Sexual Violence Board:

R3: The ICS' Suicide Prevention Partnership, led by Public Health, works together to support primary care to improve recognising and managing risk including safety planning for suicidal patients.
R4: Ensure that alcohol misuse is considered/addressed as a risk factor for all patients who self-harm or express suicidal thoughts and ensure patients treated/signposted accordingly.
R5: To seek to raise awareness and the ability to recognise and respond to the risk of suicide associated with the menopause.
R6: Work in Partnership to ensure that people who self-harm are in receipt of appropriate care and support.
R9a: The learning from the recent Domestic Homicide Review is shared across the partnership to raise awareness of domestic abuse, links to suicide and all the learning opportunities raised, that for primary care includes.
-using consistent terminology regarding risk assessment.
-opportunities to close the feedback loop with patients by asking how referrals had progressed.
-recognising the potential benefits of seeing the same GP (general practitioners)

Promoting online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.

The national commitment to action will be supported by local efforts in how we utilise social media and signpost people to appropriate resources, as well as how we engage with local media.

Actions

- Continue with local umbrella campaign materials 'I am really not Ok' and 'Take 5' for wellbeing – particularly in line with national campaign dates.
- Continue targeted messaging such as grief awareness week and World Suicide Prevention Day – including pointing people towards relevant resources.
- Communications targeting men to reduce stigma and encourage access to support.
- Encourage local media to adopt Samaritans media guidelines.
- Ensure that information and guidance around support is accessible, and available in different formats.
- Enable parents to recognise and address online bullying.

Providing effective crisis support across sectors for those who reach crisis point.

Although local safety planning tools are available, there has not been enough emphasis placed on this as a way of keeping people safe. It is our intention to ensure consistent, robust standards are in place around Safety Planning and we welcome national efforts to provide guidance and training.

Safety Planning

- Safety Planning training for professionals
- Increase engagement in safety planning among health care professionals.
- Promote currently available safety planning tools.
    - The Stay Alive app
    - Explore the Orange Button scheme.
    - Norfolk SHOUT Text message service
    - I am not ok campaign.
- Promote safety planning guidance and ensure updated national guidance is rolled out locally (2024)

Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.

Norfolk and Waveney does not have any high frequency locations. However, monitoring of high-risk locations takes place, and interventions are managed between partners including Norfolk County Council Public Health, Highways, Fire Service, Norfolk and Suffolk Constabulary, and Samaritans. These organisations will continue to work together to monitor and address any concerns identified**.** Regional partners monitor emerging means of suicide and alerts are reviewed for local impact.

Providing effective bereavement support to those affected by suicide.

- Working as part of the wider Compassionate Norfolk agenda to ensure that there is an accessible, one stop interface for bereavement services in Norfolk.
- Work across the system to increase capacity to support those impacted by 'complex' grief.
- Consider the timeliness and reach of services so that friends and affected others are enabled to access the right support at the right time.
- Joint communications campaigning during grief awareness week
- Clear pathways to bereavement services at appropriate access points
- Encourage organisations which provide bereavement services to use Support after Suicide Partnership resources and adhere to their core standards.
- Ensure collaboration across services and work with community teams to increase knowledge and signposting to services.

Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

- Identify opportunities to promote wellbeing for menopausal women.
- Ensure clear pathways of support for women and young people who have had adverse childhood experiences.
- Liaise with health and wellbeing partnerships in place.
- Frontline staff training on MHFA and ASIST (Applied Suicide Intervention Skills Training) and other appropriate training
- Consider how workplaces can increase wellbeing and promote good mental health.
- Commitment to continuously integrate best practice in suicide prevention (particularly for higher risk groups) via partnerships, information networks and ongoing research.

We have produced the following alongside the strategy to help inform and support organisations across Norfolk and Waveney:

- Safety Planning aid
- Guidance for Professionals
- Self-Harm Data report
- Anti-Depressant prescription report
- Updated webpages with relevant information for professionals, individuals and family or friends.

Norfolk and Waveney Integrated Care Partnership

Report title: Driving Integration Through Digital, Data and Technology

Date of meeting: 06 March 2024

Sponsor (ICP member): Tracey Bleakley, Chief Executive, Norfolk and Waveney Integrated Care Board (ICB)
Debbie Bartlett, Interim Executive Director, Adult Social Services, Norfolk County Council

Reason for the Report
At the last Norfolk and Waveney Integrated Care Partnership (ICP) meeting (November 2023) an item was brought to the attention of the partnership which described how we work collaboratively as a system to enable data sharing and what we are doing to drive integration through our digital, data and technology systems (DDaT). At that meeting the chair requested that a series of updates on driving integration through our digital, data and technology systems came to future meetings to update the partnership on this area of work. Since the last meeting the ICP has had its annual development session, in which drive integration through our digital, data and technology systems was discussed in more detail to review the progress of data sharing across the ICS, and to explore the challenges, opportunities and benefits of further collaboration and integration. This report provides a summary of the key topics and outcomes arising from the Norfolk & Waveney Integrated Care Partnership (ICP) development session that took place on 31 January 2024.

Report summary
This report and appendix provides an overview of the key topics and outcomes arising from the Norfolk & Waveney ICP development session on “Driving Integration Through Digital, Data and Technology “that took place on 31 January 2024 (see appendix 1). The session covered the current state of data sharing arrangements across the ICS and explored the challenges, opportunities and benefits of further collaboration and integration. The session benefitted from high levels of attendance and active participation from representatives of many health and social care organisations, as well as Districts Councils, voluntary and community sector partners.

The session demonstrated the commitment and enthusiasm of the ICP partners for data sharing, and the potential value it can bring for improving the health and wellbeing of the population of Norfolk and Waveney.

Recommendations
The ICP is asked to:

a) Note outputs from the workshop and immediate next steps to roll out benefits of existing data sharing and systems integrations platforms.
b) Receive a further update on progress and plans at next ICP meeting.

1. Background

1.1 This report and the associated workshop builds upon information shared at the last ICP meeting on the 8th November 2023 and the item titled “Driving Integration Through Digital, Data and Technology”.

2. ICP Development session: Data Sharing & Systems Integration

2.1 The session was facilitated by ICS digital leaders and information governance leaders.

2.2 The audience was briefed on current data sharing arrangements across the ICS and explored the challenges, opportunities and benefits of further collaboration and integration.

2.3 Various case study examples showed how current systems are benefitting practitioners and what information governance arrangements are in place to support the safe and ethical sharing of information.

2.4 Discussions on tables covered current successes, concerns and opportunities to do more.

2.5 Outputs from discussions highlighted the balance that is needed between data exploitation to improve direct care provision and population health management along with our duty to protect data and be transparent about how it is used.

2.6 Immediate next steps include workshops with district and voluntary organisations to understand how they can engage in data sharing and system integration work in order to improve their effectiveness and ultimately improve the health and wellbeing of the population of Norfolk and Waveney.

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Report on Norfolk & Waveney HWB/ICP Development Session: Driving Integration Through Digital, Data and Technology

Report Prepared by Geoff Connell, Director of Digital Services, NCC, 01/02/2024.

Introduction

This report provides an overview of the key topics and outcomes of the Norfolk & Waveney Integrated Care Partnership (ICP) development session that took place on 31/01/2024.

The session aimed to review the progress of data sharing across the ICS, and to explore the challenges, opportunities and benefits of further collaboration and integration. The session was very well attended by representatives from various health and social care organisations, as well as districts, voluntary and community sector partners.

The session was presented by Sarah Rank and Geoff Connell of Norfolk County Council along with Ian Riley from the ICB. The session also benefitted from table facilitators Anne Heath (ICB) and Nigel Gollop (NCC) and Richard Green (NSFT) all providing Digital and Information Governance expertise.

Session Summary

The session consisted of four main parts:

1. An update from Geoff and Ian on the background and context where we are currently at with data sharing and systems integration capabilities.
2. Facilitated table sessions led by colleagues form the ICB and NCC, where participants were asked to work through existing case studies that demonstrate the benefits of data sharing and to identify the key enablers and challenges for delivering the desired outcomes.
3. A feedback session, where each table shared their main findings and insights from the case studies and discussed the common themes and issues that emerged.
4. A closing session, where Sarah summarised the main points and actions from the session. Geoff and Ian and thanked the participants for their valuable contributions and engagement.

Findings and Outcomes Generated from Table Discussions

Main areas covered: Some of the key themes and challenges that emerged from the workshop were: the need to mainstream data-led prevention activities, the security and privacy of data, the role-based access to data, the patient's view of the data, the inclusion of district councils and voluntary sector, and the dispelling of myths and fears around data sharing.

- The need for business transformation capacity to ensure successful pilots were scaled up and out into mainstream new ways of working.
- ICS systems efficiency and effectiveness was recognised as the key driver, but the ability for residents to “tell their story once” was also very important.
- We should also consider how we gain intelligence regarding residents who do not currently engage with health and care services, but who would benefit from early intervention to reduce future needs.

Data Hub, NODA and Shared Care Record

- The workshop also discussed the benefits and use cases of the Data Hub, NODA and Shared Care Records. These are the primary platforms that enable data sharing and analysis across the system for improved direct care provision and analytic purposes such as population health management.
- The workshop participants expressed interest in knowing more about the data sources, the access rights, and the roadmap for these platforms.

Recommendations and actions Arising

- The workshop generated some recommendations and actions for improving data sharing and integration, such as: creating plain English FAQs and privacy notices, engaging the data experts and the public, starting small and building up, exploiting the aggregated and anonymised data, standardising the privacy notices and the lawful basis, and identifying the cross-system actions and priorities.
- These outputs from the workshop will be reviewed in the context of the N&W ICS Digital Strategy and Roadmap. Actions arising, priorities and progress will be reported to future ICP & HWB meetings.
- District authorities and voluntary sector organisations were highlighted as the ICP stakeholders most likely to benefit from the next phase of systems integration and data sharing arrangements. Next steps are most likely to leverage the Shared Care Record system but may also utilise other data sharing mechanisms such as direct system access, the Data Hub or NODA (the Norfolk Office of Data Analytics).

Conclusion

The workshop was a successful and productive event that provided an opportunity for the ICP leadership to share their views and experiences of data sharing, and to identify the key enablers and challenges for further collaboration and integration.

The discussion helped improve system wide understanding of current and planned capabilities for data sharing and integration and also resulted in some clear actions and commitments for the next steps, which will require ongoing monitoring and support from the ICP leadership community.

The session demonstrated the commitment and enthusiasm of the ICP partners for data sharing, and the potential value it can bring for improving the health and wellbeing of the population of Norfolk and Waveney.

Materials used: The materials that were used in the session can be found in Appendix 2.

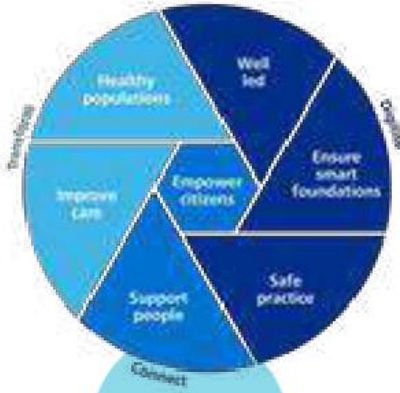
Within the materials, slides 4-6 show examples of how the Shared Care record system is being used across ICS organisations. Slide 7 highlights how multiple organisations data contributes to a combined view of a person that can better inform proactive intervention opportunities. Slide 8 shows direct care support uses of the Norfolk Vulnerability Hub. Slides 9-13 illustrate information security and information governance requirements for existing solutions as well as new systems and participating organisations.

Improving lives **together**

Norfolk and Waveney Integrated Care System

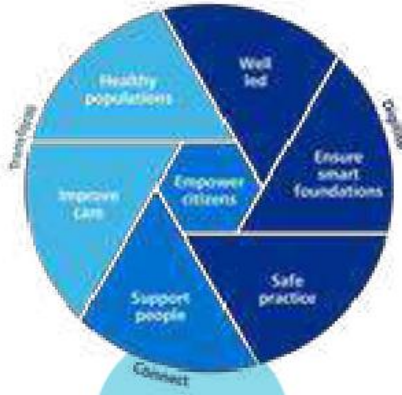
Norfolk & Waveney Integrated Care Partnership Development Session 31/01/2024

What we will cover today



- **How we have got to where we are now** – Geoff and Ian (10 mins)
- **Facilitated table sessions to consider what we are currently doing and where we can go next** – Sarah (30 mins)
- **Feedback to the whole group from the tables** – Sarah (5 mins)
- **Follow on actions and commitments** – Geoff and Ian (5 mins)

Facilitated session on tables



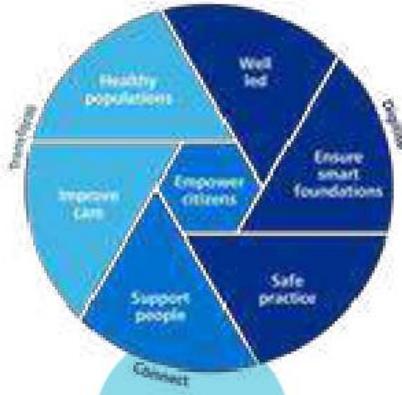
- Work through the existing case studies which show the benefits of data sharing.
- How we ensure all the appropriate controls are in place to deliver the outcome required.
- What are the benefits and opportunities for us as a system to roll out joint work even further?

What do our practitioners say ?

I used it on a case where the 87 year old person with dementia was discharged from hospital into a residential placement due to concerns raised by family and neighbours that they were wandering at night and in the early hours of the morning. Having used the shared care record I could see that they were prescribed anti-biotics meaning the confusion could have been down to an infection. Having this information allowed me to speak to family members in more details about the concerns and it was evident this was not a usual occurrence for the person. I was able to organise for them to return home with a package of care which was what the person and family wanted.

This quote is from an Assistant Practitioner in our Western Hospital Discharge team – August 2023

What do our practitioners say ? Duty Worker



"I use the shared care record for new referrals and for existing service users. It's really useful to check medical information to inform a care act assessment, to check medication that is prescribed, and to check for recent GP involvement. It saves having to contact the GP Surgery for information."

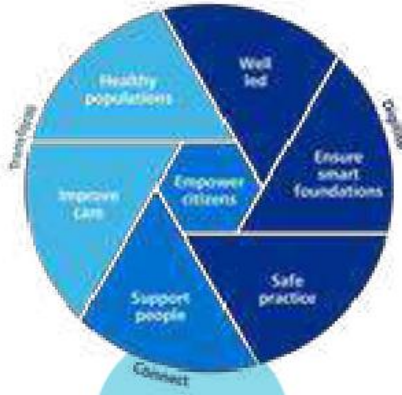
"Finally we can gain information on prescribed medications/ allergies which can again be a good tool when we are with a service user that we have little information for."

"It allows us to be able to clarify and quantify information in real time; It helps inform and direct our conversations with our health colleagues in relation to prognosis and CHC eligibility and also gives a wider picture of other professionals' involvement."

"It has allowed us to see what referrals/ encounters an individual has had and any planned referrals / encounters that we may need to integrate with to enable person centred and appropriate support."

Quotes from practitioners who triage referrals into social care – August 2023.

What do our practitioners say ? Assessors



"Having access to the shared care record has been invaluable and time saving to me, I can access up to date information on a person's health conditions and current medications. I use it most days. Previously I would have had to email the practice or ask ICC to do this for me to get a patient summary."

For the purposes of Mental Capacity Assessments (or even assessment visits), it also allows you to check on the day of a visit whether the person is presently suffering from a resolvable illness or infection which may temporarily affect capacity and saves time of not visiting to discover this when you get there and having to reschedule, again all of which uses valuable time up.

"I can honestly say this has saved me so much time and hassle and I am so grateful to have this resource available. I look forward to hospital information and MH information also coming online at some point – particularly hospitals as I must have wasted half my life trying to reach wards in hospitals (or to find out where the person is in the hospital) and to find out if they are medically fit for discharge when being able to just look this up would be so much quicker."

"The shared care record in terms of quality and compliance monitoring, is a very useful tool. To ensure parity of care between health services and social care services, we have been using the shared care record to ensure that any follow-up actions have been taken and to ensure continuity of care."

Quotes from practitioners who conduct social care or reablement assessments – August 2023.

Meet Sarah, and what different organisations know about her

District data Health data County data

County View

Sarah is 78 and lives in Winfarthing in South Norfolk. Her daughter lives locally and pops around daily to see her.
She loves walking with her husband.

She caught flu a couple of years ago and had an unplanned admission. She was discharged with a reablement package from ASC.

District View

Sarah is 78 and lives in Winfarthing in South Norfolk. Her husband passed away last month and she now lives alone, however, her daughter lives locally and pops around daily to see her. She has arthritis in her left knee and had a replacement knee operation on her right knee four years ago. She also has asthma and poor vision.

She lives in social housing and struggles to keep the house warm in winter. She is also beginning to struggle to pay her council tax and rent.

Joined up View

Sarah is 78 and lives in Winfarthing in South Norfolk. Her husband passed away last month and she now lives alone, however, Her daughter lives locally and pops around daily to see her. She has arthritis in her left knee and had a replacement knee operation on her right knee four years ago. She also has asthma and poor vision.

She lives in social housing and struggles to keep the house warm in winter, he is also beginning to struggle to pay her council tax and rent.

She loved walking with her husband.

She caught flu a couple of years ago and had an unplanned admission and was discharged with a reablement package from ASC.

Norfolk Vulnerability Hub

2020 - 2021 Pandemic response: Shielding, self-isolating and hardship

- Successfully supported Clinically Extremely Vulnerable people (approx. 42,000 people in Norfolk rising to 63,000 by Feb 2021).
- Provided 13,000+ Prescription collections, delivery of 7500+ food & Shopping, 6000+ loneliness and isolation support, 30,000+ advice and information calls
- Facilitated the linking of COVID Response resources at District and County to provide proactive contacting of residents required to Self isolate.

Mar 2022 - Supporting Homes for Ukraine

- Putting in place a framework to enable the sponsorship checks to be carried out for checking residents sponsoring Ukrainian guests under the H4U scheme and providing welfare checks for arrived guested in cooperation with Childrens services where the guest are under 18.
- The Coordinating of the resources and work across county and local councils.

2023 – Discharge Pathway Zero: Health Connect

- Connects patients to community support on discharge from hospital (Pathway 0).
- Facilitated over 250 referrals within the first 6 months.

2023 – Digital Inclusion: West Norfolk Tech Skills for Life

- Pilot to provide wraparound support to digitally excluded residents of West Norfolk.
- The pilot works in partnership with other NCC departments, VCSE, healthcare, and community organisations to target activity and make the best use of resources.
- The NVH holds referral data and activity information.

Data Hub Information Governance.
What Agreements are needed?

Data Hub

Security

Data Hub Agreements

Confirmation that the environment is secure and that you're happy for the ICB to process your data on your behalf.

Sharing

Use Cases

Agreeing the specific purpose of use of shared data.

Linking

DARS

Allows the ICB permission to link health & care data assets with the National Data sets to create a complete pathway.

Receiving

DSPT & Subliciencing

Allows the sharing of national data assets without suppression.

Each of these steps has a distinct function. Completing them all allows us to collaborate.

Data Hub Information Governance.
A bit more detail

Data Hub

Data Hub Data Controller Info Sharing Framework agreement

Sets out the conditions that providers are committing to when sending, receiving, sharing and utilising data with the 'Data Hub'

Data Hub Data processing agreement

This agreement describes the behaviours expected from the data processor to ensure that they are processing the data safely, appropriately and legally.

Security

Use Case Approval

Access to and reporting for the Data Hub will be controlled by 'Use Cases'. These documents will be used to describe the problem that we are trying to resolve, the planned resolution and how informaticians will interact with the data hub

Data Hub DPIA

A Data Protection Impact Assessment describes a process designed to identify risks arising out of the processing of personal data and to minimise these risks as far & as early as possible.

A main DPIA has been developed and each use case, approved by a representative system group will be appended this DPIA.

Sharing

NHSE Data Sharing Agreement (DARS)

Organisations wanting to use nationally processed data need to show they meet data governance standards by completing a Data Access Request Service (DARS) application, supported by a 'Data Sharing framework contract' and a 'Data Sharing Agreement' (DSA). The ICB completes this on behalf of the ICS organisations. Where new providers or linkages are identified, appropriate 'use cases' must be provided to explain how and why linked data will be used.

Linking

DSPT

The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

Receiving

Sublicensing

The ICB needs to be able to share data with providers, local authorities and other approved system partners within their ICS so they are fully able to contribute to commissioning decisions.

The ICS Sub-License approach will allow the ICB to share data they receive from NHS Digital via their commissioning agreements with members of their ICS. In order to be eligible, ICBs need to complete their DSPT and apply to be a sublicensee.

Receiving

Data Sharing Between Organisations

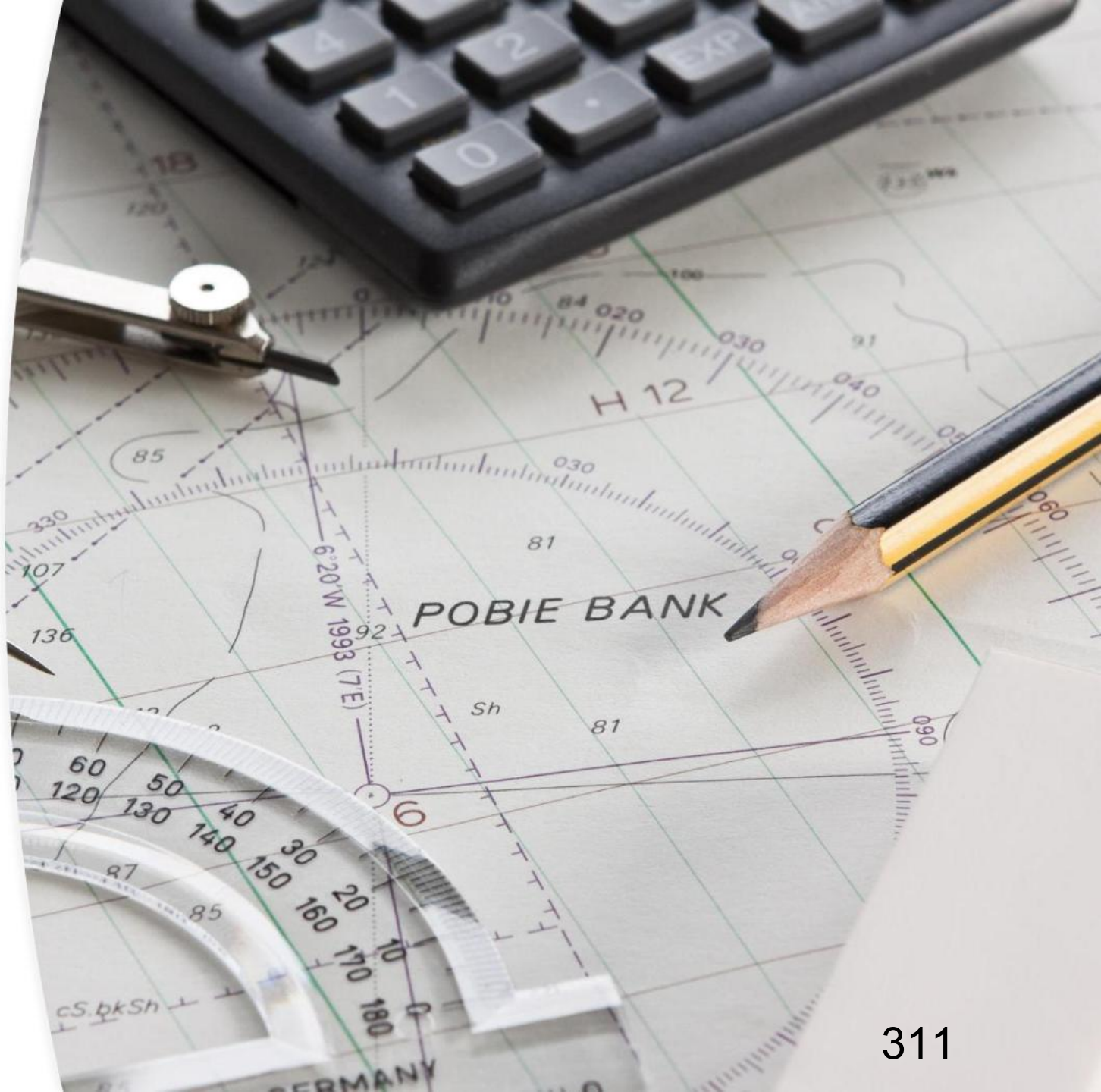
- Data sharing responsibility rests with data controllers.
- Data can only be used for the purpose it has been collected for.
- Organisations may have statutory obligations to fulfil and will need a clear lawful basis.
- Caldicott principles should be followed.
- Cybersecurity is crucial, especially when sharing sensitive information.

Data Sharing Best Practices

- Be clear about the problem being solved, as this will drive the data required.
- Establish if a contract or sharing agreement is in place to cover the data involved.
- Privacy Notices must be updated for any changes in use of data.
- Limit data sharing to only what data is necessary.
- Anonymous / aggregated data should be considered before sharing personal data.
- Ensure data is transferred, stored and accessed appropriately (legitimate relationships).
- Establish a data breach response plan.
- Conduct regular audits to ensure data privacy and security.

Foundations to sharing

- Signatory to overarching data sharing agreements (My Care Record / Norfolk Overarching Protocol / DataHub Framework).
- Complete DSP Toolkit which includes;
  - Register with ICO,
  - Caldicott Guardian role,
  - SIRO role,
  - Secure email system,
  - Privacy Notices,
  - Cybersecurity.
- Data Protection Impact Assessments and associated Use Case(s).
- Useful to engage with IG peer group.



Feedback from tables and Q and A

Norfolk and Waveney Integrated Care Partnership

Report title: University of East Anglia (UEA) Health Data interpretation reports on impact of Covid-19 on healthcare services and health outcomes in Norfolk

Date of meeting: 06 March 2024

Sponsor (ICP member): Stuart Lines, Director of Public Health, Norfolk County Council

Reason for the Report

To share the reports produced by the UEA health data interpretation group (HDIG) with system partners. These reports investigate the impact of COVID-19 on healthcare services and health outcomes, seek to understand the factors influencing healthy life expectancy and other key health indicators, and identify opportunities for preventing poor health. By sharing this analysis and insight partners can use it to enhance the quality of healthcare and reduce harms from the big risks to health including smoking, unhealthy diets and obesity, physical inactivity, alcohol and drug use.

Report summary

The primary objective of the UEA HDIG reports was to answer the following questions:

- What is happening with healthy life expectancy and other top level health measures, analysed overall and by location and socioeconomic status and what are the drivers?
- Where are the opportunities for prevention of poor health?
- What is the impact of Covid on health services activity and health outcomes?

The reports offer insights for the system in terms of future planning, capacity building, data capture and identifying areas for improvement in healthy life expectancy.

Recommendations

The ICP is asked to:

a) To note the UEA HDIG reports are available on Norfolk's Joint Strategic Needs Assessment website.

1. Background

1.1 The COVID pandemic presented challenges and opportunities for the health and care sector in Norfolk, including the increased demand on services (particularly urgent and emergency care), increased waiting lists, and catch-up programmes and workforce issues. In Norfolk there is falling life expectancy after several years of stagnation, and continuing inequalities in health and variations in quality and access to healthcare.

1.2 Norfolk County Council commissioned the University of East Anglia (UEA) to analyse various sources of information in relation to the health and healthcare of Norfolk residents. The analysis focussed on the impact of Covid on health services activity and health outcomes. It also explored healthy life expectancy and looked at where the opportunities are for preventing of poor health. The main objective was to offer valuable insights that could contribute to improving the overall healthcare system in the region.

2. UEA Health Data Improvement Group Reports

2.1 The UEA HDIG led by Professor Nick Steel have produced the following reports:

1. *Overall summary of the HDIG reports*
   (go to norfolkinsight.org.uk to read a summary of all UEA reports)
2. *HDIG report - Healthy life expectancy and prevention opportunities*
   (go to norfolkinsight.org.uk to read the healthy life expectancy report)
3. *HDIG report - Why is A&E so busy? Analysis using public data*
   (go to norfolkinsight.org.uk to read the analysis of public data on why A&E is so busy report)
4. *HDIG report - Why is A&E so busy? Analysis using individual patient data*
   (go to norfolkinsight.org.uk to read the analysis of individual patient data on why A&E is so busy report)

2.2 Below represents some of the key findings from these reports:

2.2.1 The reports offer information to assist the system in its future planning, capacity building, data capture and identifying areas for improvement in healthy life expectancy.

2.2.2 UEA have developed an approach to understand Healthy Life Expectancy at small areas (MSOA) this methodology will be shared with Public Health analysts and with OHID Regional colleagues. Note that smoking data is not available at a granular level for inclusion in the methodology.

2.2.3 Healthy life expectancy varies from one place to another. There is a variation of 21 years for men and 18 years for women across the 128 small areas within Norfolk and Waveney. This gap is as wide as the difference between the most deprived and least deprived areas in England.

2.2.4 How long people live for, what people die from and what makes people ill throughout life is dependent on many different things including weekly income, physical activity, air pollution and alcohol consumption.

2.2.5 Looking at what the numbers tell us about these smaller geographic areas can help us to prioritise which actions to take to improve the populations health.

2.2.6 There are opportunities for the system to work together to improve healthcare services and health outcomes.

2.2.7 Future strategies aimed at reducing waiting times in A&E should involve the whole health and care system, which includes improving discharge from hospitals.

2.2.8 To analyse patient flow across the system there are some opportunities for improvements in patient level recording.

Officer Contact

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

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