Norfolk Health & Wellbeing Board

Date: **Wednesday 12 June 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	Andy Wood
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	Laura Clear
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	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	Rachael Cocker
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	Cllr Jill Boyle
Norwich City Council	Cllr Claire Kidman	
Place Board Chair Great Yarmouth & Waveney	Jonathan Barber	Sheila Oxtoby
Place Board Chair Norwich	Tracy Williams	
Place Board Chair North Norfolk	Dr James Gair	Heather Farley
Place Board Chair South Norfolk	Allan Petchey	Karen Bradley
Place Board Chair West Norfolk	Carly West-Burnham	Oliver Judges
Police and Crime Commissioner	Sarah Taylor	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 Brenda Jones
Suffolk County Council, Cabinet Member for Adult Care	Cllr Beccy Hopensperger
Suffolk County Council Representative	Nicola Roper
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 12 June 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 Services
Norfolk County Council, Cabinet member for Public Health and Wellbeing
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, Chief Executive Officer (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, Representative
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 Norfolk and Waveney Integrated Care Partnership

Wednesday 12 June 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.*

Advice for members of the public:

This meeting will be held in public and in person.

It will be live streamed on YouTube and members of the public may watch remotely by clicking on the following link: Norfolk County Council YouTube

We also welcome attendance in person, but public seating is limited, so if you wish to attend please indicate in advance by emailing committees@norfolk.gov.uk

Current practice for respiratory infections requests that we still ask everyone attending to maintain good hand and respiratory hygiene and, at times of high prevalence and in busy areas, please consider wearing a face covering.

Please stay at home if you are unwell, have tested positive for COVID 19, have symptoms of a respiratory infection or if you are a close contact of a positive COVID 19 case. This will help make the meeting safe for attendees and limit the transmission of respiratory infections including COVID-19.

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: **17:00 6 June 2024**	Chair	
7.	Urgent arising matters	Chair	
8.	Election of Vice Chairs (HWB)	Chair	
9.	HWB Governance update (HWB)	Debbie Bartlett	(Page 18)
10.	Norfolk and Waveney Integrated Care Strategy and Norfolk Joint Health and Wellbeing Strategy Progress and Joint Forward Plan update (HWB)	Debbie Bartlett Tracey Bleakley / Andrew Palmer	(Page 23)
11.	Better Care Fund – Review of Core Schemes (HWB)	Debbie Bartlett / Edward Fraser Tracey Bleakley / Karin Byrant	(Page 96)
12.	Joint Strategic Needs Assessment Work Programme 2024 – 25 (HWB)	Stuart Lines / Dr Abhijit Bagade / Katherine Atwell	(Page 101)
13.	Norfolk All Age Autism Strategy 2024-2029 (HWB)	Debbie Bartlett / Tracey Walton / Lorna Bright	(Page 105)

	Norfolk and Waveney Integrated Care Partnership		
1.	Election of Chair and Vice Chairs (ICP)	Committee Officer	
2.	ICP Minutes	Chair	(Page 5)
3.	Actions arising	Chair	
4.	Declarations of Interest	Chair	
5.	Public Questions (How to submit a question: ICP) Deadline for questions: **17:00 6 June 2024**	Chair	
6.	Matters Arising – Joint strategy agreement, Integrated Care Partnership Strategy agreement of recommendations as discussed at the HWB (ICP).	Chair	
7.	ICP Governance Update (ICP)	Debbie Bartlett	(Page 172)
8.	Norfolk and Waveney Health Inequalities Strategic Framework for Action (ICP)	Tracey Bleakley / Mark Burgis / Tracy Williams	(Page 182)
9.	Driving Integration through Digital, Data and Technology including the landline switchover (ICP)	Debbie Bartlett / Goeff Connell Tracey Bleakley / Ian Riley	(Page 208)

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

Tom McCabe
Chief Executive
County Hall
Martineau Lane
Norwich
NR1 2DH

Date Agenda Published: **4 June 2024**

IN TRAN communication for all

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Health and Wellbeing Board and Integrated Care Partnership
Minutes of the meeting held on 06 March 2024 at
in the Council Chamber, County Hall.

Present:	**Representing:**
Cllr Jo Rust	Borough Council of King's Lynn & West Norfolk
Cllr Tristan Ashby	Breckland District Council
Cllr Natasha Harpley	Broadland District Council
Anna Gill	Cambridgeshire Community Services NHS Trust
David Allen	East of England Ambulance Trust
Cllr David Beavan	East Suffolk District Council
Cllr Emma Flaxman-Taylor	Great Yarmouth Borough Council
Patrick Peal	Healthwatch Norfolk
Mark Friend	James Paget University Hospital NHS Trust
ACC Nick Davison	Norfolk Constabulary
Cllr Penny Carpenter	Norfolk County Council, Cabinet member for Childrens Services and Education
Stuart Lines	Norfolk County Council, Director of Public Health
Sara Tough	Norfolk County Council, Executive Director Children Services
Kim Goodby	Norfolk & Norwich University Hospital NHS Trust
Rt Hon Patricia Hewitt	Norfolk and Waveney Integrated Care Board (Chair)
Cllr Liz Withington	North Norfolk District Council
Cllr Claire Kidman	Norwich City Council
Tracy Williams	Place Board Chair Norwich
Chris Lawrence	Queen Elizabeth Hospital NHS Trust
Cllr Kim Carsok	South Norfolk District Council
Alan Hopley	Voluntary Sector Representative
Andrew Palmer	Integrated Care Board
Christine Futter	Norfolk Care Association
Nick Clinch	Adult Social Services, Norfolk County Council
Oliver Judges	Place Board Chair – West
Tricia Fuller	Norfolk Suffolk Foundation Trust

Additional members present (non-voting):

Bernadette Lawrence	Suffolk County Council Representative
Fran Whymark	Norfolk Health Overview and Scrutiny Committee (Chair)
Prof Nicole Horwood	University of East Anglia Representative

Officers Present:

Stephanie Butcher	Policy Manager Health and Wellbeing Board
Stephanie Guy	Advanced Public Health Officer
Hollie Adams	Committee Officer

Speakers:

Diane Steiner	Deputy Director of Public Health, Norfolk County Council
Ciceley Scarborough	Consultant, Public Health, Norfolk County Council
Edward Fraser	Interim Assistant Director Communities & Integration, Adult Social Services, Norfolk County Council
Andrew Palmer	Executive Director of Performance, Transformation and Strategy, NHS Norfolk, and Waveney Integrated Care Board (ICB)
Lorna Bright	Assistant Director of Integrated Operations, Mental Health and Learning Disabilities, Norfolk County Council
Mark Burgis	Executive Director of Patients and Communities, NHS Norfolk and Waveney Integrated Care Board (ICB)
Jamie Sutterby	Director of People and Communities, Soth Norfolk District Council
Dr Abhijit Bagade	Consultant in Public Health Medicine
Paul Wardle	Strategic Human Resource Business Partner - Adults, Norfolk County Council
Sharon Crowle	Head of Professional Education, Training and Development, NHS Norfolk and Waveney Integrated Care Board (ICB)

Norfolk Health and Wellbeing Board (HWB)

1. Apologies

1.1 Apologies were received from Cllr Bill Borrett, Debbie Bartlett, (Nick Clinch substituting), Zoë Billingham, (Tricia Fuller substituting), Lynda Thomas and their substitute Laura Clear, Carly West-Burnham, (Oliver Judges substituting), Tom Spink and their substitute Rachael Cocker, (Kim Goodby substituting), Giles Orpen-Smellie and their substitute Dr Gavin Thompson, Angela Steggles, (Christine Futter substituting), Tracey Bleakly, (Andrew Palmer substituting), Jonathan Barber, Cllr Alison Thomas and Cllr Rebecca Hopfensperger.

In the absence of the Chair, Patricia Hewitt took the Chair.

2. Chair's Opening Remarks

2.1 The Chair welcomed new members of the Health and Wellbeing Board, Cllr Claire Kidman from Norwich City Council, Cllr Liz Withington from North Norfolk District Council, Nicholas Clinch from Adult Social Services, Norfolk County Council, Andrew Palmer, from the Integrated Care Board, Prof Nicole Horwood, from the University of East Anglia, Tricia Fuller from Norfolk Suffolk Foundation Trust, Oliver Judges Place Board Chair – West, and Laura Clear from Norfolk Community Health and Care.

2.2 The Chair shared that it would be Social Work week from 18 to 22 March 2024, to bring people together to learn, connect, and influence change. It was the fourth year of Social Work Week and work would build on discussions from previous years and celebrate all the amazing work social workers did each day across the system.

2.3 The Chair also shared that NHS England had confirmed that NHS Norfolk and Waveney Integrated Care Board was no longer in NHS oversight framework segment 4 and had been removed from the Recovery Support Programme, formerly known as "special measures". The Chair thanked members of the HWB for their partnership working which helped achieve this.

3. Minutes

3.1 The HWB minutes of the meeting held on 8 November 2024 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. Director of Public Health Annual Report for Norfolk 2023: Smoking, tobacco control and vaping

8.1 The Director of Public Health Annual Report for Norfolk 2023: Smoking, tobacco control and vaping was introduced to the HWB by Stuart Lines, Director of Public Health, Norfolk County Council. This was a statutory independent report. The focus was on smoking which was a key issue in parts of the Norfolk population and the biggest contributor to poorer health outcomes. It discussed the use of e-

cigarettes as a gateway to tobacco use, particularly among young people and those who had never smoked and outlined the ambition of the country to become smoke free.

8.2 Diane Steiner, Deputy Director of Public Health, Norfolk County Council and Ciceley Scarborough, Consultant, Public Health, Norfolk County Council spoke to the report. They discussed that the statistics showed rates of smoking were reducing in the long term, however, smoking rates remained at 13% in Norfolk, thus, work was still needed to achieve the smoke free generation target of 5% by 2030. Smoking contributed to diseases such as cancer, respiratory disease and cardiovascular disease and tobacco use was the third largest risk factor for diseases such as stroke and dementia. This leads to a greater demand on services. There were higher rates of smoking in Great Yarmouth, in men, in people aged 25-60 years old, in areas of greater deprivation, among those in routine and manual jobs and among people with mental health issues and in poorer health. Rates of smoking in pregnancy in Norfolk are gradually coming down but were above the national average. Interventions were in place to help people stop smoking and vaping could be used as a tool for this aim, however, more research was needed over the long-term impact. Data suggests there are likely to be a significant amount of people in Norfolk who vape but have never smoked including young people. The Norfolk Tobacco Control and Vaping Alliance are implementing an action plan on vaping including a toolkit for schools. It would take partner collaboration to tackle the issues in Norfolk.

8.3 The following points and comments were discussed:

- A Health and Wellbeing Board Member suggested that work focusing on the more disproportionately affected groups would be important.
- Cllr Harpley pointed out that marketing and packaging of vapes was often targeted towards young people and suggested this should be addressed. Officers were working with other organisations including trading standards to ensure that e-cigarettes were not marketed towards children and police colleagues aimed to work alongside other organisations to review packaging of vapes to make them less attractive to children. A toolkit was launched last October to schools providing education about vaping in young people.
- It was pointed out that illegal vapes sometimes included substances other than tobacco such as marijuana or other illicit substances. Officers worked with trading standards and police to tackle vendors who sold illegal vapes.
- A Health and Wellbeing Board Member had heard a statistic suggesting that 100% of the neonatal deaths in Norfolk had mothers who smoked. Officers replied that they favoured behaviour change techniques to provide education around smoking in pregnancy, for example they had provided an incentive scheme with the James Paget Hospital to encourage mothers to stop smoking during pregnancy. It was an area of concern as Norfolk sits above the national, and regional, average for this.
- The issues of smoking during pregnancy were discussed including the need for people to have choice, however the lack of choice for the unborn child and children in the home who were exposed to smoking was also raised.
- There was lots of work and focus on the NHS plans focussing on smoking prevention for pregnant mothers.

The HWB **RESOLVED** 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.

9. Better Care Fund Quarterly reports

9.1 The Better Care Fund (BCF) Quarterly Report was introduced by Nick Clinch, Director Communities Prevention and Partnerships, Adult Social Care, Norfolk County Council. It was part of the HWB statutory responsibility to oversee the Better Care Fund, in which there was a requirement to submit

quarterly reports to NHS England. The BCF funds the services that support the Health and Wellbeing of Norfolk residents and was a key driver for diving integration between key partners on the HWB. The HWB were made aware that there was a second stage review of the core BCF in progress. This report summarises the Q2 and Q3 BCF reports and the reviews progress to date. At the next meeting HWB in June, the strategic direction for the core BCF in Norfolk would be discussed.

9.2 Edward Fraser, Interim Assistant Director Communities & Integration, Adult Social Services, Norfolk County Council spoke to the report. It was outlined that this was a key piece of integrated activity with NHS partners that was broadly a positive story, additionally, spending was in line with expected profiles. All four of the national conditions were being met and the delivery of the schemes, apart from the rate of admissions to residential care homes, were on track to meet metrics. Work was underway to look at the data and the schemes in place to better understand why that metrics was underperforming and the impact of this. The Community Step Down Flats, which were making use of Housing with Care Flats to support reablement following a hospital stay, and the Norfolk First Support Reablement service, that looks into how occupational therapy support would be integrated as part of the pathway to offer a holistic service. A joint review was being carried out around core funded schemes to ensure they aligned to national and local priorities, and how the BCF was being used across place to demonstrate the impact for local people. Members heard that the review had identified there was no clear process for on boarding and offboarding schemes funded through the BCF.

9.3 The following points and comments were discussed:

- The issues experienced around preventing unnecessary admission seen in Suffolk was raised, and the role of working with housing colleagues in this. The Chair encouraged this to be discussed after the meeting as the Health and Wellbeing Board's remit did not include Suffolk.
- The progress of the review was noted and the opportunities for joined up working that the Better Care Fund provided across partners was welcomed.
- It was raised that each day, around 20% of beds were taken up with people who could be discharged; Edward Fraser agreed that this issue was part of a wider discussion that was required, including the issue discussed earlier around admission avoidance.
- Edward Fraser was asked what the next step would be for the case study projects referred to in the report. He replied that following the pilot of these successful projects, there was an aim to embed these into day-to-day practice.
- A Health and Wellbeing Board Member suggested that it would be helpful to review the efficacy of projects in specific areas to identify what learning could be transferred across to other areas.
- Sara Tough recognised that it was for local areas to decide whether children should be included in the Better Care Fund and noting the emotional and mental health need seen in Norfolk she suggested that this should be considered in Norfolk.
- A Health and Wellbeing Board Member discussed that report included a metric around reducing the rate of permanent admissions to Care Homes, however, it was pointed out that there were care homes able to support with short stays and reablement to provide a solution, whereas there was a shortage of home care which could impact on people being reabled if returning home. Officers confirmed it was a priority to support home first wherever possible which also included people returning to care homes.

9.4 The HWB **RESOLVED** 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 and the result of the review at the next meeting of the Health and Wellbeing Board.

10. NHS Norfolk and Waveney Integrated Care Board Annual Report

10.1 The NHS Norfolk and Waveney Integrated Care Board Annual Report was introduced to the HWB by

Andrew Palmer, Executive Director of Performance, Transformation and Strategy, NHS Norfolk and Waveney Integrated Care Board (ICB). In the annual report, ICB's must describe how they have contributed to the delivery of the priorities set by the HWB in their Strategy and consult with the HWB regarding that. Members were asked to comment on the draft narrative of the NHS Norfolk and Waveney Integrated Care Board Annual Report for 2023/24and propose any amendments. Members were asked to note that the ICB was working with all partners on their Joint Forward Plan, which provided additional opportunity for the ICB to show how it is contributing to the four strategic priorities.

With respect to Driving Integration, the following examples were noted. The joint work on ambulance handovers, Right Care Now, Shared Care records, being an active partner in work across the Primary Care networks and Place Boards, and in the Health and Wellbeing Partnerships. Examples of prevention included the continuation of Protect NoW and the and range of Population Health Management projects. A strategy was being developed for addressing Health Inequalities, in addition there was a Patient and Communities Committee which remit included looking into how the ICB was reducing Health Inequalities and enabling resilient communities. The ICB remained committed to enabling people to live independent healthy lives in their communities for as long as possible.

10.2 The following points and comments were discussed:

- Health and Wellbeing Board Members asked if case studies could be built into the report and highlight areas of improvement where partners could provide support. Andrew Palmer agreed to look into these points. The annual report and joint forward plan would together show what further could be done.
- The triage system used by the ambulance system for non-emergency cases was queried, and whether this needed review to avoid unnecessary admission. David Allen from the East of England Ambulance Trust clarified that there was an unscheduled care coordination hub who supported the Ambulance Service Triage, which involved many organisations.
- A Health and Wellbeing Board Member asked that financial viability of the voluntary sector should be included in the report due to the involvement of the voluntary sector in this work, many of whom were struggling financially. The Chair acknowledged that all partners were experiencing financial difficulties.
- The target "Making changes to help ensure people are getting the right care, at the right time and by the right person" was highlighted, in contrast to the 20% of hospital beds taken up by people requiring discharge, raised earlier in the meeting. Andrew Palmer replied that there was more work to do on this target, however this figure had been significantly reduced from the previous level.
- It was noted that the vision statement from the Ambulance Service Chief Executives discussed reducing the need for ambulances by increasing care in the community. The Chair asked for this discussion to continue outside of the meeting.

10.3 Having commented on the draft narrative of the NHS Norfolk and Waveney Integrated Care Board Annual Report, the HWB **RESOLVED** to **propose** the following amendments:

- For case studies to be built into the initiatives
- For areas of difficulty and how partners could provide further support to be looked into
- For information on financial viability of voluntary sector partners to be taken into consideration

The Health and Wellbeing board closed at 10:32

Integrated Care Partnership

1. ICP Minutes

1.1 The minutes of the Integrated Care Partnership (ICP) meeting held on 8 November 2024 were agreed as an accurate record and signed by the Chair.

2. Actions arising

2.1 None.

3. Declarations of Interest

3.1 Cllr Carpenter declared a non-pecuniary interest in relation to item 8 as a cancer patient.

4. Public Questions

4.1 None.

5. Learning Disability Plan 2023-2028

5.1 Nick Clinch introduced the plan to the HWB on behalf of NCC and the ICB. This plan was a culmination of a large amount of work that has been going on and had been developed by the Norfolk Learning Disabilities Partnership which included people with lived experience and their carers.

5.2 Lorna Bright, Assistant Director of Integrated Operations, Mental Health and Learning Disabilities, Norfolk County Council introduced the report. This replaced the previous version of the Strategy and wasthe result of 8 months of intense work. It was incredibly important that the plan included the voices and aspirations of people with learning disabilities and their carers, which were captured in co-production sessions, as well as the view of professionals and providers of services to people with learning disabilities and their carers. This approach aligned with the Oliver McGowan training that the NHS was rolling out, which talked about the importance of listening to, and consulting with people with learning disabilities and their carers, as they are the experts. An easy read version of the Plan was produced first and tested with those that co-produced it. The plan would be regularly reviewed by the Norfolk and Waveney Learning Disabilities and Autism Programme Board.

5.2 The following points and comments were discussed:

- Members of the ICB welcomed the plan.
- Anna Gill raised concerns voiced by the disabled community about changes to the Minimum Income Guarantee. Officers confirmed that the Council were having to make difficult decisions around their finances and hoped that this plan would not be affected.
- Chris Lawrence asked about the transition of young people from Children's Services to Adults' Services. Officers confirmed that the Preparing for Life Team supported children and their carers to prepare for this transition.
- The Integrated Care Board had reviewed this report in January 2024 and were pleased that people with learning disabilities had been engaged with during the plan's development and would fully support it The Chair was pleased that the easy read version of the plan was written before the full version.
- Stuart Lines noted that people with Learning Disabilities were impacted by lower life expectancy and higher rates of hospital admission and **suggested** that work should take place to encourage the uptake of health screening. Officers replied that there was an aim in the plan to support people to take up screenings and access other health care services such as vaccinations.
- Cllr Rust asked what support was in place for carers assessments. Lorna Bright confirmed that carers could get social care assessments through carers matters; practitioners working with people with learning disabilities were asked to identify carers and encourage them to get an assessment. Cllr Jo Rust **suggested** that this should be explicitly referenced going forward. The Chair noted the work being done on the carers passport across the system.
- Mark Friend asked for clarity around which aspects of the plan were 'must do's'. Lorna Bright replied that it was an aspiration to deliver everything in the plan, but health was the top priority as it impacted on all others.
- Sara Tough noted that this Plan sat alongside an area strategy for children with learning disabilities and additional needs which would be brought to the Health and Wellbeing Board. This included young adults up to the age of 25, meaning both plans incorporated transition between Children's Services and Adult Services.

5.3 The ICP **RESOLVED** 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 carer's.

d) **Recognise** the wider work being done to ensure carers have access to the support that they need

6. Norfolk and Waveney Health Inequalities Strategic Framework for Action

6.1 Andrew Palmer, Executive Director of Performance, Transformation and Strategy, NHS Norfolk and Waveney Integrated Care Board (ICB) introduced the Norfolk and Waveney Health Inequalities Strategic Framework for Action and thanked all system partners for their engagement on this critical piece of work, as it was essential that all partners worked together.

6.2 Mark Burgis, Executive Director of Patients and Communities, NHS Norfolk and Waveney Integrated Care Board (ICB) and Tracy Williams, Clinical Lead for Health Inequalities & Inclusion Health, NHS Norfolk and Waveney Integrated Care Board introduced the report. Tackling Health Inequalities was a priority for all partners which everyone had recognised. This was a framework for action that had been developed for the whole system with the involvement of over 100 organisations across our ICS. It was a first step on the journey around tackling Health Inequalities together and was a system Framework for all partners. The three key areas in the Framework were Living and Working Conditions, Lifestyle Factors and Healthcare Inequalities. It would be important to act together as a whole system as well as within our own organisations and acting locally to continue to ensure co-production with communities. In the first year priority actions would be taken acknowledging the challenging environment.

6.3 The following points and comments were discussed:

- Christine Futter pointed out that Adult Social Services were not explicitly mentioned in the report. Officers **agreed** to take this point away for action.
- Mark Friend raised Community Voices and the role that the voluntary sector could have in this strategy. Tracey Williams replied that there were programmes to engage with under-served communities and this was lead jointly with the voluntary sector.
- Bernadette Lawrence asked if Suffolk agencies were included in this framework. It was confirmed that Waveney agencies were included.
- Nicole Horwood suggested that collaboration could be taken forward with colleagues at University of East Anglia as they had numerous researchers working in this field.
- Cllr Natasha Harpley discussed that the reduction in funding over time had impacted on provision of services, for example through closure of Sure Start centres, which was reducing people's life qualities and opportunities.
- Cllr Emma Flaxman-Taylor encouraged the IPB to work with the District Councils and the voluntary sector to prioritise the Health Inequalities budget they received from NHS England.
- Nick Clinch assured the Partnership that the role of Adult Social Care was within the Framework. The Framework touched on all four aims of the Integrated Care Strategy.
- Cllr Jo Rust raised the cost of poor housing for District Councils, and it was suggested that community led housing could empower local people to have more say in local housing.

6.4 The ICP **RESOLVED** 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 to the ICP.

7. Committing to the Hewitt Review recommendations

7.1 Cllr Kim Carsok, South Norfolk Portfolio Holder for Healthy & Active Lifestyles, South Norfolk District Council introduced the report. Cllr Carsok outlined the power of the District Councils to make change in the health of their local communities through the work of the Health and Wellbeing partnerships. Work had been done to develop capacity in the partnerships within South Norfolk District Council and Broadland District Council to tackle problems with providing local solutions and delivering projects.

7.2 Jamie Sutterby, Director of People and Communities, South Norfolk and Broadland District Councils, introduced the report. South Norfolk and Broadland Health and Wellbeing Board Partnerships were unhappy with the Government's response to the Hewitt review and responses in it and so took action to put together a statement of support. The principles of the Hewitt review showed a strong frame of reference between the system and local places, and included challenge to the way the system worked at place. There was a statement in the review to shift budgets towards prevention, using 1% of the local NHS budget over the next 5 years which equated to about £24m. The Review also highlighted the consideration of pooling resources to take forward integration and embedding pilots and projects. The active work taking place in all of the Health and Wellbeing Partnerships at a locally led level had a real effect on communities and contributed to the Health Inequalities agenda. Some of these at a local level, had merit in scalability such as seen with District Direct, Mindful Towns and Villages and Proactive interventions regarding falls These are exciting interventions led locally to provide local solution to local problems.

7.3 The following points and comments were discussed:

- Members of the ICP endorsed the comments given by Jamie Sutterby during his introduction.
- Cllr Ashby spoke about a project being carried out in Watton which had saved around £650,000 to the system and asked how pilots such as this could be made sustainable in the future. Jamie Sutterby replied that each partnership had initiatives which were successful; some were scalable, and some were for local solutions for local problems. It would be important to empower people to develop projects for example by providing funding and resources.
- Cllr Kidman spoke about the wellness on wheels bus which visited areas of Norwich where children had been diagnosed with rickets. Norwich City Council was committed to the vital work of prevention.
- Christine Futter from NORCA raised an issue from the provider perspective; it was not clear about their involvement at a Health and Wellbeing partnership level as there was no explicit reference to the independent sector. Language was really important in the move towards integration, as it was important that all partners are recognised as equals. She asked that Adult Social Care was explicitly mentioned. Care Academies were highlighted as an example. . Jamie Sutterby agreed to review language.
- Cllr Rust discussed the work towards becoming a Marmot place in Borough Council of King's Lynn and West Norfolk which she hoped could be widened out to other areas and highlighted Nourishing Norfolk which had been mentioned on Radio 4 which was a testament to the work that is going on.
- Bernadette Lawrence queried the statement set out on page 247 of the report "Ensure the entirety of our spend is on prevention," and raised this as a concern as it was felt this was not realistic but should be a focus. The Chair suggested a change to the wording of the recommendation to "prioritise our spending on prevention".
- Cllr Liz Withington raised the issue of sustainability for the Partnerships
- Chris Lawrence suggested that work in the report be mapped against the recommendations to show where organisations were up to and where we should be focussing and making collaborative decisions.
- Cllr Carsok raised the issue of attendance by the anchor institutions at the Partnerships which would help on working together. The Chair mentioned this was difficult due to the alignment of

Health and Local authority boundaries.

7.4 The ICP **RESOLVED** 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, with the following change to the statements:
   - ~~Ensure the entirety of our spend is on~~ Prioritise our spending 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.

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.

8. Cancer, Public Health key indicators for Norfolk and Waveney

8.1 Stuart Lines, Director of Public Health Norfolk County Council, introduced the report on Cancer as the fourth in a series of deeper dives into key areas for our system that highlighted data and key increases in risk.

8.2 Dr Abhijit Bagade, Consultant in Public Health Medicine, introduced the report. The most common types of cancer found in Norfolk and Waveney were prostate, breast, lung, and colorectal cancer. The incidence rate had been decreasing over the past decade in Norfolk, and was slightly better than the national average, however there were inequalities which required focus. Early cancer deaths were higher in areas of deprivation and also had lower survival rates. People from these communities were likely to recognise symptoms at a later stage and come forward at a later date for medical care. The key risk factors were smoking, poor diet, lack of exercise and being overweight.

8.3 The following points and comments were discussed:

- Cllr Carpenter reported that in 2018 there were around 6000 women not attending breast screening appointments in the Great Yarmouth and Waveney Council areas. She felt it was important to find out why people were not attending screening and to increase the level of uptake,
- Tracey Williams discussed the importance of recognising inequalities as well as barriers to access, including to screening appointments.
- Mark Friend spoke about the opening of diagnostic centres and noted that communication around the opening of these would be key. He suggested that it would also be important to target these communications to priority areas.
- Cllr Flaxman-Taylor spoke about the cancer screening service pilot being held in 21 community pharmacies in the Norfolk ICB. She was interested to see if this would impact on uptake of screening and **suggested** this was added to a future ICP agenda.

8.4 The ICP **RESOLVED** to **note** the data and information relating to Cancer for people living in Norfolk and Waveney for use in their strategic and operational planning and that there was additional information contained within the Norfolk Joint Strategic Needs Assessment (JSNA).

9. Driving Integration through system wide training opportunities

9.1 Nick Clinch introduced the report to HWB. A key part of the Integrated Care Strategy was on how we drive integration together. Training, learning and development was another part of that and this built on the Development session work the Partners did.

9.2 Paul Wardle, Strategic Human Resource Business Partner - Adults, Norfolk County Council and Sharon Crowle Head of Professional Education, Training and Development, NHS Norfolk and Waveney Integrated Care Board (ICB) introduced the report. A workshop was held in January 2024 which was really valuable and indicated the need for a visible collaborative workforce strategy that addressed training and skills needs, emphasised the need to break down barriers, and pooling of resources in the ICS but also acknowledging the challenges of turning aspiration into reality. There were benefits for sharing learning across the system including sharing best practice and standardised practices. The challenges to the system were set out in the report., Oliver McGowan training, delegated healthcare interventions and the opportunity to explore a digital skills passport could be considered as well as a shared learning management system to enable transfer and recording of data across the system and between partners.

9.3 The following points and comments were discussed:

- ICP members supported this report.
- Christine Futter highlighted the integrated work that was ongoing and spoke about the system skills passport that may replicate the national skills passport.
- It was confirmed that teaching sessions were for Norfolk and Waveney and were held online. Bernadette Lawrence **asked** if Suffolk Adult Social Services could be linked into this training as this would help with join up.
- Anna Gill spoke about upskilling other community roles to reduce the need of people to see doctors.
- Cllr Carsok asked if degree apprenticeships were being investigated. Sharon Crowle replied that it was the case and there were a variety of apprenticeships across the health profession such as nursing associates and nursing apprenticeships that were in place. Paul Wardle replied that Norfolk County Council supported the system with the apprenticeship levy and had a social work apprenticeship in place.
- Sara Tough had attended the workshop in January 2024 which she found to be positive. She felt that it was important to think about how capabilities across the workforce could be maximised to upskill professionals across the wider workforce to provide support to individuals.
- There was a challenge to ensure there was good representation from all sectors including the voluntary sector and district councils.. Paul Wardle confirmed that there was a vision to achieve this and this would be worked towards..
- Alan Hopley noted the importance of consistent case notes and data sharing. This could be supported by shared training.
- The Chair felt that encouraging people to learn together would also encourage them to work together.

9.4 The ICP- **RESOLVED** 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) Make maximum use of shared learning, education and training including where new needs are identified and including 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).

f) Ask officers to consider how to get further involvement with District Councils and the Voluntary Sector.

10. Norfolk & Waveney NHS System Capital Distribution for 2024/2025

10.1 The Integrated Care Partnership (ICP) received the report to inform 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.

10.3 The ICP- **RESOLVED** to:

a) **Endorse** the proposed NHS distribution of the NHS system Capital Departmental Expenditure Limit resource to deliver organisational and system capital plans.

b) **Note** the sums assigned to the central NHS programmes for 2024/25.

11. Norfolk and Waveney Integrated Care System Suicide Prevention Strategy 2023-2028

11.1 The ICP received the report setting out the draft suicide prevention strategy for the ICS and 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.

11.3 The ICP**RESOLVED** 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.

12. Driving Integration Through Digital, Data and Technology

12.1 The ICP **RESOLVED** to **note** the outputs from the workshop and immediate next steps to roll out benefits of existing data sharing and systems integrations platforms and **RESOLVED** to **receive** a further update on progress and plans at next ICP meeting, including the chance for discussion.

13. University of East Anglia (UEA) Health Data interpretation reports on impact of Covid-19 on healthcare services and health outcomes in Norfolk

13.1 The ICP **RESOLVED** to **note** the UEA Health Data interpretation reports on impact of Covid-19 on healthcare services and health outcomes in Norfolk and to **note** that the UEA HDIG reports are available on Norfolk’s Joint Strategic Needs Assessment website.

Meeting concluded at 12:22

Patricia Hewitt
Vice Chair Health and Wellbeing Board

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Health and Wellbeing Board and Integrated Care Partnership Attendance Record Appendix A

(From the last 3 meetings)

Member Organisation Represented	Named Member	27 Sept 2023	08 Nov 2023	06 Mar 2024
Borough Council of King's Lynn & West Norfolk	**Cllr Jo Rust**	X	X	X
Breckland District Council	**Cllr Tristan Ashby**			X
Broadland District Council	**Cllr Natasha Harpley**	X		X
Cambridgeshire Community Services NHS Trust	**Anna Gill**		X	X
East Coast Community Healthcare CIC	**Ian Hutchison**	X*	X*	
East of England Ambulance Trust	**David Allen**	X	X*	X
East Suffolk Council	Cllr Mike Ninnmey **Cllr David Beavan**	X	 X	 X
Great Yarmouth Borough Council	**Cllr Emma Flaxman-Taylor**		X	X
Healthwatch Norfolk	**Patrick Peal**	X	X	X
James Paget University Hospital NHS Trust	Joanne Segasby **Mark Friend**		X*	 X
Norfolk Care Association	Christine Futter **Angela Steggles**			X
Norfolk Community Health & Care NHS Trust	**Lynda Thomas**		X*	
Norfolk Constabulary	**ACC Nick Davison**	X	X	X
NCC, Cabinet member for Adult Social Services	**Cllr Alison Thomas**	X		
NCC, Cabinet member for Childrens Services	**Cllr Penny Carpenter**			X
NCC, Cabinet member for Public Health and Wellbeing, Leader (nominee)	**Cllr Bill Borrett**	X	X	
NCC, Interim Executive Director Adult Social Services	**Debbie Bartlett**	X	X	X*
NCC, Executive Director Children's Services	**Sara Tough**	X	X	X
NCC, Director of Public Health	**Stuart Lines**	X	X*	X
Norfolk & Norwich University Hospital NHS Trust	**Tom Spink**		X*	X*
Norfolk & Suffolk NHS Foundation Trust	Stuart Richardson **Caroline Donovon**	X*	 X	 X*
NHS Norfolk and Waveney Integrated Care Board (Chair)	**Rt Hon Patricia Hewitt**	X	X	X
NHS Norfolk and Waveney Integrated Care Board (Chief Executive)	**Tracey Bleakley**		X*	X*
North Norfolk District Council	Cllr Wendy Fredericks **Cllr Liz Withington**			 X
Norwich City Council	Cllr Cate Oliver **Cllr Claire Kidman**		X	 X
Place Board Chair (Great Yarmouth & Waveney)	**Jonathan Barber**	X	X	
Place Board Chair (Norwich)	**Tracy Williams**	X	X	X
Place Board Chair (North Norfolk)	**Dr James Gair**			
Place Board Chair (West)	**Carly West-Burnham**	X		X*
Place Board Chair (South Norfolk)	**Dr Ge Yu**			
Police and Crime Commissioner	**Giles Orpen Smellie**			
Queen Elizabeth Hospital NHS Trust	**Chris Lawrence**			X
South Norfolk District Council	**Cllr Kim Carsok**	X	X	X
Voluntary Sector Representative	**Emma Ratzer**	X		
Voluntary Sector Representative	**Dan Mobbs**	X		
Voluntary Sector Representative	**Alan Hopley**	X	X	X
Norfolk Health Overview and Scrutiny Committee (Chair) (Guest)	Cllr Fran Whymark	n/a	X	X
Suffolk County Council, Cabinet member for Adult Care (Guest)	***Cllr Beccy Hopfensperger***			
Suffolk County Council Representative (Guest)	***Bernadette Lawerence***			X
University of East Anglia Representative (Guest)	Prof Nicole Horwood	N/A	N/A	X

*X member attended, * Indicates Substitute attended*

Norfolk Health and Wellbeing Board

Item No: 9

Report title: Amendments to the Health and Wellbeing Board Terms of Reference

Date of meeting: 12 June 2024

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

Reason for the Report

There have been changes to the membership of the Norfolk Health and Wellbeing Board (HWB) due to a review of the Norfolk County Council Constitution, therefore it has become necessary to make amendments to the HWB Terms of Reference (ToRs).

Report summary

HWBs were introduced as statutory committees of all upper-tier local authorities under the Health and Social Care Act 2012. The Norfolk HWB then came into effect on 1 April 2013 and subsequently has had Terms of Reference (ToRs) for its meetings. It is also good governance to review the HWB ToRs yearly. There have been recent changes to the membership due to the change in landscape such as the change of East Suffolk Council, changes to the titles of cabinet members, removal of the Area Director for NHS England and Leader of the council nominee.

Recommendations

The HWB is asked to:

a) Note the changes to the Health and Wellbeing Boards Terms of Reference.

1. Background

1.1 The Health and Care Bill was published and first introduced in the House of Commons on 6 July 2021, with the reforms set to come in to effect on 1 July 2022. It is good practice to review the Governance and Membership of the HWB yearly and there have been recent changes which have prompted the need to revise the ToRs.

2. Revised Terms of Reference

2.1 As a result of the changing landscape locally there is no longer a need for the Area Director NHS England representative, the Leader of the council nominee. The East Suffolk Council representative has replaced the Waveney District Council and there have been further changes to cabinet members titles which has resulted in a required change to the HWB Terms of Reference, these will then be taken as an amendment to Norfolk County Councils constitution. The revised Terms of Reference are attached at **Appendix A.**

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

Name: Debbie Bartlett Tel: 01603 303390 Email: debbie.barlett@norfolk.gov.uk

Health and Wellbeing Board – Terms of Reference

Health and Wellbeing Board

5.1 Composition

Cabinet Member for Adult Social Care
Cabinet Member for Children's Services
Cabinet Member for Public Health and Wellbeing
Director of Public Health*
Chief Executive Officer (or their nominee), Norfolk County Council
Executive Director of Children's Services*
Executive Director of Adult Social Services*
Chair of Healthwatch Norfolk*
Representatives agreed with the Integrated Care Board
Representatives agreed with all 7 District/City/Borough Councils
Three representatives from the voluntary sector, as agreed through Norfolk Voluntary, Community and Social Enterprise System Leadership Group
Norfolk's Police and Crime Commissioner
Norfolk's Chief Constable
Cabinet Member for Community Health – East Suffolk Council
East Coast Community Healthcare CIC
James Paget University Hospital NHS Trust
Norfolk Community Health & Care NHS Trust
Norfolk Care Association
Norfolk & Norwich University Hospital NHS Trust
Norfolk & Suffolk NHS Foundation Trust
Queen Elizabeth Hospital NHS Trust
Cambridgeshire Community Services NHS Trust
East of England Ambulance Trust
* Denotes statutory Member

5.2 Terms of Reference

Aim

The Norfolk Health and Wellbeing Board will work to lead and advise on work to improve the health and wellbeing of the population of Norfolk by providing strategic system leadership of, and oversight for, the commissioning across the NHS, social care and public health.

Purpose is to:

1. Lead the development, with Norfolk County Council and the Integrated Care Board, of the Joint Strategic Needs Assessment (JSNA).

2. Influence and support commissioners of health and wellbeing services to act in line with the evidence-based findings of the JSNA and to highlight where commissioning is out of step with best evidence.

3. Lead the development, with Norfolk County Council and the Integrated Care Board, of the Joint Health and Wellbeing Strategy (JH&WBS).

4. Undertake the Norfolk Pharmaceutical Needs Assessment (PNA).

5. Speak up for Norfolk, championing the health and wellbeing needs of the people of Norfolk at a local, sub-regional, regional and national level and challenging central government policy where it conflicts with locally identified priorities.

6. Lead and encourage a broad base of partners outside of formal health, public health and social care settings to tackle the wider determinants of health and wellbeing including, for example, housing.

7. Work as system leaders to drive the further integration of health and social care services, and other public services, and to ensure collaboration across the health and social care system, seeking assurance of the vision of the Norfolk and Waveney Integrated Care System.

8. Promote the sharing of good practice and learning across the Norfolk health and wellbeing system, through workshops, training sessions, HWB events, good practice awards, etc.

9. Seek assurance on whether the Integrated Care Systems commissioning plans take proper account of the JH&WBS, and provide a view to NHS England, as part of the annual performance assessment of Integrated Care Boards, on the Integrated Care Boards contribution to the delivery of the JH&WBS.

In addition to the above Terms of reference, the following provisions apply:

- Establishment of sub-committees and delegation – the Health and Wellbeing Board will have the power to establish sub-committees and to delegate functions to them.
- Voting restrictions – voting rights will be extended to all members of the Health and Wellbeing Board (not just elected Members).
- Political proportionality requirements – will not be a requirement for the Health and Wellbeing Board.
- Disqualification for membership – provision for disqualification for membership will apply to the Health and Wellbeing Board.
- Codes of Conduct and declarations of interest – the provisions in the Council's Constitution relating to Codes of Conduct and the disclosure of pecuniary interests will apply to all Members of the Health and Wellbeing Board.

Questions by the Public:

The public are entitled to ask questions at meetings of the Health and Wellbeing Board, in line with the following procedures:

1. How to ask a question

A question must be put in writing and in advance:

a) 3 working days' notice of the question is given in writing to the Assistant Director of Governance (Democratic and Regulatory Services); e.g. no later than 9:00am on the Monday preceding the Health and Wellbeing Board meeting on a Wednesday;

or,

b) If the question relates to urgent matters, and it has the consent of the chair to whom the question is to be put, and the content of the question is given to the Assistant Director of Governance (Democratic and Regulatory Services) by 4pm on the day before the meeting.

2. Who may ask a question and about what

A person resident in Norfolk, or who is a non-domestic ratepayer in Norfolk, or who pays Council Tax in Norfolk, may ask at a public meeting of the Health and Wellbeing Board through the Chair any question within the terms of reference of the Health and Wellbeing Board about a matter for which the Board has collective responsibility or particularly affects the Board. This does not include questions for individual Board members where responsibility for the matter sits with the individual organisation.

3. Rules about questions

a) Number of questions - At any public Health and Wellbeing Board meeting, the number of questions which can be asked will be limited to one question per person plus a supplementary. No more than one question plus a supplementary may be asked on behalf of any one organisation. No person shall be entitled to ask in total under this provision more than one question, and a supplementary, to the Health and Wellbeing Board in any six-month period.

b) Other restrictions - Questions are subject to a maximum word limit of 110 words. Questions that are more than 110 words will be disqualified. The total time for public questions will be limited to 15 minutes. Questions will be put in the order in which they are received.

c) Supplementary questions - One supplementary question may be asked without notice and should be brief (fewer than 75 words and take less than 20 seconds to put). It should relate directly to the original question or the reply. The Chair may reject any supplementary question they do not consider compliant with this requirement.

4. Response

The Chair shall exercise their discretion as to the response given to the question and any supplementary.

Not attending - If the person asking the question indicates they will not be attending the Board meeting, a written response will simply be sent to the questioner.

Attending - If the person asking the question has indicated they will attend, response to the questions will be made available at the start of the meeting and copies of the

questions and answers will be available to all in attendance. The responses to questions will not be read out at the meeting.

Supplementary question - The Chair may give an oral response to a supplementary question or may require another Member of the Board or officer in attendance to answer it. If an oral answer cannot be conveniently given, a written response will be sent to the questioner within seven working days of the meeting.

Written response - If the person who has given notice of the question is not present at the meeting or if any questions remain unanswered within the 15 minutes allowed for questions, a written response will be sent within seven working days of the meeting.

5. Rejection of a question

The Director of Democratic and Regulatory Services may reject a question if it:

a) Is not about a matter for which the Board has collective responsibility or particularly affects the Board;

b) Is defamatory, frivolous or offensive or has been the subject of a similar question in the last six months or the same as one already submitted under this provision;

c) Requires the disclosure of confidential or exempt information, as defined in the Council's Access to Information Procedure Rules.

Norfolk Health and Wellbeing Board

Item No: 10

Report title: Norfolk Joint Health and Wellbeing Strategy and Norfolk and Waveney Integrated Care Strategy Progress and Joint Forward Plan update

Date of meeting: 12 June 2024

Sponsor (ICP member): Debbie Bartlett, Executive Director, Adult Social Services, Norfolk County Council
Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney Integrated Care Board

Reason for the Report

The Integrated Care System has been in existence for two years now and it is timely to review and reflect on the work since its inception. Under the Statutory Guidance on the preparation of Integrated Care strategies it states that the *'Integrated Care Partnerships (ICP) must consider revising the Integrated Care Strategy whenever they receive a joint strategic needs assessment (JSNA)'.* The Integrated Care Partnership (ICP) has just received an updated JSNA, and therefore needs to refresh the combined Integrated Care Strategy for Norfolk and Waveney and the Joint Health and Wellbeing Strategy for Norfolk, remove the transitional aspect, and review the progress made against the four priorities within it since its agreement by the ICP on 21 September 2022.

The second part of this report seeks an opinion of the Norfolk Health and Wellbeing Board (HWB) on the 2024/25 – 2028/29 draft Joint Forward Plan (JFP) (Appendix B). The JFP is a rolling five-year plan and must describe how the Integrated Care Board (ICB) proposes to implement relevant joint local health and wellbeing strategies. This Board provided an opinion last year which was published in the first JFP. The guidance makes it clear that this should be repeated each time the JFP is refreshed. Go to NHS England to read the guidance on developing the JFP, page 7 sets out the role of Health and Wellbeing Boards.

Given that the two documents are so closely linked, this joint report brings these two requirements together.

Report summary

This report updates the combined Integrated Care Strategy for Norfolk and Waveney and the Joint Health and Wellbeing Strategy for Norfolk and highlights just some of the progress made against our system priorities. In addition, this report takes the opportunity to request an opinion from the Norfolk Health and Wellbeing Board on the proposed refreshed 2024/25 Joint Forward Plan (JFP). The report also signals the intent to undertake further joint consultation with our local population during the latter part of 2024/25 to sense check the priorities within both the Strategy and the JFP, ready for 2025/26.

Recommendations

The HWB is asked to:

a) Agree the combined Integrated Care Strategy for Norfolk and Waveney and the Joint Health and Wellbeing Strategy for Norfolk that has been refreshed with the latest JSNA data; that it will be kept as a live document and updated as required as our system

progresses; and acknowledge the system breadth of progress made so far against the priorities.

b) Consider the content of the draft 2024/25 – 2028/29 JFP for Norfolk & Waveney and whether it takes proper account of the Integrated Care Strategy for Norfolk and Waveney / Joint Health and Wellbeing Strategy for Norfolk that relates to any part of the period to which the JFP relates.

c) In the coming year agree to sense check the priorities within the strategy and the Joint Forward Plan with people who live and work in our area and look to establish high level measures we will hold ourselves accountable for as a system against our Strategic aims.

d) To agree a statement of opinion on behalf of the Norfolk Health and Wellbeing Board for inclusion in the 2024/25 – 2028/29 JFP.

1. Background

1.1 At the ICP meeting on 21 September 2022, there was an agreement to adopt the combined Transitional Norfolk and Waveney Integrated Care Strategy and the Norfolk Joint Health and Wellbeing strategy.

1.2 It has been two years since the creation of our Integrated Care System and the development of our transitional strategy. As a system it is timely to refresh the data as we have received an updated JSNA, remove the transitional aspect of the strategy, and reflect on some of the progress made since that time against the four agreed priorities of, Driving Integration, Prioritising Prevention, Addressing Inequalities and Enabling Resilient Communities.

1.3 There have been huge amounts of work involving all partners across the system towards our priority actions contained within the Strategy. It is not possible to list them all so this report contains some of the progress highlights for partners since the Strategy was adopted. Examples of the work that is taking place is contained in **Appendix A**.

1.4 It is also important to note the Health & Wellbeing Partnerships (HWPs), since being formed in 2022 have gone from strength to strength and their unique positioning within our Integrated Care System has enabled them to deliver work tailored to local need that is delivering against our Strategic priorities. This work is contributing to reducing health inequalities and increasing community resilience through driving integration and focusing on prevention and wider determinants of health, see Appendix A for examples of this.

1.5 The rolling five-year JFP is one of the delivery mechanisms of the Health and Wellbeing Strategy, and Appendix A also includes outcomes delivered through the eight Ambitions within the JFP during 2023/24.

1.6 Our Integrated Care Strategy has had a light touch refresh to update the document with the latest JSNA data and to remove the transitional wording. The document is attached at Appendix B.

2. 2024/25 – 2028/29 JFP refresh summary.

2.1 This section of the report brings partners up to date with the refresh of the rolling five-year JFP, building on the progress made in 2023/24. To view the five year JFP in detail go to improvinglivesnw.org.uk.

2.2 N&W undertook a public engagement exercise in 2023, which is described in section 3.6 of the JFP. The 2024/25 refresh has been undertaken with our ICS partners and stakeholders and shared with both Norfolk and Suffolk Healthwatch organisations. The leads for each of the Ambitions have led their own refresh and taken these through local delivery boards, groups and workshops with our partners using a matrix working approach utilising established governance.

2.3 The JFP underpins our ICS mission to help the people of Norfolk and Waveney to live longer, healthier, and happier lives. The structure of the 2024-2029 JFP is unchanged in that Part 1 sets out the Why, What, When, How and our commitment to deliver, and Part 2 is our response to our Legal Duties.

2.4 The financial context in which we set out to deliver the JFP is more challenging than ever though. We have aligned the 2024/25 objectives and deliverables to our Medium-Term Financial Plan, but the final planning return was not submitted until 2nd May.

2.5 The 2024-2029 N&W JFP is a summary refresh and remains focussed on the eight Ambitions which were developed through public consultation in early January 2023. To view these 8 ambitions go to improvinglivesnw.org.uk. As per Recommendation b) in today's paper we are proposing to sense check these later in the year as an aligned piece of work between the strategy and the JFP.

2.6 Underpinning the eight Ambitions are 21 Objectives. These have all been reviewed with system partners as part of the rolling five-year programme of work, and some of them will be concluded in years three or four. One specific change to highlight is that objective 3(d) 'to develop an improved and appropriate offer for children's occupational therapy' has been moved to business as usual. A new objective 3(d) will 'develop an improved and appropriate offer for children's neurodiversity', which was determined with partners to be an important priority.

2.7 N&W JFP indicators are set against each of the 21 objectives. These are shown on Figure 14 on pages 130 and 131 of the draft published JFP.

2.8 Each of the Objectives have key dates for delivery, and measurables to track how we will know we are achieving. These are set out in section 4.0 of part 1. They are reported to the ICB Commissioning and Performance Committee, published in the ICB annual report and on the dedicated JFP pages on the ICS website.

2.9 The N&W JFP takes account of the four cross-cutting themes of the combined Integrated Care Strategy for Norfolk and Waveney and the Joint Health and Wellbeing Strategy for Norfolk. In addition, some examples of the alignment are highlighted below:

2.9.1 ***Driving integration:*** Section 6.0 in part 1 of the JFP is all about working together differently and shows how the community services review, our five Place Boards, eight Health & Wellbeing Partnerships, provider collaboration, and work with the VCSE continue to align to the priorities within the JFP.

2.9.2 ***Prioritising Prevention:*** The role of prevention is a key thread throughout the N&W JFP and a refreshed, evidence-based Life Course approach supports where to focus our effort. Ambition 1 is about supporting prevention and continues three specific objectives i.e. a maternity led stop smoking service, early cancer diagnosis through targeted lung checks and interventions targeting high blood pressure and cholesterol. The focus is now on

ramping up the pace of delivery, expanding coverage, monitoring and evaluation. In 2024/25 Ambition 2 includes a refreshed objective to stabilise dental services and Ambition 5 has been updated to implement the recently published Ageing Well framework.

2.9.3 ***Addressing inequalities:*** In 2023/24 an objective within Ambition 1 was to develop a Health Inequalities Strategic Framework for action. This has been completed, with excellent system engagement, and the 2024/25 focus is on delivery. Approval of the Framework is item 8 on today's ICP agenda. ICB's have a legal duty to reduce health inequalities and our approach is updated within Part 2 of the JFP.

2.9.4 ***Enabling resilient communities:*** The JFP makes a commitment to the principle of subsidiarity so if we can do something better locally, then we should do so, co-ordinated through Place Boards and the H&WB Partnerships. Our recent work with the Community Voices programme is referred to in the JFP in section 6.1 of part 1 and has been particularly helpful in the development of the Health Inequalities Framework for action.

2.10 In addition to the alignment described here, the Strategy is referred to a key document within section 6.3, part 1 of the JFP - our partners plans and strategies.

2.11 Other updates to the JFP include a new case study about Learning Disabilities and Autism and reference to the 59 specialised NHS services that have been delegated to the six ICB's in the East of England from NHS England on 1 April 2024.

2.12 The HWB is asked to agree the statement of opinion on behalf of the Norfolk Health and Wellbeing Board for inclusion in the 2024/25 - 2028/29. The Suffolk Health and Wellbeing Board provided a statement of opinion at their meeting on 16 May 2024 and both will be included. The JFP will be published in July subject to any final feedback from the NHSE regional team.

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Integrated Care Strategy Progress

JFP Ambitions/Objectives	Key work strands - Description and Outcomes	Driving Integration	Prioritising Prevention	Addressing Inequalities	Enabling Resilient Communities
Ambition 1	**Population Health Management, Reducing Inequalities and supporting prevention.** • The N&W ICS Population Health Management Strategy (2024 -2029) has been published. It describes a proactive way of working and data driven priorities for action to improve health and reduce health inequalities. • The N&W ICS Health Inequalities Strategic Framework for Action (2024 – 2034) is on today's agenda for final approval. The Framework has been developed through our Health Inequalities Conversation across multiple partners and sectors across Norfolk & Waveney. 10 initial actions have been identified that will be implemented this first year of the strategic framework to lay the foundations for future years. • A new maternity led stop smoking service has been developed and is being delivered by Norfolk's three acute hospitals with system partners. NCC led a pilot Smoking in Pregnancy Incentive Scheme which is being evaluated. • A programme of lung checks is being rolled out in the Great Yarmouth and Lowestoft area, with the aim of diagnosing cancer earlier. Uptake levels are slowly increasing. • A programme is underway to identify patients with high blood pressure and cholesterol and to act early in primary care and community settings. The work has	✓	✓	✓	✓

	started but further training and support is needed for GP practices.				
Ambition 2	**Primary Care Resilience and Transformation** • There has been a delay to the development to strategic planning for general practice due to the need to focus on operational day to day resilience and new work such as the roll out of Pharmacy First. This objective continues in 2024/25. • The long-term dental plan is agreed and being published. Delivery of the short-term dental plan published in September 2023 is underway. We have mobilised an urgent dental treatment service to improve access for any individual in dental pain through a new pilot scheme. 18 new dentists recruited, there is a 25% increase of approved foundation dental training practices and 66% increase of approved dental supervisors across the system.	✓	✓	✓	
Ambition 3	**Improving services for Babies, Children and Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS)** • 7 Family hub sites are operational, including an alternative virtual offer. Additional services have been aligned to hubs. • Our LMNS continues to develop. The LMNS dashboard has been published. The maternity vacancy rate has reduced and improved to 7% (Sept 2023 figures). • We are implementing the national asthma and epilepsy recommendations, for Children and Young People. There has been excellent engagement across the system with successful campaigns in place to raise awareness of Asthma.	✓	✓	✓	✓

	• An improved and appropriate offer for Children's Occupational Therapy has been delivered. The co-designed website and handbook for schools and training packages for professionals have all been published and rolled out. The parent page has been published and recruitment of additional therapists is underway.				
Ambition 4	**Transforming Mental Health Services** • We are working together to increase awareness of mental health; to enable our population to develop skills and knowledge to support wellbeing and improve mental health. The refreshed Suicide Prevention strategy has been developed with stakeholders and is in final stages before being published. • Adult and Children and Young People Mental Health Collaboratives were launched April 2023 and projects undertaken. • The Integrated front door service has been launched and the number of children and young people accessing the right support to meet their emotional wellbeing and mental health needs has increased. • We want to see the whole person for who they are and have targeted some specific improvements in the areas of complex emotional needs (CEN) and dual diagnosis. 300 additional staff have been trained in CEN approaches in 2023/24 and therapies is part of the wider community transformation work. Dual Diagnosis workshop took place 23/01/2024 - feedback and comments have been collated and translated into a new five-year JFP workplan	✓	✓	✓	✓

Ambition 5	**Transforming Care in Later Life** • Stakeholder workshop held December 2023 and Ageing Well Strategic Framework published. • 5 workstreams identified: (Frailty Focussed Acute Care; Prevention; Care Home and Housing with Care; Dementia; and Education). • Links established with other key interdependent programme areas (Palliative and End of Life Care, Urgent & Emergency Care, Population Health Management, Medicines Management) • Inaugural meeting of Norfolk & Waveney Clinical Ageing Network • Finalised Dementia Charter and shared across the system. • Development of N&W Ageing Well news bulletin	✓	✓	✓	✓
Ambition 6	**Improving Urgent and Emergency Care** • This is core business. Ambition is managed through an Urgent & Emergency Care Board. The improvement trajectories are part of national monitoring and tracking processes. • The pressure remains within the operational element of urgent and emergency care. This has been compounded by industrial action reducing capacity for transformation. Areas of improvement have continued, albeit slower than anticipated. • Successes include a reduction in demand, the number of patients awaiting discharge from hospital, the unscheduled care coordination hub now includes support to ambulance crews on scene and there is support for mental health patients who are ringing 999. Focus of partners is to address root causes of issues affecting ambulance handover.	✓		✓	

Ambition 7	**Elective Recovery and Improvement** This Ambition is managed through an Elective Recovery Board. The improvements trajectories are part of national monitoring and tracking processes. As per UEC, progress against the headlines has been challenging and reducing the number of long waiting patients remains a key priority in 2024/25. • We are using capacity across health system partners to reduce waiting times and deliver care locally. 742 patients chose to be treated elsewhere in 2023/24 to reduce their waiting time. • The NNUH Paediatric Centre opened in January 2024 which increased capacity for elective care. The three Diagnostics Centres are all on track to open in 2024/25, and the Elective Orthopaedic Hub at the JPUH will be open in October 2024 • The number of patients waiting 63 or more days after referral from a cancer patient tracking list continues to decrease. • In March 2024, all three trusts achieved a noticeable improvement in the Faster Diagnosis Standard with the NNUH achieving over 75%.	✓		✓	
Ambition 8	**Improving Productivity and Improvement** • Three cases for Change to improve productivity were delivered. These were in the areas of Human Resources, Digital and reducing the length of stay in hospital.	✓			
Health and Wellbeing Partnerships - Programme/Project	**Key Work strands -Description and Outcomes**	**Driving Integration**	**Prioritising Prevention**	**Addressing Inequalities**	**Enabling Resilient Communities**

Shadowing Programme	Run a match making service for staff within the system to shadow others. This is with the intention of raising awareness of different motivations, remits, and barriers to enhance understanding of how to best work together increasingly collaboratively. Outcomes: • 21 people have expressed an interest in the programme. • 7 placements complete (100% would recommend this programme to someone else). Feedback from placements have been overwhelmingly positive, comments on what they will do differently following the placements includes: *"I'll be more confident with my referrals and will know how each team within Children's Services will be able to deal with my referral. Sharing best practice has also been really useful." "[I] speak with greater knowledge and confidence, [and will] involve DWP in more conversations which are relevant to them."*	✓			
Great Yarmouth Community Hub	The Great Yarmouth Community Hub currently has 343 professional partners from 41 organisations. Partners of the Community Hub attend bi-weekly meetings which are an opportunity to discuss cases and encourage the provision of multi-agency wrap around support. Community Marshals and Case Workers work within the Hub supporting residents with wider welfare and social needs. Outcomes: • Oct 2022 – March 2024, Community Marshalls: • 8458 residents engaged with service, • 1492 residents spoke foreign language, • 721 Case Work, • 142 Diabetic Risk calculation, • 1175 Home visits.	✓	✓	✓	✓

All To Play For	Using football to engage with men with mental health concerns. Improve social support network, physical activity. Provide information & advice on alcohol, drugs, health checks & men's issues. Outcomes: • To date, the project has supported 110 men across Norwich sessions. The funding has also enabled 70 men who were already engaged in the project to remain supported. • During this time, the project had engaged with 29 support services. • 75% reported an increase in weekly physical activity levels with 55% also reporting improved fitness. • 59% reported making friends. • 64% reported feeling less anxious and stressed as a result of attending All To Play For. • 41% reported improved mood. • 36% reported they were better able to manage their health. • Of the participants takin medication for their mental health, 50% saw a reduction in medication at 3 months, whilst the other 50% reported no change to their medication intake. • The project has facilitated better connectivity internally within NHS services and supporting better integration of voluntary sector and the role it can play in helping the strain on the NHS.	✓	✓	✓	✓
Stroke Reach	Co-developed pathway of support across Norfolk & Waveney for stroke survivors post discharge from stroke wards. Wrap-around support includes exercise provision (provided through AgeUK's Health Coaches, Broadly Active, and others), Help	✓			

	Hub support, Headway's ABI Connections Programme, and more depending on locality. This project uses Active NoW as one referral point into these services and has taken over 290 referrals since beginning. Outcomes • 81% take-up demonstrates the need for wrap-around support such as this. • Increased trust between clinical and non-clinical services to deliver the right support at the right time. • Feedback from an individual supported by Health Coaches: "You have given me the confidence to carry on exercising and thinking positively about the future."				
PositiviTea events	A series of informal events for people to seek support and signposting regarding financial issues, physical and mental health problems, or simply for a reassuring chat and refreshments. Outcomes: • Adult Social Care attendee said: "…PositiviTea events have assisted me to do my role as I have very limited hours to get out into the community. The information shared enables me to provide better information to vulnerable individuals…" • Matthew Project attendee said: "The events they hold in more remote parts of North Norfolk … enable us to promote our own services to people in those communities and other local organisations." • North Norfolk Council attendee said: "The events were a really great place to take the opportunity to put right any preconceived ideas people may have about claiming benefits and making sure they have the real facts so they're able to claim what they're entitled to."	✓	✓		✓

	• Healthwatch attendee said: "…we've been able to make new connections with local groups and spent time furthering existing relationships."				
Falls Prevention Initiatives	A range of initiatives developed by the partnership workstream to prevents falls and reduce admission to hospital and up skilling the local workforce for system sustainability. These include: Community Exercise sessions delivered by Your Health Norfolk and Dance to Health, Trusted Assessor Training, Physical Activity Training, Equipment purchase for communal room cross the borough for community providers to use, slipper swap event in libraries, and a decluttering service. Outcomes: • Your Health Norfolk 12-week exercise classes 159 participant (Jan 2024). Dance 2 Health in progress. • Level 3 & 4 Trusted Assessor Training. L3 – 12, L4 in development. • Equipment available and easy to access by community groups in 4 / 5 community rooms across the borough. • Decluttering service for ½ day house clearance for referrals from Community Hub and James Paget Hospital.	✓	✓		
Our Day Out	Creative activities focused on wellbeing, using dance, music, and movement to reduce loneliness & social isolation. For people with dementia, LTC's, long covid and their carers & bereaved. Outcomes: • 80% of participants experienced increased wellbeing, • 97% have increased social connections, • 91% experience a sense of belonging.		✓	✓	✓

Box Up	In a first in the UK, 'Box Up' is coming to Lowestoft this spring! Box Up is a modular system of storage boxes, placed in public areas like parks, playing fields or beaches, which hold a range of sports and leisure items. These could include a rounders bat and ball, football, frisbee, cricket bat, ball and stumps or litter picking equipment. Residents can use the items free of charge by registering on the App and using this to open and close the boxes. The boxes are solar panel controlled and only Bluetooth is required to use the App, which can record key information about usage, what equipment is popular, how long it was loaned for, user ages and home location (to check reach into our most deprived communities). The boxes can be relocated, or the equipment changed, if the data shows low usage in any given area. The project has been developed by the Lowestoft and Northern Parishes Community Partnership, with the aim of increasing sport and leisure participation and supporting positive mental health and wellbeing. As most activities require others to join in, it is hoped that using the equipment could also help reduce social isolation and loneliness in the target areas.		✓	✓	✓
Community Alcohol Partnership, Youth Health Champion Training	Youth Health Champion training around alcohol delivered in schools. Education provided by Royal Society for Public Health Level 2 qualification. Anticipated outcomes: • Enable 30 disadvantaged young people to obtain a Level 2 qualification.		✓	✓	✓

	• Support and enable young people to develop a health improvement message on an issue that matters to them and share with their peers. • Take part in their local CAP and develop further social action campaigns. • Form a group of Young Health Champions across West Norfolk who can provide views on health and wellbeing issues affecting young people and share ideas for social action.				
Healthy Hearts	Data shows that in Lowestoft, emergency hospital admissions for cardiovascular (CVD) related health conditions and premature deaths are significantly higher than the national average. So, this project aims to address health inequalities in Lowestoft with a focus on CVD. It has three main elements: Community engagement (Community Voices), Lowestoft Health Hearts, Community-led interventions. Anticipated outcomes: • Increase diagnosis of hypertension and optimise hypertension management. • Reduce health inequalities by reducing morbidity and mortality from CVD in most deprived communities. • Reduce barriers to accessing healthcare and empower Lowestoft residents to make healthy behaviour choices which have an impact on heart health.		✓	✓	✓
PitStop	Drop-in/social support/workshop spaces for men with a focus on mental health, wellbeing, alcohol & CVD. Swaffham, Watton, Dereham, Thetford. Led by health champions to deliver low level health check and positive activities. Outcomes:		✓	✓	✓

	• 84 individuals signed-up, 86% maintained engagement (Breckland). • 60 individuals signed up, 78% maintained engagement (West Norfolk). • Activities included visual arts, fishing, ceramics, card and board games, walking groups, woodland project, and many more. • "MensCraft has helped me to be able to leave my house and meet people which is something I have not been able to do for a lot of years." "It has helped with my anxiety meeting new people."				
Food for Thought/Lily	Cooking classes, budgeting, and referrals to other Lily services. Outcomes: • Round 3: 201 attendees. • Round 4: 168 attendees. • Attendees signposted from local services including: Pandora Project, Harbour Centre, Boudica Court Accommodation, Targeted Youth Support Service (Momentum). • 100% agreed Food for Thought helped increase their knowledge and understanding of the importance of eating healthy and having an intake of basic nutrition. • 100% agreed Food for thought helped improve or maintain current health condition. • Attendee consumption of fruit and vegetables per week increased from 0 to 3 consuming 10+ a week. • 100% agreed Food for Thought increased confidence in household budgeting.		✓	✓	✓

Community Health Workers	Recruit community health workers to proactively engage with households in a set area in Watton to provide universal, comprehensive, and continuous support to residents. Outcomes: • 15% reduction in A&E attendance. • Watton had its best year in flu jab uptake on record in 2023. • 404 onward referrals for basic needs (food, finance, housing, adult social services).		✓		✓
Waveney Health and Wellbeing Partnership	Brings Partners together including the three Community Partnerships and the physical and mental health networks that sit underneath the partnership. Key projects are: • Lowestoft Health Hearts Programme. • Winter Warmth Warm Homes pilot in partnership with ICB. • Inclusive Communities Programme. • Invested more than £100k in a wide range of community led projects ranging from dance for fitness classes, mental wellbeing courses and an 'Community Soup' seed funding programme to oral health projects for primary school children. • ESC Ease the Squeeze programme - including funding for Warm Welcomes, Field to Fork Growing Spaces, Cooking on a Budget classes, Community Pantries, low energy cooking equipment, Field to Fork Growing kits and Uniform Banks. • Community Help Hub Team has taken almost 2,000 referrals for help with money, accessing food, social care, mental wellbeing and a wide range of practical needs ranging from baby equipment to furniture.	✓	✓	✓	✓

	• Feel Good Suffolk programme which helps people with weight management.				
Norwich Health Justice Partnership	Scaling up an existing initiative: Help Through Crisis: delivered by Norfolk Citizens Advice and MAP, Health @ Home: delivered by Age UK Norwich. Norfolk Community Law Service: legal help on family/domestic abuse/wider social welfare legal matters, Equal Lives: advice and increased opening hours of Shopmobility site, The Bridge Plus: help with complex needs through intensive one to one information, advice and advocacy support, Shelter, access to specialist legal help and representation for clients facing housing crises. Outcomes: • Supported 1833 clients to access relevant advice in 2022/23. • Total amount of debt written off/re-negotiated for Norwich clients: £1,212,262.86.		✓	✓	✓
Migrant Digital Support	Deliver digital training and provide devices to migrant community using a mixture of approaches. Outcomes: • The Digital Skills Coach supported 21 people via Hanseatic Union Sessions, alongside further work done by Hanseatic Union. • Case study: A woman struggling with English has now received a laptop and help to use it as she was finding it difficult to apply for jobs on her phone. She also received food vouchers from Hanseatic Union and is now having intensive support as she faces homelessness from her landlord selling the house she lives in. Without Hanseatic Union and Tech Skills for Life working together, she would not have known where to access support.			✓	✓

Warm Homes Project	Identifying clinically and socially vulnerable residents by overlaying health and council data sets to proactively target financial support to reduces exacerbations of living in a cold / damp home. Outcomes: • The project demonstrated the benefits to linking health and local authority data sets to identify specific vulnerable households to receive non-clinical support to improve their health. • 720 residents in Great Yarmouth were identified and received a letter and call to discuss financial vulnerability and further information about keeping warm and where wider support is available, e.g. energy providers, local warm spaces, financial assistance schemes. • 115 referrals made to GYBC Community Hub for Household Support Fund and welfare support.	✓	✓	✓	✓
Mindful Towns and Villages	Delivering free wellbeing and mental health awareness training though NSFT and mental health champion training to local community groups, businesses, shops, pubs, etc. This is to raise awareness of mental health and wellbeing issues at the most local level and build a genuinely available group of people in local communities who can provide support and a 'listening ear'. Outcomes: • 19 courses delivered. • 170 people have received training and have joined the Wellbeing Champion Network receiving regular updates to support in wellbeing conversations.				✓

	• 8 areas awarded 'Mindful Town/Village' status which is dependent on number of wellbeing champions compared to overall population size.				
Safe and Habitable Homes	A self-neglect and hoarding service, delivered as an extension to the existing INTERACT (Integrated Anticipatory Care Team) service. INTERACT is a multi-agency service which was established to tackle housing issues that are negatively affecting health and wellbeing. It is preventative and supports individuals to remain independent in their homes and reduce their risk of needing input from health, social care or other support services and to prevent the possibility of formal eviction proceedings. Outcomes: • Significant numbers of people needing support with clutter, hoarding and/or self-neglect – often exceeding the offer from INTERACT. • A multi-agency team bringing together colleagues already working in this area such as social workers, housing colleagues, fire and rescue service. • Uncovering a hidden issue – working with or have supported around 60 people in Norwich, but now aware of over 130 more people who need our support. • Working long-term with clients as a wrap-around service to build rapport, declutter at their own pace, and provide support to approach the underlying causes of the client's self-neglect and hoarding behaviours.		✓	✓	✓
Age Friendly Communities	Age-friendly Communities commit to following the World Health Organisation's Age-friendly Communities Framework. This includes looking at the areas of the built and social			✓	✓

	environment which, when acted upon, can help to address barriers to ageing well. Outcomes: • North Norfolk have become an Age Friendly Community in 2024. Further outcomes to follow.				
Community Engagement Van	The van is a mobile space that will be used to visit towns and parishes across South Norfolk and Broadland, to provide support and advice to residents. The van will be parked in convenient and accessible locations, where residents can come along to talk to a member of the Help Hub team. Partners will be able to borrow the van for the purposes of community engagement as well as join the Help Hub Team on their regular weekly visits. This will help bring services together to meet the needs of our residents and promote collaborative working as services can get to know each other and understand opportunities for joint working. Outcomes: • The van made its debut visit to Coltishall Village Hall on 12th March 2024 and will be visiting weekly for 8 weeks. • Van will be visiting 5 locations in South Norfolk & Broadland between March 2024 and February 2025. • Outcomes from early visits will follow soon.	✓			✓
FLOURISH	**Key work strands -Description and Outcomes**	**Driving Integration**	**Prioritising Prevention**	**Addressing Inequalities**	**Enabling Resilient Communities**
Children and young people's system collaborative	In April 2023, a children and young people's system collaborative was established between Cambridgeshire Community Services NHS Trust, Norfolk County Council, Norfolk & Suffolk NHS Foundation Trust and the Norfolk & Waveney Integrated Care Board, with an initial focus on multi-disciplinary community-based delivery models for children	✓	✓	✓	✓

	and young people with mental health needs. It presents an extremely powerful opportunity to realise our ambition that all children flourish in Norfolk, through a focus on early intervention and prevention, 'place', looking holistically at needs, and a move away from a clinical model to one rooted in community-led early help. Recent developments have included greater integration of front door services, development of joint practice models, mental health support teams in schools and the introduction of School and Community zones.				
School and community zones	The adoption of 15 school and community zones, each with an average of 26 schools and around 40 early years settings or childminders, and approximately 11,500 children and young people, is allowing us to deploy resources and services locally. With schools, settings and colleges at the heart of the work that we do, the aim is to make it easier for them to access support and enable collaboration at a community level. Through the Local First Inclusion programme, Children's Services have been able to invest in new school and community teams which are now operating within each zone, with an initial focus on children with SEND and other emerging needs, to support their inclusion in mainstream settings. Working in this way, alongside our community and partnerships teams and local community organisations, is helping to identify and meet children's needs earlier, prevent escalation and the need for more specialist services.	✓	✓	✓	✓
Local First Inclusion programme	The Local First Inclusion programme commenced in April 2023 as a six year plan to deliver additional investment and changes as part of adopting a system-wide local first inclusion		✓	✓	

	approach to help intervene early and more holistically to prevent escalation of need, focusing on how we incentivise and increase mainstream inclusion practice. The programme is being led by Children's Services and delivered through 5 workstreams and over 80 individual projects. These projects span the full range of support for Special Educational Needs & Disabilities, and Alternative Provision, with the primary focus on local mainstream inclusion through 'SEN Support', alongside building more specialist resource bases (hosted by mainstream schools) and expanding state funded special schools.				
Start for Life and family hubs programme	Following Central Government's announcement in April 2022 that Norfolk was one of 75 local authority areas in England pre-selected to be part of the Start for Life and family hubs programme, as a partnership we have signed up to the programme given that it supports our shared Flourish ambition and therefore is integral to our wider partnership work to strengthen our prevention and early help offer for families. As a result, the County Council is receiving up to £6.4m of transformation funding for the period up to 31 March 2025, to enable the development of a Start for Life and family hubs approach that supports families with children aged 0-19 (25 with SEND). In line with our existing partnership Prevention and Early Help Strategy, it is an approach grounded in community engagement and partnership, working closely with local organisations and agencies to provide a wider range of joined-up services tailored to the needs of families in their area, in places that families already access. District Family Hub Partnership Groups have been established and are enabling us to assess local needs and identify local priorities for		✓	✓	✓

	families, with parents and carers playing a pivotal role in planning, decision making, quality assurance and evaluation of services including via a new Parent and Carer Panel. Reporting into the Children and Young People Strategic Alliance via the Prevention and Early Help Board, it is a significant and complex project which is being led by Children's Services as a partnership transformation programme with excellent ongoing support from colleagues across the Council, the ICB, partner agencies and providers.				
Digital and Data Programme/Project	**Key work strands**	**Driving Integration**	**Prioritising Prevention**	**Addressing Inequalities**	**Enabling Resilient Communities**
Norfolk and Waveney Shared Care Record	Phases 1 and 2 are complete, with the record now accessible in Norfolk County Council, all three Acute Hospitals, the community providers, Norfolk & Suffolk Foundation Trust, NHS 111, GP Practices and Out of Hours services. All of these organisations, apart from the community providers, are also contributing data to the record, which is being accessed by an average of 4,000 staff a week for 30,000 citizens.	✓			
Social Prescribing system	A Social Prescribing system, Joy, has been purchased and will be rolled out across Norfolk & Waveney. This will enable delivery of the Shared Care Record to the VCSE sector, as well as improving the uptake of social prescribing pathways and ultimately improving people's lives, and saving time in primary care. An initial engagement session was held with VCSE sector representatives.	✓	✓	✓	✓
Digital Champions and NHS App Ambassadors	A network of Digital Champions and NHS App Ambassadors has been established through GP Practice Patient Participation Groups and other community groups. Champions and Ambassadors have access to a range of	✓			

	resources to run NHS App events or provide access to digital skills training.				
Cloud based telephony	Cloud based telephony is being rolled out to all GP Practices in Norfolk & Waveney. These telephony systems will have call back functionality, which addresses an issue identified whereby people were using significant sums of mobile phone credit whilst waiting for their call to be answered. Calls will now be automatically answered and callers can then select the option to receive a call back when they reach the front of the queue.	✓	✓		
Remote observation technology	Remote observation technology has been rolled out to 40 care homes in Norfolk & Waveney and is being expanded to 40 more. The ability for remote observations gives clinicians at the GP Practice or in the 111 or Out of Hours setting, better information to assist decision making and means that residents can receive care at home where appropriate, avoiding a trip to A&E.		✓	✓	✓
Wi-fi	Reliable and resilient wi-fi is being rolled out to all GP Practice sites in Norfolk & Waveney. This will be available in all areas of the practice, which will mean that patients can use it to access services and information whilst in the waiting areas. 30 sites will be live in the next few weeks and the rest will follow.				✓
Access to records	Access to records has been enabled for Norfolk & Waveney citizens, accessible via the NHS App. This includes access to letters, GP consultations and test results. The Wayfinder project is extending this to secondary care referrals and outpatient appointments, and all hospitals in the area are signed up to this. This gives citizens better access to their data and reduces follow up queries to practices and hospitals.				✓

Digital Inclusion	• Digital Inclusion Programme set up in 2022 tackling Digital Exclusion through working in partnership, enabling universal access to connectivity, supporting access to devices and equipment and increasing digital skills and confidence in the community and finally developing the digital skills of all of our staff to enable them to better exploit technology and support residents. • We have been able to refurbish and distribute (to the community) 1342 devices this financial year and loan 860 laptops through the libraries laptop loaning scheme which launched in August. We have also supported over 3300 learners with digital skills courses over the last 2 years and rolled out an ambitious staff training scheme consisting of a basic digital skills training course for all new starters at council. • Collaborative bids enabled over £280k of inward investment for Digital inclusion work in 2023/24 and £574k worth of investment from DHSC through the Accelerating Reform Fund. We have an innovative proof of concept pilot which we launched in West Norfolk in July 2023 to provide a wraparound tech support service in the local community. Community Tech Coaches provide support with devices, connectivity, skills and confidence using a trusted place, trusted person approach. This will be rolled out even further in 24/24 with an emphasis on unpaid carers.			✓	✓
Digital Switch	• From 2025 the old analogue copper telephone landline network will be switched to digital, meaning that all phone calls will go through the internet, and everyone				✓

	will require broadband to make landline phone calls. We are actively promoting the ongoing landline to digital phone switchover as well as the 3G switch off. We have included an article in Your Norfolk. There is a potential risk if a resident uses a service that relies on a landline connection as they may be impacted. These are services such as Telecare Services, Fire, Burglar and Personal alarms. • We have added this piece of work to our Digital Inclusion Programme and we are providing advice and guidance on the landline telephone switchover to digital and the 3G switch off. This advice and guidance is for all of our citizens, staff, and members. The council's website contains information about the Landline Telephone Digital Switchover as well as 3G switch off. There was an article in the March edition of Your Norfolk focussing on the changes and the potential impacts as well as where people can find further information and support. We will also be providing advice and guidance for our staff who may be working with customers who are at risk as well as promoting internally. We will be sharing this advice and guidance with our partners in health, the Districts and VCSE.				
SHREWD Resilience system	This project sits within the Norfolk and Waveney Integrated Care Board Urgent and Emergency Care Directorate. SHREWD Resilience provides real-time intelligence, creating a whole-system view of our services, to inform decision-making and the operational management of escalating pressures, and patient flow blockages. Some of the benefits we expect to see are:	✓			

	• Significantly reduced time spent on conference calls, due to the availability of shared real-time operational data on an at-a-glance dashboard • Faster response to whole-system pressure through early warnings and collaborative actions to encourage mutual aid • Reduced time spent on operational reporting • Improved collaborative approach to managing patient-flow and minimizing blockages across organisational boundaries • Improved cross-provider collaborative response, as well as internal responses, to minimise escalation • Improved system calls, utilising the dashboard to focus discussion on actions and proactive planning				
Workforce Programme/Project	**Key work strands**	**Driving Integration**	**Prioritising Prevention**	**Addressing Inequalities**	**Enabling Resilient Communities**
Norfolk and Waveney International Recruitment Hub	From an international recruitment perspective, the collaboration has yielded: • The creation of the Norfolk and Waveney International Recruitment Hub, providing international recruitment and OSCE education services for partners in the Norfolk and Waveney ICS. • Over 850 internationally educated nurses recruited in 3 years. • Expansion of international recruitment from the 3 Acute providers to MH and Community Providers. • Created a ground-breaking NHS/ Social Care Partnership which has seen NHS staff working with social care providers to recruit internationally trained healthcare support workers.	✓	✓	✓	✓

	• Created a Strategic partnership for recruitment of nurses and healthcare staff from Sri Lanka. • Supporting each of the 3 Acute providers to reduce their expenditure with Recruitment Agencies for international recruitment.				
Support Workers Programme	The Large Scale Recruitment of Support Workers programme has brought NHS and representatives of the social care market together too, and resulted in: • Promotion of NHS and Social Care Careers at events in King's Lynn (twice), Norwich (twice) and across 13 other market towns in Norfolk and Waveney • Hosted on-line training sessions for over 300 individuals looking to work in care in Norfolk and Waveney, with over 80 of these going on to be referred to providers as potential recruits. • Developed a Development and Pastoral Support Programme for Care Support Workers across Health and Social Care, hosted on a virtual learning platform.	✓	✓	✓	✓
Careers Engagement Leads	Bringing together NHS providers, social care, HEIs and some of the local authority agencies who are engaged in supporting people into work. Whilst the Careers Engagement Leads Group is still forming, there is a belief that bringing organisations together to discuss and collaborate on opportunities to promote health and care careers will be advantageous.	✓		✓	✓
Norfolk and Waveney Health and Care Academy	The original aim of Health and Care Academies, as identified by NHSE/ HEE, was "to give young people the opportunity to see some of the things that healthcare professionals do, to	✓		✓	✓

	learn some essential life skills, work as a team, solve problems and find out more about what they are interested in". The Academy offers local students at Year 10, Year 12 and Year 13 the opportunity to engage in a programme that will strengthen their insight and understanding into the health and social care sector, the roles and careers that are available and how to pursue those opportunities. It undertakes outreach work, engaging with local schools and FE colleges to attract interest from students in participating with the programmes. Students are invited to participate having expressed their interest in doing so through their place of education. Each of the selected year groups has a cohort per year, with cohorts spaced throughout the year. The programmes are a mix of face to face and virtual sessions. Since the inception of the N&W Health and Care Academy, over 350 young people have participated in a programme, with a number now working locally as registered health and care professionals or progressing to complete apprenticeship programmes with providers. This programme is currently having a relaunch to widen its offering to more individuals across Norfolk and Waveney , aiming to encourage them into roles in health and social care. This programme works with all partners and aims to further expand, increasing understanding of roles and functions in different areas.				
Education and training across health and social care	Coordinated education study sessions for staff across Norfolk and Waveney, sharing expertise and expanding knowledge. The aim of these sessions is to upskill staff and increase confidence on a range of topics benefitting many across Norfolk and Waveney.	✓			

Health Inequalities Clinical Professional Development	In 2022/23 we agreed to 'top-slice' the ICB CPD budget, 22% of the overall Primary Care allocation was provided to the ICS Workforce Team. Pooling our CPD funding with local NHS providers supports partnership working across health, local authority, social care and VCSE, provides joined-up solutions to shared challenges and maximises opportunities to have an impact on specific target groups where inequalities may exist. In particular, the continuation of the ICS Crisis Prevention programme and in addition, we would support using CPD top slicing for: • Population Health Management - Reducing Inequalities and Supporting Prevention. • Transforming Care for Older People. A training needs analysis was carried out to determine the key clinical training educational elements needed for front facing general practice staff. The results allowed us to see the training needs grouped by category and linked to the 'Joint Forward Plan' Priorities and 'Core20PLUS5'	✓	✓	✓	✓
Estates Project/Programme	**Key work strands**	**Driving Integration**	**Prioritising Prevention**	**Addressing Inequalities**	**Enabling Resilient Communities**
New Hospital Programme	JPUH and QEH are both part of the New Hospital Programme which will see them both rebuilt by 2030 with government funding from over £20 billion infrastructure investment as part of the government's Health Infrastructure Plan. These new hospitals will help transform services and deliver against national and local policy and priorities, as well as accommodate for the expanding population in these areas of Norfolk and Waveney.	✓	✓	✓	✓

Diagnostic Centres	Creation of new outpatient diagnostic centres adjacent to the acute hospital trust sites as part of £85.9 million regional capital investment, to include: • JPUH – 1 MRI, 1 CT, 2 Ultrasound and 1 X-ray room. • NNUH – 5 MRI, 4 CT, 2 Ultrasound and 2 X-ray rooms. • QEH – 1 MRI, 1 CT, 2 Ultrasound and 1 X-ray room. Building work commenced during Summer 2023. The JPUH and QEH Diagnostic Centre buildings are planned to be operational by Summer 2024 and the NNUH Diagnostic Centre building will be operational early in 2025. It is hoped that these new facilities will help to: improve waiting times; patient health outcomes with earlier diagnoses; experience of staff & patients with the setting up of modern, state-of-the-art equipment; and standardise practices & collaborative working across regional imaging services. Once complete, these facilities will deliver over 281,000 tests, scans and checks to patients across N&W per year.		✓	✓	✓
Hellesdon Hospital – The Rivers Centre	£49.7m NSFT project providing 3 new acute mental health wards, gym and hub building at the Hellesdon Hospital Site.			✓	✓
NCHC – Willow Ward	£19.3m new 48 bedded ward located on the NCHC Norwich Community Hospital site, Bowthorpe Road. Willow Therapy Unit will be a state-of-the-art, therapy-led centre providing a supportive and comfortable environment for 48 patients. It will enable patients to make steady, step-by-step improvements and gain independence as they prepare to return to the community.		✓		✓

NNUH – New Theatres	Orthopaedic Surgical Hub • Due to open in summer 2024, this is a new twin theatre and 20 bedded standalone unit. • Orthopaedic patients currently have some of the longest waiting times. • The hub will be ring-fenced for elective orthopaedic surgery which will protect capacity. This will help to address wait times by performing 2,500 procedures a year for patients who need ankle, foot, hip, knee or shoulder operations. New paediatric theatres • Two new Paediatric Theatres. These will provide a more appropriate environment for children and young people as they will be located within the Jenny Lind Children's Hospital. • In addition, their creation frees up two theatres in the hospitals main (adult) theatre complex.			✓	✓
Healthcare Hubs	Kings Lynn Healthcare hub based in South Lynn, on Nar Ouse Way. The new site will deliver a range of health and care services, including: o Maternity and Neo Natal Services (provided by QEH). o Rehabilitation Services (provided by QEH). o General medical services delivered by the NHS Norfolk and Waveney Primary Care Network team (e.g., nursing, clinical pharmacy, social prescribing, paramedic, etc.). <u>Rackheath</u> New build healthcare hub based in Rackheath	✓	✓	✓	✓

	• The new site will deliver a range of health and care services, including:
	  o General medical services (delivered by Hoveton and Wroxham Medical Practice)
	  o General medical services delivered by the NHS Norfolk and Waveney Primary Care Network team (e.g., nursing, clinical pharmacy, social prescribing, paramedic, etc.)
	  o Community care (provided by NCH&C)
	<u>Thetford</u>
	Refurbishment of the Thetford Healthy Living Centre.
	  o The works are spread across two floors but the largest element of the project will see 14 new clinical rooms created via conversion of existing void admin space.
	  o It will be a modern, fully accessible, and digitally enabled facility where local people can access a range of health and care services in a central location.
	  o The addition of a second lift within the building and expansion of the existing car park will improve patient experience and access to services.
	
	<u>Sprowston</u>
	Refurbishment at Sprowston will help to transform the delivery of primary care and provide additional space for delivery of general medical services provided by the existing provider, East Norwich Medical Partnership. It will be a modern, fully accessible, and digitally enabled facility where local people can access a range of health and care services in a central location.				

CASE STUDIES

Community Connectors (North Norfolk):
"I can't thank you enough for all the help… I know of at least two random calls you made to me, when I was quite happy to end my life and get free of this burden, where just having a chat with you made a world of difference…"

PitStop:
"I'm a woman, a wife and a mother and I have benefited from MensCraft's work. I supported my husband to reach out to MensCraft after he expressed thoughts of taking his own life. He received one-to-one phone calls, support and still attends Pit Stops. He is very open now to talking to others about how he felt at the time and how having this and peer support has helped him socially, emotionally and to not feel alone in those thoughts. I now have a different husband; I have a more emotionally in-tune husband, a more attentive husband, a more understanding, tolerant and engaged-in-us and family-life husband. A man that is not afraid to be him. That is real. Our boys have an engaging Dad, a man that plans and a father that is present. My husband is in a very different place now; it took a while, but he sees a future and we are forever grateful for the role MensCraft played in that journey".

Caring Together Counselling Service:
"When my dad passed away 8 months ago I felt like someone had thrown a hand grenade in the room and smashed my life to smithereens. My mum had undiagnosed dementia and I left my partner to move in and look after her. I begged and pleaded with all the local authorities to help me but as my mum was deemed to have full mental capacity until her official mental health assessment nobody would help or listen to me. I was at my wits end. When I was offered counselling with Caring Together I grabbed it with both hands.

My Caring Together counsellor was the only person who listened to me. She was amazing. She guided me through the hardest and darkest days of my life, and I can't thank her enough. Without my counsellor I don't think I would still be here. Since the end of the counselling my mother has had 2 strokes and I would give anything to continue my counselling. I know this isn't possible and hopefully I have the strength to carry on and see this through. Without this support I would still be stuck in a very dark tunnel".

Safe and Habitable Homes:

Background:

A couple (both in their 80s) have been living in a private owned property. Over the years there have been concerns about the property but they were unwilling to engage with any services, distrusting the local authority after a compulsory purchase of a family member's properties previously. The property was discovered in a state of despair, hoarded and dirty with a significant rodent infestation present. In November, one of the individuals was admitted to hospital with a long-term mental illness. She was discharged to a residential setting as care could not be delivered safely at home. She does not require or want residential care.

- *The van made its debut visit to Coltishall Village Hall on 12 March 2024 and will be visiting weekly for 8 weeks.*
- *The van will be visiting 5 locations in South Norfolk & Broadland between March 2024 and February 2025.*
- *Outcomes from early visits will follow soon.*

What the project enabled:

- *Regular MDTs arranged by the Safe & Habitable Homes team including Norwich City Council's Independent Living Manager, Environmental Protection and Home Improvement team, and allocated social workers from Norfolk County Council ASSD.*
- *ASSD built rapport with the couple enabling them to agree to the work and temporarily move into the residential home whilst it is completed.*
- *Obtained quote from a local deep cleaning and decluttering provider on shared provider framework.*
- *Environmental Protection arranged and completed treatment of the rat infestation and completed an HHSRS assessment identifying 6 x Category 1 hazards and 6 x Category 2 hazards in the property.*
- *Home Improvement Team case worker clarifying works needed to improve the property, grants and charitable funding options.*

Improving lives **together**
Norfolk and Waveney Integrated Care System

Norfolk and Waveney Integrated Care Strategy and Norfolk Joint Health and Wellbeing Strategy

Setting the agenda for our Integrated Care System across Norfolk and Waveney

Improving lives together
Norfolk and Waveney Integrated Care System

Welcome

Every local area must have a Joint Health and Wellbeing Strategy setting out priorities, identified in the Joint Strategic Needs Assessment (JSNA), that partners will deliver together to improve health and wellbeing outcomes. The Health and Wellbeing Boards for Norfolk and Suffolk have their own strategies aimed at highlighting the need for collective responsibility for health and wellbeing. The Boards have a proven history of holding partners to account and enhancing everyone's responsibility to improve the health and care of their counties.

The changes under the Health Act 2022 created anIntegrated Care System (ICS) which has formally brought together a wide range of organisations and stakeholders to improve services and provide more joined-up health and care for our residents. Our ICS is comprised of Norfolk with the addition of Waveney.

It also created an Integrated Care Partnership which key organisations – including health, care, local authority, Healthwatch, and voluntary sector from across Norfolk and Waveney – are part of. This partnership must produce an Integrated Care Strategy which is the key document for all ICS partners to develop their strategies and plans from and sets out the challenges and opportunities we face that can only be addressed by partnership working and joint approaches.

As there is a clear cross-over between an Integrated Care Strategy and a Health and Wellbeing Strategy, this creates an opportunity to work together as a collective ICS around shared high-level health and wellbeing priorities. We have already achieved a lot by working in partnership, which has been strengthened through our collaborative response to the Covid-19 pandemic. The past few years have seen unprecedented challenges, but also incredible stories of communities and providers working together to ensure the people of Norfolk and Waveney have the support and care they need.

We want to build on what we have learned from the pandemic to enhance our integrated working within the Integrated Care System structure, but this will take time to do.

This strategy builds on that collaborative mandate – our vision is working as a single sustainable system that enables us to achieve our overarching mission to **help the people of Norfolk and Waveney to live longer, healthier, and happier lives.** To do this, we are evolving our longer-term priorities from our previous Joint Health and Wellbeing Strategy to help us face the challenges of the future.

Prevention and early intervention are critical to the long-term sustainability of our health and wellbeing system – stopping ill health and care needs happening in the first place and targeting high risk groups, as well as preventing things from getting worse through systematic planning and proactive management.

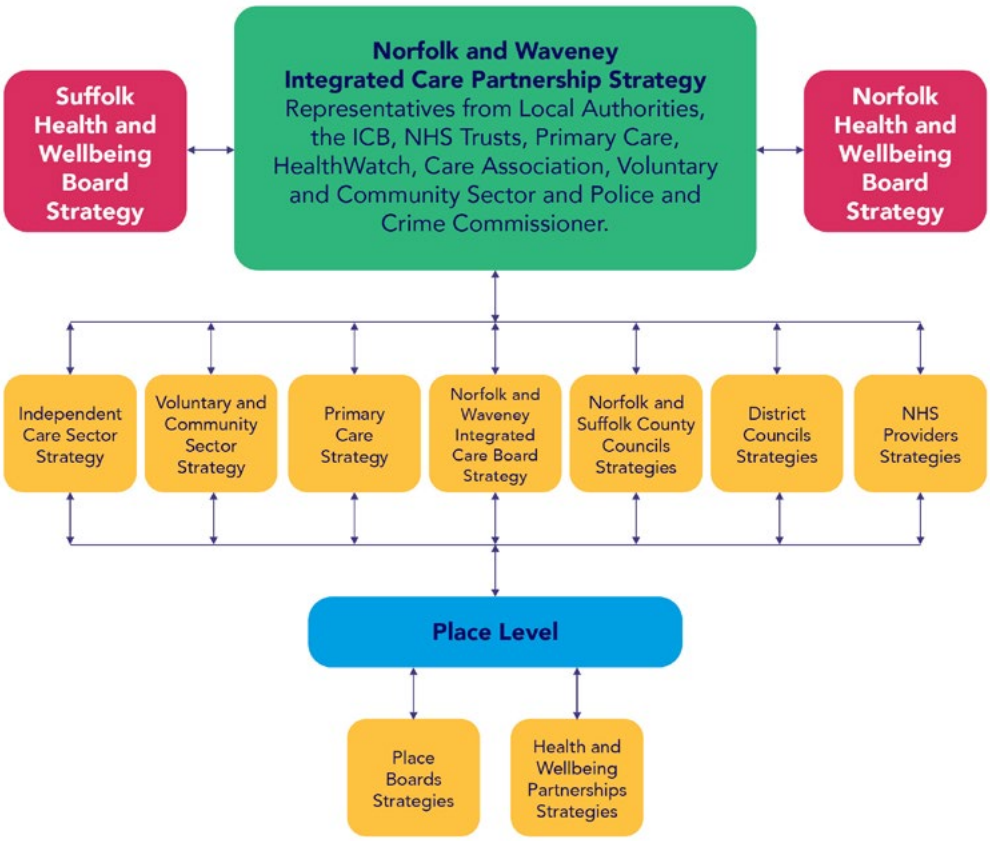
For us to achieve our goals, we have developed these priorities which are reliant on everyone taking a collective and collaborative approach:

Rather than duplicate and replicate work being undertaken at place-level, it makes sense to coordinate an integrated approach for the whole System. This document encompasses both the Integrated Care Strategy for Norfolk and Waveney and the Joint Health and Wellbeing Strategy for Norfolk and is a 'living' document that will change and grow as our new collaborative system develops.

Councillor Bill Borrett
Chair of Norfolk Health and Wellbeing Board and
Chair of Norfolk and Waveney Integrated Care Partnership.

System and strategy

A key strength of our system is that it is built from the ground-up, meaning that District, City and Borough Councils, grass-roots voluntary and community organisations, NHS partners, providers, and most importantly the communities and people we provide services for, all have input. This includes ensuring that strategies and plans across the system work cohesively and collaboratively. The diagram below shows the working relationship between the Integrated Care Strategy and other boards and committee strategies across the ICS, and how we all work together in partnership.



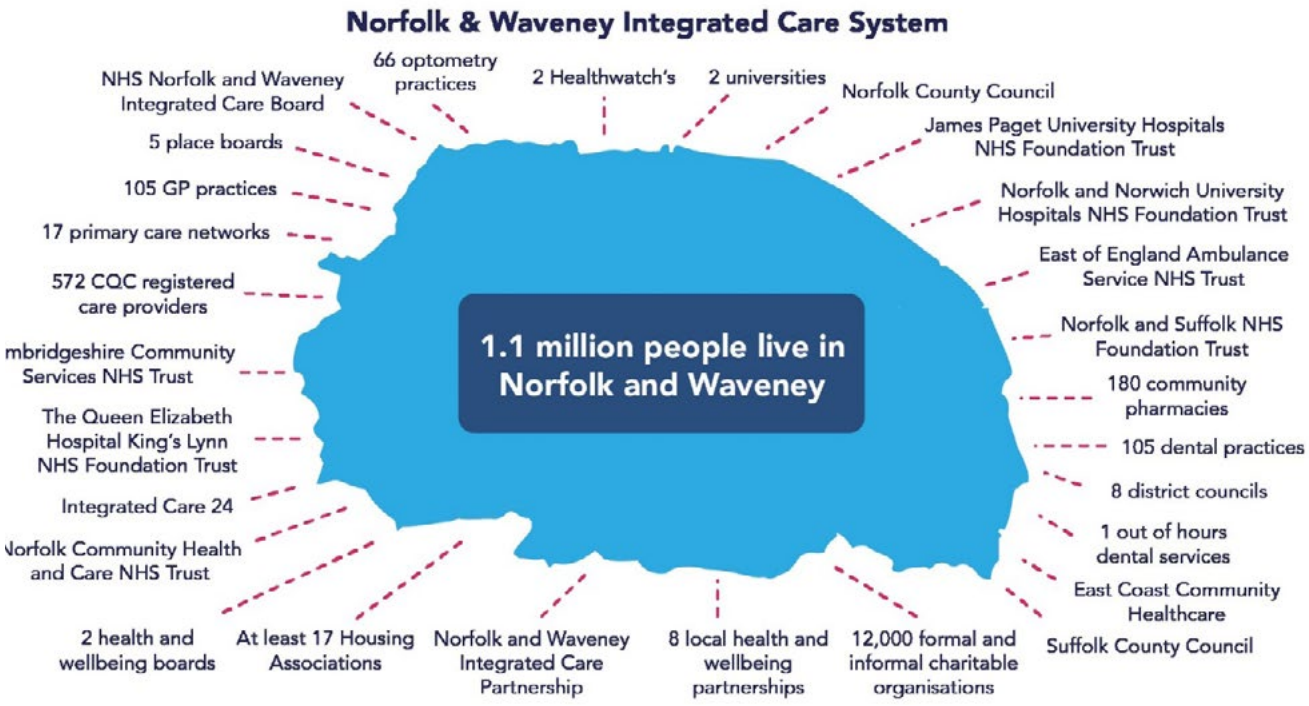
The diagram also shows the Norfolk and Waveney Integrated Care Partnership Strategy with arrows alongside connecting this to Norfolk Health and Wellbeing Board strategy and the Suffolk Health and Wellbeing Board strategy. From this level there are double ended arrows down to the Independent Care Sector strategy, the Voluntary and Community Sector strategy, Primary Care strategy, Norfolk and Waveney Integrated Care Board strategy, Norfolk and Suffolk County Councils strategy, District Councils strategies and NHS Providers Strategies. These are also connected together by double ended arrows. The final level of the diagram shows double ended arrows to the Place Board Strategy and Health and Wellbeing Partnerships strategies at place level. The purpose of the diagram is to show how all the strategies in the system link together.

Setting the scene for our system

Norfolk and Waveney consist of over a million residents living in eight districts across rural, urban and coastal geographies. These include Breckland, Broadland, Great Yarmouth, King's Lynn and West Norfolk, North Norfolk, Norwich, South Norfolk, and Waveney.

Our health and wellbeing system is complex and made up of lots of different organisations under the umbrella of the Norfolk and Waveney Integrated Care System, which came into being on 1 July 2022. While we have been working closely together for many years, the new Health and Care Act 2022 made it easier to bring partners together and push forward collaborative working and a single sustainable system. It offers us the unique opportunity to build on what we already have and take the steps towards a truly integrated model which delivers for everyone across the area.

The map below shows everybody involved in our system supporting health and care for the people who live in Norfolk and Waveney.



Our system mission

As an Integrated Care System, we have developed an overarching mission to **help the people of Norfolk and Waveney to live longer, healthier, and happier lives.**

To fulfil our mission we have three goals, these are:

To make sure that people can live as healthy a life as possible
This means preventing avoidable illness and tackling the root causes of poor health. We know the health and wellbeing of people living in some parts of Norfolk and Waveney is significantly poorer – how healthy you are should not depend on where you live. This is something we must change.

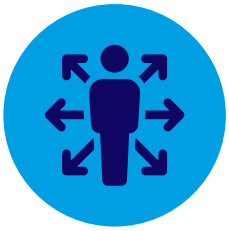
To make sure that you only tell your story once
Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have, which medication they are on. Services have to work better together.

To make Norfolk and Waveney the best place to work in health and care
Having the best staff and supporting them to work well together will improve the working lives of our staff and means you will get high quality personalised and compassionate care.

From these system-wide goals and overarching purpose, we have developed shared guiding principles for the Norfolk and Waveney Integrated Care Partnership. These are designed to drive the cultures and behaviours of the Integrated Care System at a more local level, and to enable everyone to work together to make improvements and address challenges.

Our Integrated Care Partnership Principles are:

Partnership of equals
To find consensus and make decisions including working though difficult issues, where appropriate.



Collective model of accountability
As system leaders, taking collective responsibility for the whole system and partners hold each other mutually accountable for shared and individual organisational contributions to health and wellbeing objectives.

Improving outcomes for communities
Including improving health and wellbeing, supporting people to live more independent lives, reducing health inequalities, and tackling the underlying social determinants. Listening to the public and being transparent about our strategies across all organisations.

Collaboration and integration
Under the umbrella of the Integrated care Partnership and the Health and Wellbeing Board foster a culture of broad collaborations and integration at every level of the system to improve outcomes and reduce duplication and inefficiency. A commitment to joint commissioning and simpler contracting and payment mechanisms.

Co-production and inclusivity
Create a learning system which makes decisions based on evidence and insight. Using data, including the Joint Strategic Needs Assessment to target our work where it can make the most difference - making evidence-based decisions to improve health and wellbeing outcomes.

For us to achieve our mission and goals as a partnership, we have developed these priorities which are reliant on everyone taking a collective and collaborative approach:

Driving integration
Collaborating in the delivery of people-centred care to make sure services are joined-up, consistent and make sense to those who use them.

Prioritising prevention
A shared commitment to supporting people to be healthy, independent, and resilient throughout life. Offering our help early to prevent and reduce demand for specialist services.

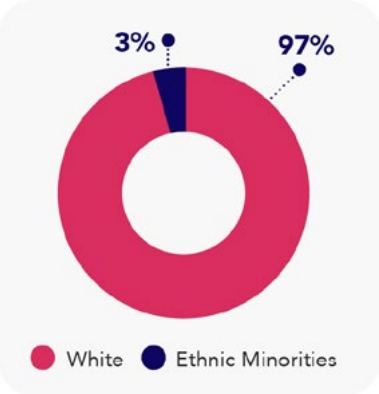
Addressing inequalities
Providing support for those who are most vulnerable using resources and assets to address wider factors that impact on health and wellbeing.

Enabling resilient communities
Supporting people to remain independent whenever possible, through promotion of self-care, early prevention, and digital technology where appropriate.

Living in Norfolk and Waveney: Who we are, and where and how we live

The population in Norfolk and Waveney is generally **older** than the England population. **1 in 4 are over 65.**

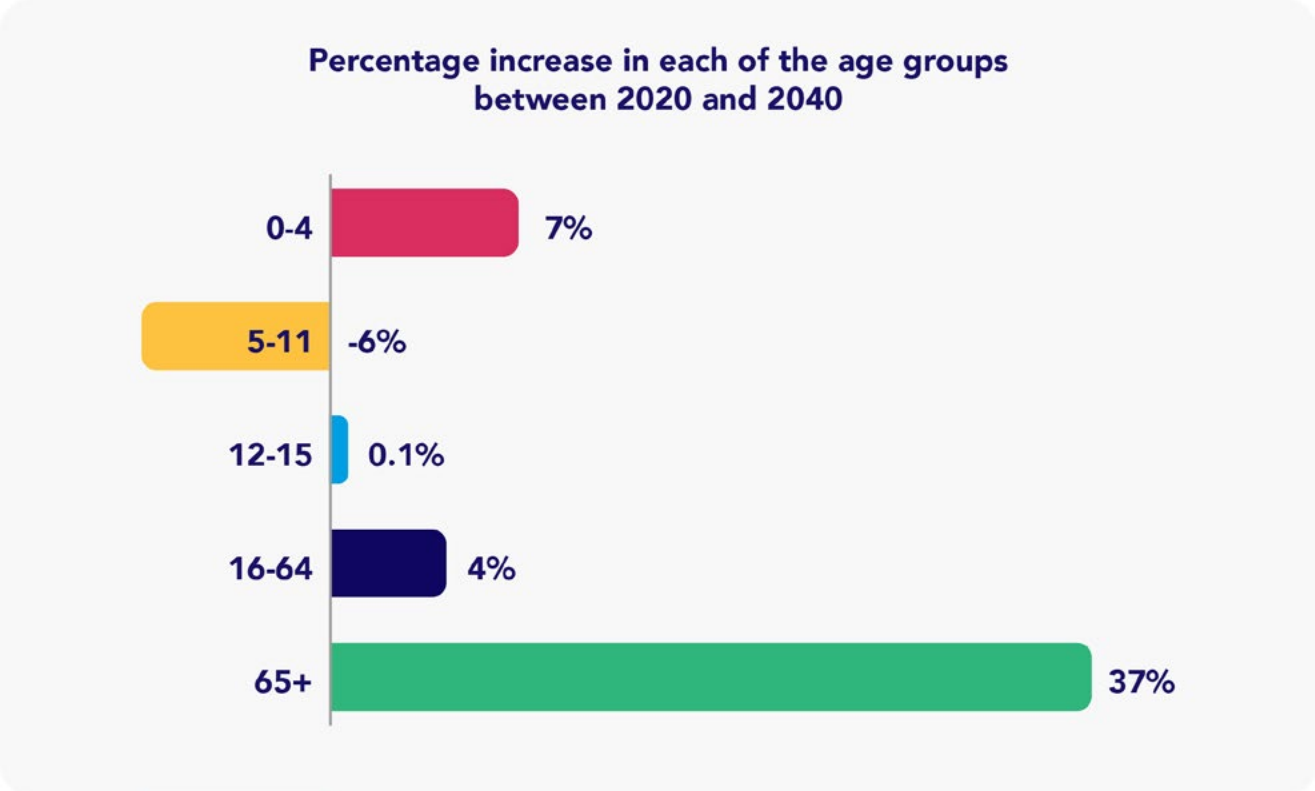
Norfolk and Waveney population is expected to **grow** by about **116,500** people between 2020 and 2040, the **largest growth** is expected in the older age groups, with those aged 65+ increasing by **95,000**. This is likely to put extra pressure on the working age population and potentially the availability of staff to deliver services.



The Norfolk and Waveney population is less ethnically diverse than average in England. The most diverse areas across Norfolk and Waveney are Norwich, Great Yarmouth and Breckland.

There are around **160 languages** spoken in Norfolk & Waveney. English is not the first language of around **12,400** school children.

20% of people in Norfolk and Waveney have a disability defined under the Equality Act.



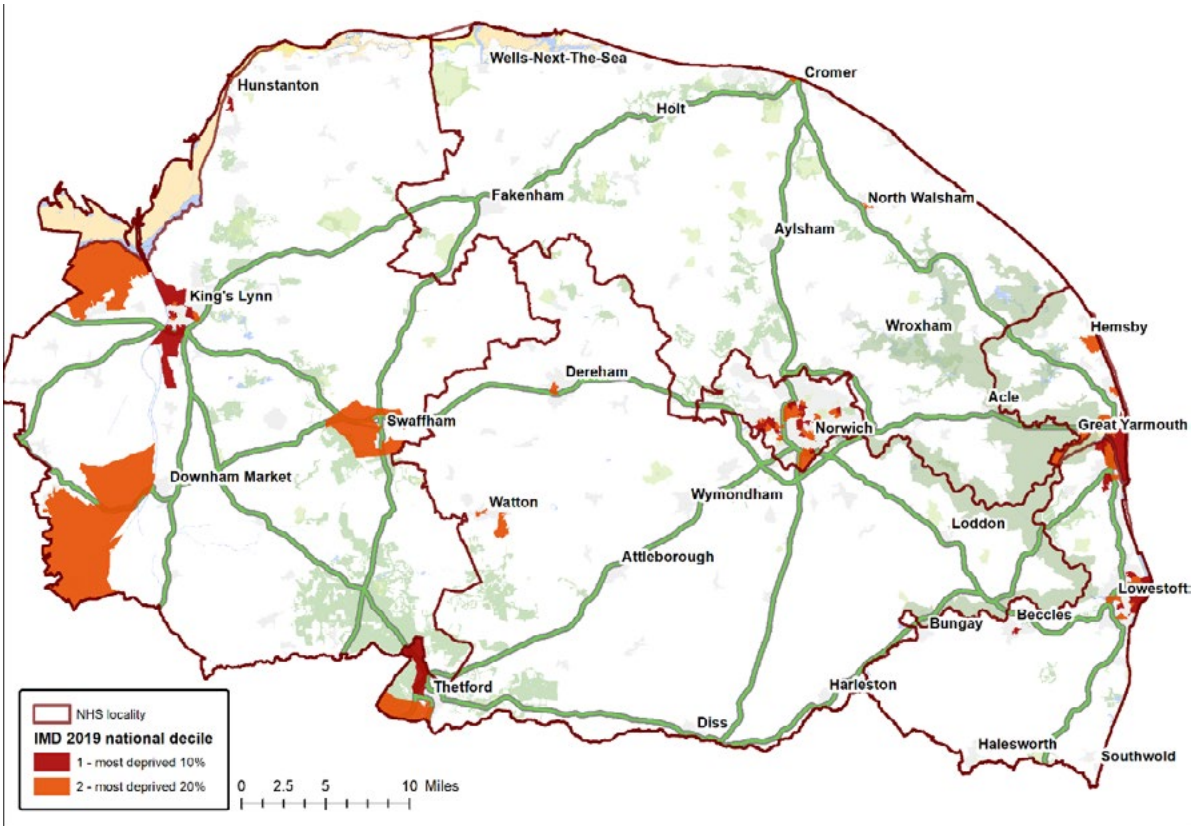
Where we live

There are 42 communities across Norfolk and Waveney where almost 164,000 people live in the 20% of the most deprived areas in England. However, none of these communities are in Broadland or South Norfolk.

The map below shows the most deprived communities are mainly in urban areas of Great Yarmouth, King's Lynn, Lowestoft, Norwich, and Thetford but there are smaller areas of deprivation in rural areas too. 30% of people in Great Yarmouth and 25% in Norwich live in the most deprived fifth of areas in England compared to 16% for Norfolk and Waveney as a whole.

The areas shown in red on the map are the most deprived 10% in the Index of Multiple Deprivation (IMD) 2019 National Decile. These are parts of King's Lynn, Thetford, Norwich, Great Yarmouth and Lowestoft.

The areas shown in orange are the most deprived 20% in the IMD 2019 National Decile. These are parts of King's Lynn, Thetford, Norwich, Great Yarmouth, Watton, Downham Market, Dereham, North Walsham, Hemsby, Beccles, Cromer, Hunstanton, Swaffham and Lowestoft.



16% of children live in low-income families

16% of households experience fuel poverty

The built and natural environment is inextricably linked to health across our lifetime. Populations in more deprived areas are more likely to have worse health outcomes, are more likely to be admitted to hospital in an emergency and are more likely to die early.

The design of neighbourhoods can influence physical activity levels, travel patterns, social connectivity, mental and physical health, and wellbeing outcomes. There is a higher occurrence of behavioural risk factors in the more deprived areas in England.

The connection between inappropriate or inadequate housing and poor health, effects everyone from childhood through to the elderly.

In Norfolk and Waveney, we have populations which have historically been excluded or have found our services hard to access. This includes refugees and asylum seekers, those experiencing homelessness or substance misuse, prisoners, sex workers, and those from Roma or traveller communities.

This results in missed opportunities for preventive interventions and further exacerbates existing inequalities. We need to breakdown the difficulties and barriers in engaging with our services to enable better outcomes for those with seldom heard and excluded voices. Our system should provide services that are available to everyone. This will require us to work differently, to include and involve better. By working together our system can bring expertise in hearing the voices of those excluded.

Mortality from respiratory disease is **2 times worse** in people aged 65+ in the most deprived communities compared to the least deprived.

Mortality from all cardiovascular diseases in people under 75 is **3 times worse** in the most deprived communities compared to the least deprived.

Mortality from causes considered preventable i**s 3 times worse** in those under 75 in the most deprived communities compared to the least deprived.

Emergency hospital admissions for unintentional injuries are **1.5 times worse** for children under 5 in the most deprived communities compared to the least deprived.

All-age suicide is **3 times worse** in the most deprived communities compared to the least deprived.

**comparison between the most and least deprived 20% of the population in Norfolk and Waveney.*

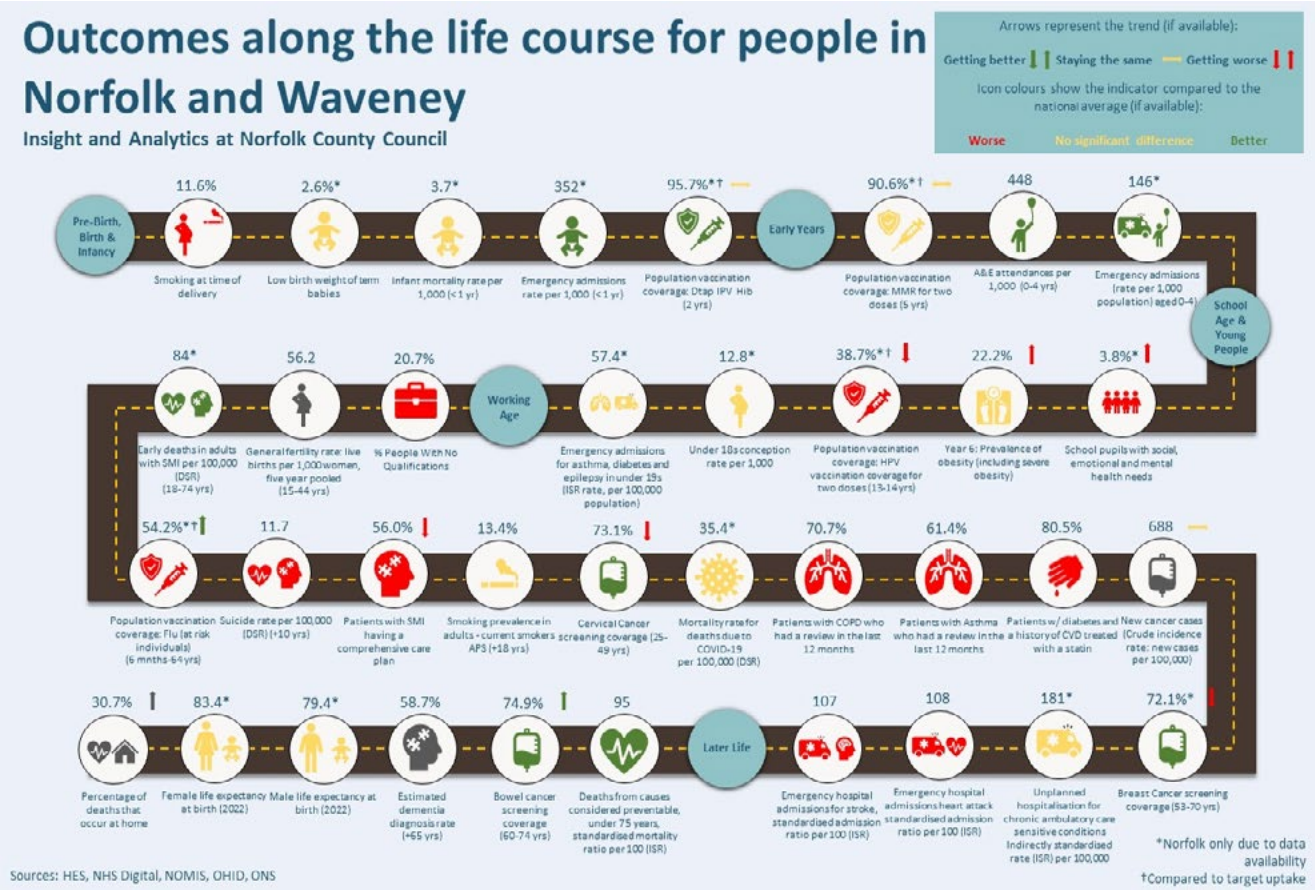
Health outcomes along the life course

Preventing Long Term Conditions improves outcomes for people and reduces costs. While the impacts of health behaviour change might take longer to take effect, we can see impacts over a shorter timeframe by improving other aspects of the health and care system. These include urgent and emergency care, mental health services, and services for families and babies, children and young people and people in later life – all of which are ambitions in our Joint Forward Plan.

However, there can be poorer outcomes for different people at different stages in their life course, and we want to tackle those. For example, in children and young people, a high proportion of pregnant females smoke, and children are more likely to have social, emotional and mental health needs. In addition to smoking, being overweight is one of the biggest causes of preventable illness – it can lead to diabetes, problems with bones, joints and muscles (musculoskeletal) and heart disease (cardiovascular).

When developing our ambitions and objectives, we have carefully considered what the outcome's life course is telling us. We can then focus on where we need to make improvements based on the evidence.

Outcomes along the life course for people in Norfolk and Waveney are shown below.



How we live

Births in Norfolk and Waveney are declining.

The rate of births to mothers aged 15-44 is lower compared to the rest of England.

1 in 20 children are under 5

8,700 births in 2021

Both Norfolk and Waveney have higher prevalence of smoking at time of delivery compared to the rest of England.

Early years to age 25

Overall health outcomes for children and young people in Norfolk and Waveney are similar to those for the rest of England. There are, however, differences in health outcomes based on where children live and in some groups of children, such as children with Special Educational Needs and Disabilities (SEND) and children in care.

5-11 year olds represent **8%** of our total population

The past couple of years have seen more children and young people accessing our services due to emotional wellbeing and mental health needs and gaps in learning following the pandemic.

More than 1 in 3 children in Year 6 (10-11yrs old) are overweight or obese

Further work is needed across Norfolk and Waveney for children and young people in the areas of prevention, early help, and health inequalities to promote healthier lifestyles and emotional wellbeing.

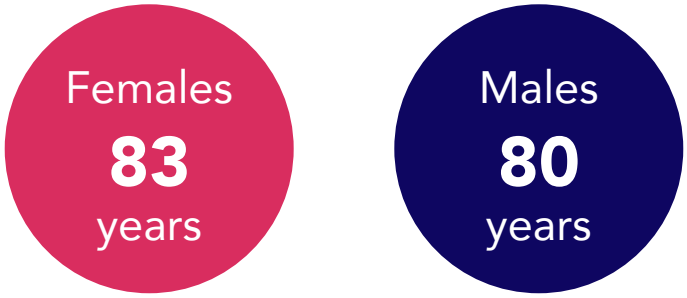
Across Norfolk and Waveney, we already have in place some strategies and operational plans to provide improved outcomes for our early years, children, and young people. Flourishing in Norfolk: A Children and Young People Partnership Strategy, which can be found by visiting the Norfolk County Council website. and, in the Family 2020 Strategy for Waveney which can be found by visiting Suffolk County Council website. The Family 2020 Strategy is currently in the process of being updated.

Life expectancy

Life expectancy is a person's estimated length of life based on age, gender and where they live.

Life expectancy in Norfolk and Waveney has consistently been higher than the national average for both men and women.

A person born in Norfolk and Waveney can expect to live:



Deaths from **circulatory diseases, cancer and respiratory diseases** contribute to most of this life expectancy gap.

Healthy Life expectancy is the average years somebody is expected to live in good health. In Norfolk and Waveney healthy life expectancy is about **63 years for males** and **64 years for females**, lower than England and has decreased over the last few years. This means that the time people spend in ill health is getting longer and is **17 years for males and 20 years for females**.

Inequalities exist from birth to older age (e.g. smoking in pregnancy, obesity, educational outcomes, lifestyle, unemployment). These contribute to a gap in peoples life expectancy of nine years for men and seven years for women between the least wealthy and most wealthy areas in Norfolk and Waveney. The life expectancy gap between these communities is mainly due to more people dying at an earlier age of circulatory, cancer and respiratory diseases.

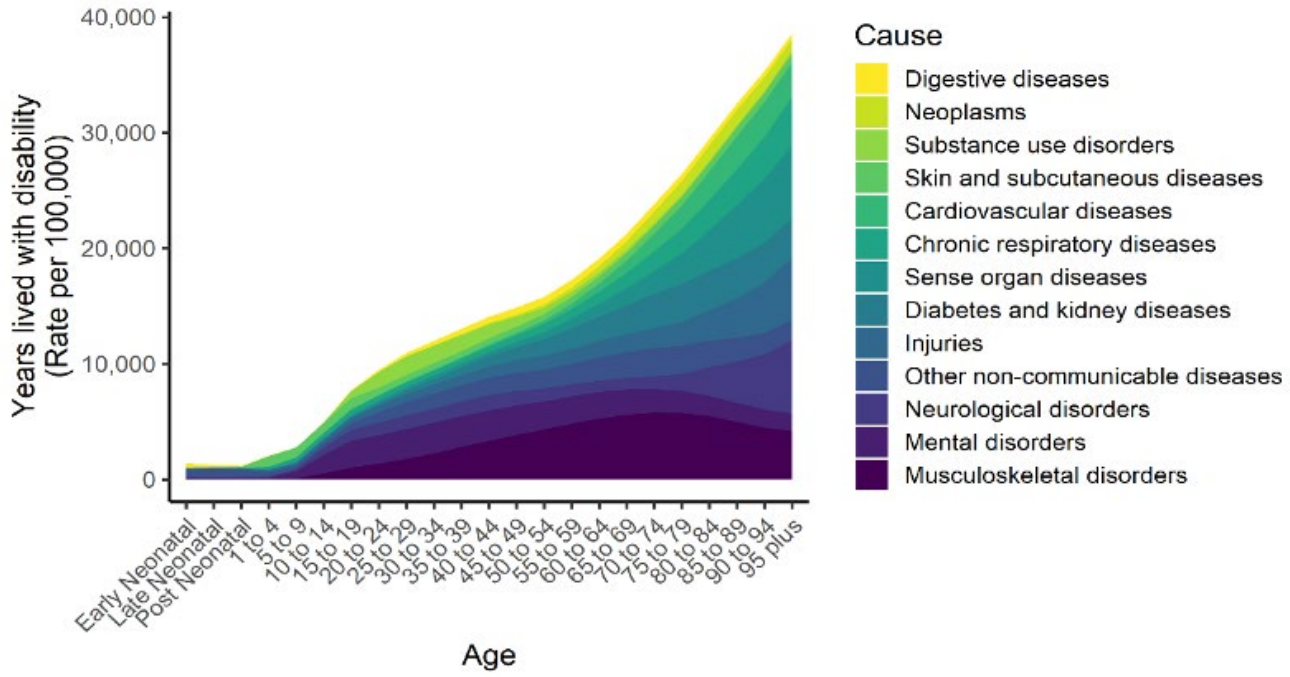
Alcohol consumption is the biggest risk factor of ill health, premature death, and disability for younger adults (aged 15-49 years) in Norfolk and Waveney.

Healthy life expectancy and long-term conditions

Physical health problems typically seen in older age, such as cancer, heart disease, diabetes, dementia, and musculoskeletal issues, are more prevalent in the areas of Norfolk with older populations (such as North Norfolk). The number of people with dementia is forecast to double by 2040. Overall health-related quality of life in Norwich and Great Yarmouth is poorer than other areas in Norfolk and Waveney.

As we age, the type and number of health conditions that we experience changes, and in old age we experience more neurological disorders and problems with eyesight and hearing loss. Ill health increases with age, with rates for those in their 80s almost double the rates for those in their 60s, which in turn are almost double that of those in their 20s. Most deaths are now associated with frailty conditions such as dementia. This change in pattern of health and care need has significant implications on health and social care services.

Causes of years lived with disability across age groups in Norfolk in 2019:



Lifestyle factors

These are the things that have an impact on our life expectancy in Norfolk and Waveney.

1 in 7 adults smoke. That's **100,000+** smokers

1 in 4 adults drink more than 14 units per week. **180,000+** adults drink too much.

3 in 5 adults carry excess weight. That's **480,000** adults that are overweight or obese

1 in 5 adults are inactive. **160,000** adults do not exercise

3 in 5 adults eat the recommended '5-a-day'. **280,000+** adults could eat better

Mental health

As a group of conditions, mental health disorders are a leading cause of ill health. This reflects the fact that most mental health conditions start early in life, some of them are very common (e.g. depression and anxiety) and many have a major impact on quality of life. People with long-term conditions, including diabetes and heart disease, are two to three times more likely to have depression.

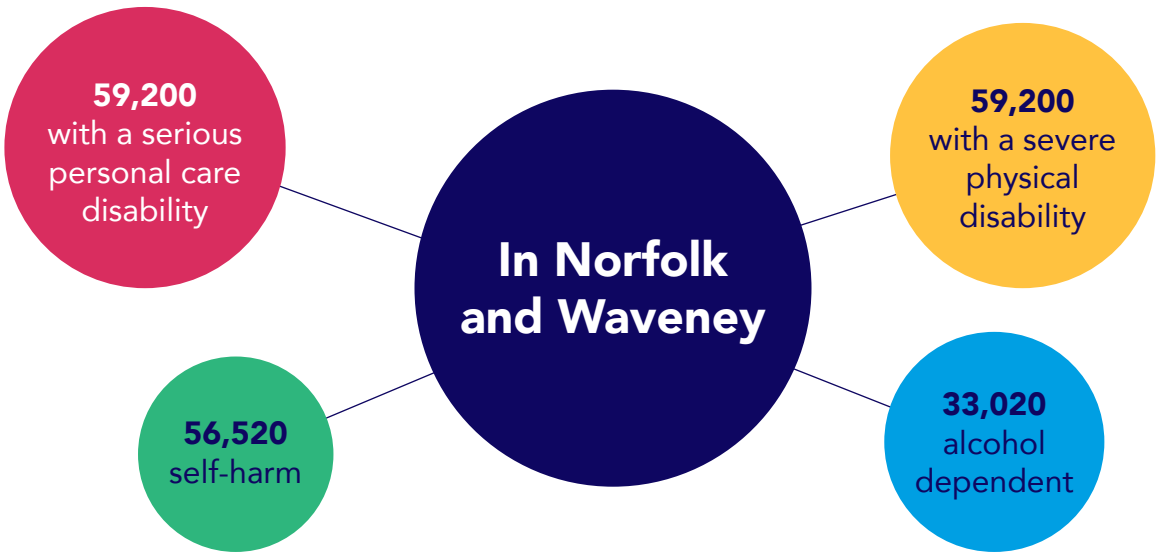
In Norfolk and Waveney, **143,400** people live with a common mental disorder. Suicide rates are higher than the England average, with suicide more common in men, those living in deprived areas, are unemployed, and who live alone. We have seen an increase in people wanting to access mental health services, especially children and young people.

Care and Carers

A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support. Around **1 in 10 people are carers**, in the UK. According to the 2021 census, there are over 95,000 unpaid carers in the Norfolk and Waveney Integrated Care System with a fifth of these being young carers and young adult carers.

The Carers UK's report "Alone and Caring" reveals 8 out of 10 carers have felt lonely or isolated as a result of their caring responsibilities. 57% had lost touch with friends and family, and 38% of carers in full time employment have felt isolated from other people at work.

The health and wellbeing of carers is also reported to be affected by the levels of caring, with carers who care for someone for more than 50 hours a week twice as likely to be in poor health as non-carers.



Safeguarding: its everyday business

Every child, young person and adult has a right to live their life free from abuse and harm. When safeguarding is done well, it permeates through every part of our workforce, across our communities and through our voluntary and social enterprise sector. Safeguarding isn't just everyone's business, it's everyday business.

From the start of your career to the end, from frontline to board, in every conversation, in our working lives to our leisure time, we are all responsible. When done effectively we can 'feel' it in all contacts we have with an organisation and its people. This feeling is outwardly demonstrated because raising a safeguarding concern is done with total ease and confidence.

We all have a role to play. We are all accountable.

Impact of Covid-19

The impacts of the pandemic are likely to be both short and long-term, and the ongoing impacts on services and changes to healthy behaviour will have a negative impact on health outcomes for future generations.

Norfolk and Waveney and all district, city and borough areas had death rates lower than the East of England and England averages.

Unequal impacts of Covid-19

Populations in more deprived areas are more likely to have more pre-existing health conditions, which means that reduction in service use during the pandemic will have disproportionately impacted those groups.

The 20% most deprived areas had the highest case rates, the lowest vaccination uptake and the highest death rates once age was taken into consideration.

There were more cases in the female population, but national research shows that males are at a higher risk of dying.

Highest case rates were shown in older children and working-age adults compared to other age groups.

Ethnicity and Covid-19

Highest case rates were seen in:

Long Covid-19

Long Covid is defined as symptoms reported by individuals themselves that last for more than four weeks after a suspected Covid-19 infection. The most common symptoms reported were fatigue, shortness of breath and loss of smell.

Nationally, around 1 in 40 people experience Long Covid. That would mean around **26,000 in Norfolk and Waveney.**

14,000
would have moderate impacts

4,000
would have more severe impacts

Highest rates are in women, people **aged 35-49 and those living in more deprived areas.**

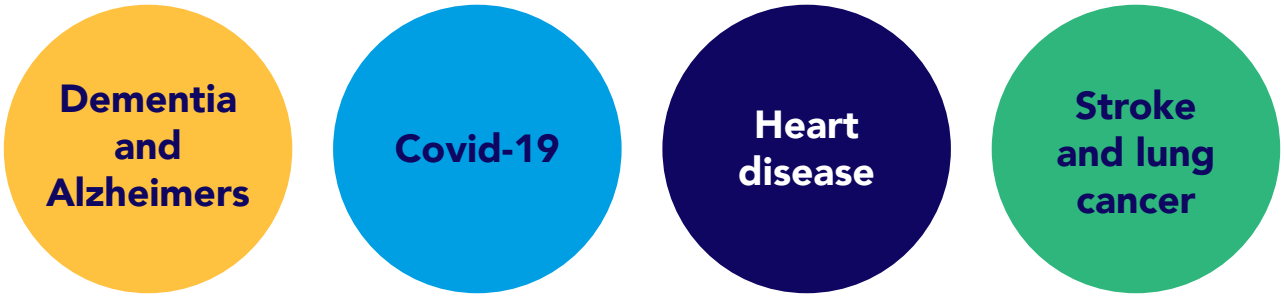
How we end our life

Generally, as the population in Norfolk and Waveney increases and ages, the actual number of people dying each year is increasing. Most deaths are in older people, with very few deaths in younger age bands. The increasing age at death means more need for our health and care services.

There were about 13,000 **deaths** in 2022. All-cause mortality rates are **lower** than England. The districts of Great Yarmouth, Norwich and former Waveney have the highest preventable mortality rates. It is the Core20 most deprived communities in these areas which experience the highest rates, sometimes more than double the England rate. On average there were about 1,900 preventable deaths each year across Norfolk and Waveney. This means almost 1 in 6 deaths are preventable.

Where someone dies is an important consideration in delivering high quality palliative and end of life care. Of all the deaths that occur each year, the majority occur in hospital and in the other places where people die, and the proportion of deaths that occur at home is higher than the England average and is increasing. This could have implications for delivery of palliative care in the community.

The leading causes of **death for males and females are:**



So, what does this information mean?

Looking at the Norfolk and Waveney picture, we have developed four priorities which are key to achieving our system-wide mission to **support the people of Norfolk and Waveney to live longer, healthier, and happier lives:**

Driving integration
Collaborating in the delivery of people-centred care to make sure services are joined-up, consistent and make sense to those who use them.

Prioritising prevention
A shared commitment to supporting people to be healthy, independent, and resilient throughout life. Offering our help early to prevent and reduce demand for specialist services.

Addressing inequalities
Providing support for those who are most vulnerable using resources and assets to address wider factors that impact on health and wellbeing.

Enabling resilient communities
Supporting people to remain independent whenever possible, through promotion of self-care, early prevention, and digital technology where appropriate.

Driving integration: What's important strategically?

Norfolk and Waveney have an annual budget in excess of £2bn for health and social care services. However, as a system we are seeing increasing demand resulting in budget pressures. Needs are becoming increasingly complex and so our service improvements must be more co-ordinated and effective for the service user and their carer. Services are improved where there is a coordinated, effective, and seamless response.

Interviews with members of the Norfolk and Waveney Integrated Care Partnership and Norfolk Health and Wellbeing Board emphasised the collaborative and innovative working during the pandemic. This involved breaking down some of the organisational barriers to support one another and moving resources accordingly. Norfolk and Waveney Integrated Care Partnership and Norfolk Health and Wellbeing Board members are keen for these changes to continue with collective resources used to their best effect, and duties and responsibilities shared to better support communities.

Our key challenges are:

- Increasing demand on health and care services and post-covid challenges, puts the focus on operational pressures ahead of cultural changes, behaviours, and partnership development.
- Reducing and levelling budgets within a stretched system.
- Recruitment and retention issues with high number of vacancies across health and care.
- Lack of joined up records and information across the system.

Our priority actions are:

- To work as a single sustainable system in the delivery of people centred care, across a complex organisational and service delivery landscape.
- Shift in focus and investment to community based support so that people stay healthier for longer in their own homes and communities.
- Use and share evidence and data intelligently, lived experience and evidence from service users, to help us keep our Strategy and System Plans on track and understand their impact.
- Use partners' existing plans – building on the priorities partners are already working hard to address, identifying the added value that collaboration through this strategy can bring.
- Develop mechanisms such as the sharing of information, pooling of resources and budgets (including Section 75 arrangements), to target health and care where it is needed most.
- Create a joint workforce strategy and long-term plan to include recruitment and retention of health and care staff across Norfolk and Waveney.

We know we will have achieved this when:

- We are all working together as a single system and sharing thinking, planning, funding, opportunities, and challenges – to inform new ways of working and the required transformation.
- We are effectively engaging with, and listening to, staff, residents, and communities to inform our understanding and planning for the future.
- Investment and funding has shifted focus to community provision.
- Someone only has to tell their story once when accessing multiple health and care services.
- We have a resilient and sustainable workforce to meet system need.

Prioritising prevention: What's important strategically?

There is strong evidence that interventions focussed on prevention are both effective and more affordable than just focussing on providing reactive emergency treatment and care. Although the language of prevention is not spontaneously used by people, the concept itself is well understood.

To build a financially sustainable system means we must promote healthy living across a life course, seek to minimise the impact of illness through early intervention, and support recovery, enablement, and independence. This starts with early years and childhood and throughout the life course.

Our research shows primary responsibility for health and wellbeing is seen to fall to individuals, with personal responsibility heightened by the pandemic for most. Despite agreement that health and care partners have some role to play in supporting residents to be healthy and well, there is a lack of understanding of what this role looks like in practice.

Our key challenges are:

- Prevention and Early Help are seen as difficult to do and not everybody's priority.
- Prevention support doesn't always show immediate results.
- Stretched services due to lack of investment and provision in prevention awareness and intervention at an early stage.
- Residents across various age and demographic groups are sometimes unclear what services might be available to help them stay healthy and well.
- The current costs of ill health, providing health and social care and anticipated demographic changes in the next 20 years means it is not sustainable to continue to work as we currently do.

Our priority actions are:

- Review historic practices to develop, in partnership, the opportunities for a systematic approach to preventing ill health from birth through early years to older age and end of life, starting with those areas that need it most
- Funding of prevention services alongside existing services, to shift the system focus to helping people lead healthier lives at the earliest opportunity especially at a younger age.
- Embed prevention and early help across all system and organisational strategies, plans and policies and shift focus to community provision.
- Have joint accountability so that as a system we are preventing, reducing, and delaying need and associated costs.
- Prevent people from becoming ill through promoting healthy lifestyles and mental wellbeing and healthy communities.

We know we will have achieved this when:

- System strategies, budgets, plans and policies reflect a focus on prevention and early help and future proofing for our changing demographics.
- All partners are prioritising prevention and early help both at a policy level and in decision-making that resonates with our communities.
- People and communities are able to independently access prevention help and advice, and activities, with the support of partners if needed.
- A reduction in the gap between life expectancy and years spent in poor health by better outcomes for everybody.

Case study: Age Healthy Norwich

Age Healthy Norwich

About

This project is aimed at 50-65 year olds with high blood pressure and weight concerns, to help prevent further deterioration in their health and wellbeing.

Age Healthy Norwich is a collaboration of VSCE providers who specialise in supporting people aged 50+ with their physical and mental health. The team consists of qualified staff from Age UK Norwich, Exercising People in Communities, Norwich Theatre, and Norwich Door-to-Door.

Two GP surgeries from OneNorwich PCN were involved in a pilot programme, which started in February 2022. 50 individuals from each surgery took part.

Approach

Participants could choose from a diverse range of over 30 activities which were a mixture of one-to-one or group-based and delivered within the home or garden, surgery, parks, community buildings or online.

Everyone received weekly one-to-one coaching sessions over a six-month period. This supported behavioural changes, helped to identify wider determinants of health (such as smoking cessation and healthy diets), accredited advice, hardship and transport subsidies as required.

Results

After six months, a variety of tools were used to evaluate participant goals and progress. These showed frequency of activity remained consistent over the six-months with a positive shift to more vigorous activity and walking. Time spent on physical activity increased from 4 hours-per-week to 5hrs 20 mins-per week, with time spent on vigorous activity trebling in duration.

Participants rated the quality of the service **10/10**

Across all types of feedback, people reported improvements in sleep, anxiety, nutrition, and levels of physical activity – all factors that can impact high blood pressure and overall wellbeing. There was also positive improvement across the majority of factors, including life satisfaction, happiness, physical health, and life purpose, and a significant improvement in mobility and ability to perform activities of daily living.

Although participants received one-to-one coaching in their home, 50% of people were supported to connect to community clubs for ongoing self-care, increasing their levels of social connection, support, and friendships.

Age Healthy Norwich will be continuing this model into 2023. You can find out more by visiting their website at AgeHealthyNorfolk.org.uk.

Addressing inequalities: What's important strategically?

Those living in our most deprived communities experience more difficulties and poorer health outcomes. Health and Wellbeing Board members told us that this was magnified during the pandemic and gaps between communities widened.

We recognise that together, we need to deliver effective interventions, to break the cycle, mobilise communities and ensure the most vulnerable children and adults are protected. To be effective in delivering good population outcomes we need to most help those in most need and intervene by working together at system, place, and community levels to tackle issues reflecting whole system priorities as well as specific concerns at the right scale. Reducing inequalities in health and wellbeing will involve addressing wider issues that affect health, including housing, employment, and crime, with community-based approaches. These need to be driven by partnerships at a place level involving councils, health services, the voluntary sector, police, public sector employers and businesses.

Our key challenges are:

- Deprivation, poverty, and multiple overlapping risk factors for poor health outcomes are found throughout Norfolk and Waveney, and are more concentrated in some areas.
- Seldom heard communities, the most vulnerable and those that are socially excluded experience additional difficulties accessing services.
- Not everyone has a positive experience when accessing and using our services.
- We have pockets of inadequate and poor housing, as well as inappropriate living conditions which are linked to poor health outcomes
- There are differences between some of our rural and urban communities in their levels of need and the support available to them.

Our priority actions are:

- Provide, share, and use the evidence to address needs and inequalities.
- Identify and target collaborative interventions, services and resources to those communities and areas that have more need.
- Plan for the future by joining up development planning and working with those with planning responsibilities.
- Consult and engage with residents, including those from seldom heard and excluded communities, to design and input into our services. This should include a variety of engagement methods and technologies.
- Ensure our services are easily accessible to all and improving accessibility to our services for those who need more support
- Build confidence and trust in everyone who engages with our services and learn from those with lived experience
- Reduce the impact of injuries, accidents and crime in our most deprived areas

We know we will have achieved this when:

- Populations in areas of most need show better health outcomes.
- There is an increase in availability of services in deprived and rural communities.
- We are consistently able to engage and support those in seldom heard communities and those who have previously experienced difficulties in accessing services.
- Our services are shaped by feedback from those with lived experience and everyone can access our services with confidence.
- There is a reduction of injuries, accidents, and crime in our most deprived areas.

Case Study: Tricky Friends

Friendships are important and valuable to everyone and have a major impact on our health and wellbeing. Friendships are as important as healthy eating and exercise, and support
a sense of belonging. Belonging fulfils an important emotional health need and helps decrease feelings of depression and hopelessness.

It is important that people with learning disabilities and autism, those who have cognitive difficulties, and children and young adults, have positive opportunities to make and maintain friendships. However not everyone who says they are your friend is genuine and some people can be exploited and abused by so called friends.

Over the last few years, Norfolk Safeguarding Adults Board (NSAB) have had discussions with groups and organisations in Norfolk who support people with learning disabilities and autism, about how to raise awareness of issues like exploitation, county lines, cuckooing.

We wanted to help them to do this, to reduce the risk of harm and exploitation in groups who may be less able to recognise the intentions of others. So, working with adults with learning disabilities and autism we have produced a short three minute animation called Tricky Friends.

This video can be used with or by anyone - carers, family, organisations, groups, to start conversations about what good friendships look like and what to look out for if something is not right.

Tricky Friends has been adapted for children and young people, and there's now a version in Ukrainian for those working with refugee families and vulnerable adults.

NSAB has shared this resource nationally and now over 35 safeguarding adult's boards and other organisations are using it

Enabling resilient communities: What's important strategically?

District, City and Borough Councils work hard with partners to identify areas of increasing concern, poverty and inequality across Norfolk and Waveney. Health and Wellbeing Board Members told us that, through the pandemic, local resilience arrangements were key to providing clear messages and communication with communities, partners, and members.

Communities have the knowledge, assets, skills, and ability to help their residents flourish. Communities and individuals that are able to meet their own needs have better outcomes. It is important that our services support those living in our communities to look after themselves and live an independent life for as long as possible.

Our key challenges are:

- Gaps in support services to enable people to live independent healthy lives in their communities for as long as possible.
- Inconsistencies in our communities with accessing help and support through a variety of means.
- Loneliness and social isolation, especially for those with caring responsibilities.
- People and communities including those with lived experience are often not involved in planning and developing their environments and care, as well as shaping the redesign of services and support.

Our priority actions are:

- Support people to live independent healthy lives in their communities for as long as possible, through promotion of self-care, early intervention, and digital technology where appropriate.
- Enable local resources, skills, and expertise to help people, families, and communities to thrive by accessing local support using community assets such as green spaces, village halls, leisure centres etc.
- Build capacity in our voluntary, community and social enterprise, faith groups and third sector.
- Create healthy environments so healthy choices are the easiest choices.
- Improve access and encourage people to use our natural and cultural landscapes to benefit their physical, mental and emotional wellbeing.
- Identify investment and funding opportunities from a variety of sources to develop new initiatives e.g. to combat loneliness and isolation.

We know we will have achieved this when:

- There is increased partnership working and engagement of local authorities, parish councils, the voluntary, community, faith groups and third sector offering.
- There are better health outcomes such as decrease in admissions because of early interventions and more support services in the community.
- More people are independently able to access the support they need by using a variety of methods such as digital tools, apps and websites.
- Personalised advice is helping people to navigate our services and the use of self-directed support, such as new technologies and innovative models of care, are engrained in people's experiences.
- Healthy living environments are created at a local level through good holistic Planning design.

Case study: Lowestoft Rising - The Power of Collaboration

Lowestoft Rising is a multi-agency place partnership set up to take a holistic and asset-based approach to tackling the challenges faced in the town. Just over £500,000 of investment by the Lowestoft Rising funding partners over seven years has generated more than £4m of funding for the town. The funding partners are East Suffolk Council, Suffolk County Council, Great Yarmouth and Waveney ICB and Suffolk Police/Police and Crime Commissioner, but Lowestoft Rising is so much more than funding.

A few of our key achievements include our Mental Health Ambassador role and Positive Mental Health Manifesto, the Lowestoft Interventions process – where we work together to triage and support the most vulnerable, enabling Lowestoft Solutions (the first social prescribing project in Suffolk), our schools mentoring programme, high impact Cultural Education Partnership, work around homelessness and street drinking and our innovative 'Collaboration Academy' to inspire current and future leaders to work across organisational boundaries.

Current priorities are supporting vulnerable people (including financial and food poverty, substance misuse), mental health and wellbeing, and aspiration and achievement in young people. Our emphasis is on maximising the benefits of integration and partnership working for Lowestoft (including through the new Place Board, Waveney Health and Wellbeing Partnership and Waveney Health and Wellbeing Network, as well as the existing Lowestoft and Northern parishes Community Partnership), and inspiring individuals and families to believe in a better future.

Social Prescribing

- Operating in all GP surgeries across the town where patients with long-term conditions can access a holistic package of care within the community, through Solutions Lowestoft.
- Delivered by Citizens Advice North East Suffolk and funded by Better Care Fund, East Suffolk Partnership and the Suffolk Transformation Challenge Fund (plus Kirkley Mill) to March 2021.
- There was an approximately 40% reduction in GP appointments in the six months after support compared to the six months before but, more importantly, much better life outcomes for individuals.

"I am so pleased to have seen the adviser at Solutions because I know they are professional and they aren't going to scam me. I am being taken seriously because they are in the surgery so I know I can trust them".

"After visiting Solutions I feel like everyone is coming together to help me and I am going to be able to sort everything out now. For so long I have been getting bits of advice from 'here and there' and have never resolved anything".

"I felt the appointment with Solutions was really good, the adviser listened to me and took lots of notes. She is going to get some information to send to me so it was 45 minutes well spent".

Food Bank response

- Signpost East-led Food Bank collapsed in November 2017. An interim solution was quickly deployed by Access Community Trust to maintain food bank service across most sites – with 22 tons of food moved by volunteers to a new storage site.
- Lowestoft Community Church launched a new Food Bank in February 2018, with college and church volunteers working together. This provides six-day coverage across Lowestoft, plus an outreach service.
- There is a Free Period Scheme (sanitary products) in schools, colleges, and the library, which is now funded by national government.
- Special homeless persons Food Parcels are allocated by MEAM workers.
- 2 Year celebration event held for the 70+ volunteers who help keep the food bank running and helping to provide on average 750 parcels per month.

How can we make a change?

Working together is an opportunity to achieve joint outcomes, as a partnership we commit to:

- **Identifying the actions** that each Integrated Care and Health and Wellbeing Board partner will take in delivering our strategy, either through their existing plans or new initiatives.
- **Developing a joint system plan** so we can focus on the important things we have agreed to do together.
- **Holding ourselves to account** and be an accountable public forum for the delivery of our priorities.
- **Monitoring our progress** by reviewing data and information that tells us if we are making an impact.
- Reporting on our progress to the Integrated Care Partnership and/or Health and Wellbeing Board and **challenging ourselves** on areas where improvements are needed and supporting action to **bring about change**.
- **Recognise that social exclusion** impacts health outcomes, experiences, and access, and will require us to work different to include and involve better.
- **Developing and promoting a culture** within our system that actively addresses the
- **prevention of abuse and neglect** across all ages.
- **Keeping our Strategy live** and reflecting the changes as we work together towards a single sustainable system.

Plans going forward

The guidance from the Department for Health and Social Care outlines various areas where the Integrated Care Strategy must or should develop to be comprehensively support the health and care of our communities. As this document is a live strategy, which encompasses both the Joint Health and Wellbeing Strategy for Norfolk and the Integrated Care Strategy for Norfolk and Waveney, we plan to build on what is here to ensure we meet those requirements as our system progresses and needs change.

Over the coming months we will:

- Engage with people, services and staff across Norfolk and Waveney to sense check our priorities.
- Identify any areas of unwarranted variation and disparities in health and care outcomes through our data.
- Identify any gaps in our knowledge and research.
- Keep under consideration whether the needs outlined in the strategy could be more effectively met with an arrangement under section 75 of the NHS Act 2006.
- Continue working across our system with partners in children and young people's services to highlight the safety and development of early years and transition into adulthood.

Improving lives **together**

Norfolk and Waveney Integrated Care System

Versions

Transitional Norfolk and Waveney Integrated Care Strategy and Norfolk Joint Health and Wellbeing Strategy 2022/23 v1

Norfolk and Waveney Integrated Care Strategy and Norfolk Joint Health and Wellbeing Strategy Refresh 2024 v2

Norfolk Health and Wellbeing Board

Item No: 11

Report title: Better Care Fund Report - Review of Core Schemes

Date of meeting: 12 June 2024

Sponsor (HWB member): Debbie Bartlett, Executive Director of Adult Social Services, Norfolk County Council
Tracey Bleakley, Chief Executive, Norfolk and Waveney Integrated Care Board

Reason for the Report

The Norfolk Health and Wellbeing Board (HWB) is responsible for overseeing the Better Care Fund (BCF), including signing off yearly planning submissions and quarterly update reports as requested by the national BCF Team. The purpose of this paper is to outline the findings and recommendations from a review of the Norfolk BCF that was requested by the HWB.

Report summary

In June 2023, the HWB requested a review of the Norfolk BCF to cover the core BCF, which includes sixty schemes totalling £77,165,711 funding. The aims were to:

- Ensure that the BCF schemes are aligned to current system priorities, local BCF priorities and the national BCF metrics.
- Understand whether the current BCF schemes suitably address the inequalities which exist in Norfolk, including linkages with the ICS work on Core20Plus.
- Understand how the BCF is used at Place and across the Health and Wellbeing Partnerships.
- Build on the national BCF metrics to develop a set of system BCF metrics, in a dashboard format, that can be shared with stakeholders to show the impact and the level of impact the BCF investment is delivering.
- Recommend an approach to additional discretionary funding that could be included to further achieve the BCF aims and objectives.
- Support investment/disinvestment decisions by clarifying for the lead commissioners how the schemes support BCF priorities.
- Collate information to contribute to the BCF Narrative Plan (an annual requirement as part of the BCF planning cycle) and capture examples of how the system meets national and local BCF priorities.

The following key findings emerged from the review:

- Most schemes are contributing positively to national and local priorities.
- There is huge variation between the size and nature of schemes.
- Whilst most schemes funded through the core BCF have service level KPIs, BCF reporting is limited to national metrics that are not linked to specific service delivery or outcomes.
- The governance around the BCF should be strengthened.

Ultimately, the review has concluded that there is a real opportunity to move to a more strategic approach, whereby the BCF becomes the key vehicle to enable joint oversight over core integrated services that operate at scale across Norfolk.

Recommendations

The HWB is asked to:

a) We move to a refined BCF model, refreshing the Norfolk BCF priorities to fit wider strategic ambitions under the following themes; Place Based Initiatives, Prevention & Community Support, Admission Avoidance, Discharge and Recovery, Enablers for Integration and Mental Health, Learning Disabilities and Autism. Within these six themes there will be a focus on core integrated schemes that operate at scale across the county and require joint commissioning and oversight.

b) We document a process for on/offboarding schemes. All schemes that do not align to the six proposed themes and/or do not operate at scale will be reviewed following this process to identify if they should continue to draw down funding through the BCF.

c) We work with partners across the system to map activity against the new High Impact Change Model for Transfers of Care, identifying areas of development with the support of the Regional BCF Team.

1. Background

1.1 The BCF Review was requested by the Norfolk HWB and Norfolk and Waveney Integrated Care Board (ICB) Executive Management Team. It focused on Norfolk BCF schemes funded via the core BCF. This funding is used by NCC and the ICB to individually or jointly commission schemes that align with the BCF guidelines and contribute to the national BCF metrics and local BCF priorities. All schemes are jointly agreed each year and signed off by the HWB before being set out in a Section 75 agreement.

1.2 Norfolk last carried out a review in 2021-22 which determined that wherever possible the BCF should fund schemes that represent whole services using joint funding, where they have a joint impact across both health and social care and/or would benefit from joint oversight. At that time five key priority themes were identified under which schemes were aligned; Inequalities and Support for Wider Factors of Wellbeing, Prevention, Person-centred Care and Discharge, Cross-Cutting and Housing and, Sustainable System (including Admission Avoidance). This review builds on the work undertaken, revisiting the priority themes and assessing how the sixty schemes align to those themes and meet the local and national priorities.

1.3 Schemes funded by the ICB and delivered across Waveney were excluded from the review as they are included in the Suffolk BCF review being led by 31ten Consulting Group. We have engaged with Suffolk colleagues and 31ten as part of this review.

2. Findings from the Review

2.1 A review team was established comprising of commissioning and finance colleagues from Adult Social Care and the ICB, to undertake the review and deliver recommendations on the direction of the BCF. The methodology agreed saw the joint development of a spreadsheet to capture details of each scheme, including KPIs and wider feedback from lead commissioners.

2.2 **Schemes funded within the core BCF:** The BCF enables a broad range of schemes, delivering a varied array of services to support local people. Currently, there is no defined balance between spend on admission avoidance services, discharge services and community-based prevention services. The HWB has previously suggested a minimum of 20% of the BCF should be dedicated to delivery of prevention services and this remains an ambition. The chart below shows the breakdown of spending on each BCF scheme type (these are selected according to national criteria) in 2023-24 for the core BCF:

Scheme Type	Value	% of spend
Community Based Schemes	£19,153,368	24.82%
Residential Placements	£14,927,234	19.34%
Home-based intermediate care services	£13,851,300	17.95%
Assistive Technologies and Equipment	£7,373,387	9.56%
Home Care or Domiciliary Care	£4,567,270	5.92%
Integrated Care Planning and Navigation	£4,084,461	5.29%
Prevention / Early Intervention	£3,944,230	5.11%
Bed based intermediate Care Services	£1,836,864	2.38%
Urgent Community Response	£1,609,500	2.09%
High Impact Change Model	£1,458,685	1.89%
Personalised Care at Home	£1,443,781	1.87%
Carers Services	£1,435,965	1.86%
Enablers for Integration	£1,414,081	1.83%
Housing Related Schemes	£65,586	0.08%
Total	**£77,165,711**	**100%**

2.2.1 Almost all schemes contribute to one or more of the national and local priorities. There is no process for measuring the scale of a scheme's contribution. Similarity, schemes meeting fewer priorities than others may still be of vital importance to our local health and social care system.

2.2.2 There is huge variation between the size and nature of schemes currently funded through the core BCF. Some schemes are specific to certain Places, whereas others are delivered across the whole of Norfolk (and Waveney, if commissioned by the ICB). Below shows the number of schemes that are operating at a Place level or County wide:

- 1 place = 33% of schemes,
- 2-6 places = 12% of schemes and
- Across Norfolk (and Waveney if ICB) = 55% of schemes.

2.2.3 The BCF has developed organically and to some extent the diversity of initiatives that are funded may be regarded as positive. However, having such a varied collection of schemes does make it difficult to identify a clear strategic ambition for the BCF, and complicates efforts to evidence impact and value for money against a consistent set of criteria.

2.2.4 The above notwithstanding, funding made available to Health and Wellbeing Partnerships in 2023-24 to deliver locally identified priorities has been positively received. There is more work to do in 2024-25 to determine the role of Place with regards to the BCF, which is in part linked to the system work on the role of Place as a vehicle for localised change as well as to ensure the service user voice and that of providers, are included in understanding the impact of BCF expenditure.

2.3 Outcomes and Reporting: The mechanism for commissioning schemes is through a mixture of contracts and grants. Approximately 20% of schemes are funded through grants, not all of which have KPIs, which can make it difficult to monitor impact. Furthermore, some schemes represent only part of the funding for an entire service, which provides challenges in separating out the different funding streams and demonstrating the specific impact of the BCF investment. Even in cases where schemes do have service level KPIs and are funded in full by the BCF, BCF reporting is currently limited to national metrics that are not easily linked to specific service delivery or outcomes.

2.3.1 As part of this review, we have drafted an approach for a dashboard to enable better oversight and reporting of the BCF at a strategic and scheme level. The dashboard is intended to include:

- Simpler overview of BCF investment; e.g. by theme area, commissioner, provider etc.

- Performance data over time against national BCF metrics; the purpose of this aspect will be to enable trend analysis, which is not possible through the national reporting templates.
- Local performance oversight at a scheme level; one of the recommendations arising from is to reprofile the BCF into a refreshed set of priority themes. Building on this we propose to establish a KPI for each theme to support consistent evidence of impact.

2.3.2 Further work is required with business intelligence colleagues to develop the dashboard in full.

2.4 Governance: The review has demonstrated that there is a disconnect between the BCF as a programme and the commissioners of the schemes that are funded through the BCF. Some lead commissioners believed that the funding for their schemes did not come from the BCF, whilst others had little awareness of what the BCF is aiming to achieve. There were instances where lead commissioners had followed internal organisational governance processes to make changes to their schemes without these changes being clearly visible. There is no mechanism for the sharing of outcomes and achievements of individual schemes.

2.4.1 Strengthening the governance for the BCF will enable more effective usage of BCF funding for local people. Moving forwards, we will be refreshing roles and responsibilities as follows:

The BCF team:
- Are NCC and ICB colleagues who work collaboratively together on the BCF alongside other elements of their individual portfolios.
- Are responsible for collating the BCF Plan and reporting submissions for the Joint Social Care & Health Assurance Board, the Norfolk Health & Wellbeing (HWB) Board and the national BCF team.
- To be responsible for managing the on/off-boarding protocol and associated decisions regarding the eligibility of schemes for BCF funding.

Lead commissioners will be expected to:
- Provide assurance that each BCF scheme has a contract, a service specification and is being actively performance managed, which is evidenced through regular reporting against theme KPIs.
- Support case studies to further demonstrate the impact of BCF investment.

2.5 Priority themes: The approach taken in 2021-22 to consolidate the schemes within the BCF into priority themes was felt to be useful. The themes themselves were reviewed and refreshed to reflect changes in local system priorities over the last few years:

Themes arising from the last review	**Proposed themes**
Inequalities & Support for Wider Factors of Wellbeing	Place Based Initiatives
Prevention	Prevention & Community Support
Person-centred Care & Discharge	Discharge & Recovery
Cross-Cutting & Housing*	Enablers for Integration
Sustainable System (including Admission Avoidance)	Admission Avoidance
	Mental Health, Learning Disabilities and Autism

*Note housing remains a key priority within the wider BCF through the Disabled Facilities Grant (DFG). The DFG is not funded through the core BCF and so was not in scope for this review.

2.6 Recommendations: The work to review the BCF has resulted in three recommendations for further development, as stated below:

1) We move to a refined BCF model, refreshing the Norfolk BCF priorities to fit wider strategic ambitions under the following themes; Place Based Initiatives, Prevention & Community Support, Admission Avoidance, Discharge and Recovery, Enablers for Integration and Mental Health, Learning Disabilities and Autism. Within these six themes there will be a focus on core integrated schemes that operate at scale across the county and require joint commissioning and oversight.

2) We document a process for on/offboarding schemes. All schemes that do not align to the six proposed themes and/or do not operate at scale will be reviewed following this process to identify if they should continue to draw down funding through the BCF.

3) We work with partners across the system to map activity against the new High Impact Change Model for Transfers of Care, identifying areas of development with the support of the Regional BCF Team.

3. Next steps

3.1 If the recommendations are endorsed by the HWB, the immediate next step will be for all schemes within the core BCF to be consolidated under the key themes proposed in this paper. Through this process, schemes that do not operate across the County will be reviewed to identify if there are equivalent initiatives being delivered elsewhere that are not on the current BCF Plan. In these cases, related schemes should be on-boarded to the BCF (where they fit the agreed themes) so that the totality of the scheme type is included within the BCF Plan.

3.2 If no equivalent schemes are being delivered elsewhere, then the scheme will be off boarded from the BCF. In these cases, the commissioning organisation will decide whether to source alternative funding or to decommission the scheme through existing organisational prioritisation processes. Any proposed changes could take 12 months or longer to take effect depending on contractual requirements and any need for stakeholder and public engagement.

3.3 Through this process, the overall spend represented in the BCF could rise to more than the nationally mandated minimum NHS spend. However, it should be noted this would be a re-classification of existing funding already committed to services (which were not previously identified as BCF-eligible) rather than new funding.

3.4 Where possible, we will look to implement changes during 2024-25. However, it should also be noted that spending plans for 2024-25 have already been approved as part of our BCF submission for 2023-24. Major changes, whether introduced during this financial year or in the future, will require support from the NHS England BCF team.

3.5 This joint review has been a valuable experience for both NCC and the ICB colleagues. Further work to consider the whole of the BCF funding streams is suggested as a next step.

Officer Contact

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Norfolk Health and Wellbeing Board

Item No: 12

Report title: Joint Strategic Needs Assessment Work Programme 2024 – 25

Date of meeting: 12 June 2024

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

Reason for the Report

This report presents to the Norfolk Health and Wellbeing Board (HWB) an update on Norfolk's Joint Strategic Needs Assessment (JSNA), forward work plan and governance arrangements.

Report summary

This report provides members of the HWB with an update on both the Norfolk and Waveney Population Health Management Strategy and Norfolk joint strategic needs assessment. Including work undertaken in the past year and planned work for the coming year.

Recommendations

The HWB is asked to:

a) Agree the JSNA forward work programme;
b) Continue to engage, raise awareness and feedback on the JSNA so that Norfolk's JSNA can best support HWB and ICB strategic commissioning intentions, strategies, or frameworks for action.

1. Background

1.1 Since 2013, it has been a legal requirement for the HWB, to produce a Joint Strategic Needs Assessment. The JSNA is a continuous process which Norfolk's local authorities and the Norfolk and Waveney Integrated Care Board (ICB) uses to assess the present and future health, care and wellbeing needs of the community. Its purpose is to highlight gaps and inequalities between various groups and communities, as well as to inform strategies, commissioning, planning and service provision. Additionally, it serves as an evidence base for funding bids and business cases.

1.2 Norfolk's JSNA website (Go to norfolkinsight.org.uk to access the JSNA resources) is centred around three key themes (population; health inequalities and healthcare evaluations). It offers a variety of resources such as needs assessments, topic-based reports, interactive data reports, audits, health and wellbeing profiles and data analysis.

1.3 The governance structure for the JSNA was agreed by the HWB, in 2019 to ensure that Norfolk's JSNA is delivered appropriately in order that priorities can be shaped by the identified needs of local people.

2. Population Health Management Strategy

2.1 Work on the JSNA is aligned to local work on population health management. Population Health Management is a way of working, delivering care in a proactive rather than reactive way. Using local knowledge and linked-up data, we can accurately target support, care, and services to those who need it or will benefit from it the most. In this way we can focus on preventing ill-health and addressing health inequalities and make the biggest impact on

improving health outcomes.

2.2 The Norfolk and Waveney ICB Population Health Management Strategy sets out our 5-year vision our working principles and data-driven priorities for action and how we will deliver them, to improve health and reduce health inequalities for our residents. Go to improvinglivesnw.org.uk to view the Population Health Management Strategy in detail.

3. Recent Updates to the JSNA

3.1 The JSNA products recently produced aligned to joint strategic commissioning intentions, strategies, or a framework for action. Depending on the required need different products have been produced which include:

3.2 **Population Theme:**

3.2.1 **Population Overview Place Profiles for Norfolk & Waveney:** This interactive tool enables users to understand the population by ICS, Norfolk, place board, health and district level geographies. It provides key demographic facts as well as information about areas of deprivation, birth trends, life expectancy, mortality and leading factors for morbidity and mortality.

3.2.2 **Electoral Division Health & Wellbeing profiles:** Summary of health and wellbeing measures at electoral division area. Profiles based on tackling health inequalities, prioritising prevention and integrating ways of working.

3.2.3 **Pharmaceutical Needs assessment supplementary statements:** Recording the changes in opening or closure of pharmacies to the provision of pharmacy services since the publication of the pharmaceutical needs assessment in 2022, these become part of the pharmaceutical needs assessment.

3.2.4 **Tobacco Health Needs Assessment & infographic:** Documents the evidence base and needs for Norfolk to achieve its smokefree target by 2030.

3.2.5 **Air Quality summary:** Documents the risks to Public Health in Norfolk.

3.2.6 **Healthy Homes & Housing summary:** Documents the issues in Norfolk covering the types of hazards in housing, the impact on health and vulnerable people, the occurrence of disease and vulnerable populations in Norfolk, tenure, the state of the housing stock in Norfolk, legislation and guidance and the current services in the county.

3.3 **Health Inequalities Theme:**

3.3.1 **Core20 Plus Groups of Focus – Norfolk & Waveney:**
Analysis of coastal communities.
Analysis of protected characteristics.
- Learning disabilities
- Neurodiversity (autism)

Analysis of Inclusion health groups
- Gypsy Roma Traveller Health Inequalities
- Homeless people
- Refugees and Asylum seekers
- Young Carers
- Looked After Children
- Armed Forces Community.

3.3.2 **Gypsy, Roma Traveller Health Inequalities Assessment & infographic:** Report describes the health needs of this community.

3.3.3 **Refugees & Asylum Seekers in Norfolk Summary & infographic:** Report describes the health needs of this community.

3.4 **Healthcare Evaluation Theme:**

3.4.1 **Cancer** – Public Health outcomes for Norfolk & Waveney.
3.4.2 **CVD** – Public Health outcomes & prevention priorities.
3.4.3 **Mental Health** – Public Health outcomes & prevention priorities.
3.4.4 **Respiratory Disease** – Public Health outcomes & prevention priorities.
3.4.5 **NHS Health Checks Programme in Norfolk Summary & Infographic** - Report takes a closer look at the evidence and delivery of NHS Health Checks in Norfolk.
3.4.6 **UEA Health Data Interpretation** - Group Summary of reports on:

- Healthy Life expectancy and prevention opportunities: Explored healthy life expectancy at small area level and looked at where the opportunities are for preventing of poor health.
- Why is accident & emergency so busy? Analysed patient flow across the system.

3.5 The following products have also been approved for publication on Norfolk's JSNA:

- Director of Public Health Annual Report 2023 on Smoking, tobacco control and vaping
- Public Health Strategic Plan Ready to Change…Ready to Act.

3.6 For each of the published products there has been proportionate engagement and dialogue with key stakeholders to share and disseminate the key findings. All feedback received is collated and used to improve future JSNA products as well as communication and engagement approaches.

4. JSNA Governance and 2024-25 Work Programme

4.1 The JSNA steering group membership is being refreshed to reflect organisations changes and will meet to oversee the JSNA work plan ensuring it is relevant for the priorities of the HWB and for informing system strategies and commissioning decisions.

4.2 Individuals, HWB members & external organisations can propose new topics & changes to existing products for inclusion in the JSNA workplan through their JSNA Steering Group member or by completing the webform. Go to norfolkinsight.org.uk to complete the webform to request JSNA content.

4.3 The JSNA Working Group on behalf of the HWB provides a quality assurance and publishing function for the JSNA. Regular JSNA sessions are delivered by the Public Health to provide guidance and support. To book onto a session please send an email to jsna@norfolk.gov.uk.

4.4 Once a topic is approved by the steering group the JSNA Working Group will liaise with the requesting department for names of lead author & project manager from their department / organisation who will deliver this piece of work and identified resources who will jointly produce the document.

4.5 For 2024-25 JSNA products planned which are aligned to joint strategic commissioning intentions, strategies or a framework for action relate to the following themes as displayed in the table below:

2024 – 2025: JSNA Product	Who requested	Aim of product
Pharmaceutical needs assessment	Statutory Lead Public Health	Work will commence to publish in 2025 in line with the national 3-year publishing cycle. Continue to produce quarterly Supplementary Statements.
Sexual Health Needs Assessment	Requestor Public Health Lead Public Health	To inform vision, ambitions, key actions and & commissioning of services.
Norfolk Drug & Alcohol Joint Needs Assessment	Requestor Norfolk Drug & Alcohol Partnership Lead Police	Will be used by NDAP strategy group to develop the 5-year vision, ambition, key actions & outcome metrics.
Special Educational needs and disabilities needs assessment	Requestor SEND Board Lead NCC, Children's Services	To review progress against strategy.
Health, Weight & Nutrition health needs assessment	Requestor Public Health Lead Public Health	To ensure a joined-up pathway for tackling weight in children and young people.
Learning Disabilities summary update	Requestor NCC Adult Social Care Lead NCC Adult Social Care	To inform re-commissioning of services.
Coastal Populations	Requestor Public Health Lead Public Health	To support wider determinants of health actions.
Social Isolation & Loneliness	Requestor NCC Adult Social Care Lead NCC Adult Social Care	To inform the re-commissioning of the services.
Falls Prevention	Requestor NCC Adult Social Care Lead NCC Adult Social Care	To inform priorities.

Annual updates (aligned to national data publication dates)
[requested and led by Public Health with an aim to inform priorities]

- Healthy Life Expectancy summary
- Population overview
- Health and Wellbeing profiles.

4.6 Further topic specific analysis will focus on the wider determinants of health, and it is anticipated that further analysis will arise either through requests from officers within the local authority and/or external organisations, or in response to local requirements.

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Norfolk Health and Wellbeing Board

Item No: 13

Report title: Norfolk All Age Autism Strategy 2024 to 2029

Date of meeting: 12 June 2024

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

Reason for the Report

There is a requirement under the Autism Act 2009 for local areas to develop and implement an autism strategy. Through a co-produced approach, the Norfolk Autism Partnership Board (NAPB) has refreshed the Norfolk All Age Autism Strategy. The NAPB reports to the Norfolk Health and Wellbeing Board (HWB) as part of its governance arrangements. The NAPB is asking the HWB to adopt the refreshed Norfolk All Age Autism Strategy for 2024 to 2029, on behalf of all the organisations in Norfolk who have a responsibility to implement it, and to agree that individual organisations represented will work with the NAPB to develop a delivery plan.

Report summary

This report gives a brief overview of why and how the Norfolk All Age Autism Strategy has been refreshed for 2024 to 2029. It explains how the strategy will be published and implemented following adoption by the HWB. The Norfolk All Age Autism Strategy shares the NAPB's vision for improving the lives of autistic people in Norfolk and sets out six priorities to achieve this.

Recommendations

The HWB is asked to:

a) Adopt the refreshed Norfolk All Age Autism Strategy for 2024 to 2029.
b) Agree that individual organisations represented on the Board will work with the NAPB to develop a delivery plan.

1. Background

1.1 The previous Norfolk All Age Autism Strategy 2019 to 2024, 'My Autism, Our Lives, Our Norfolk' was presented to and signed off by the HWB in July 2019.

2. The Norfolk All Age Autism Strategy 2024 to 2029

2.1 The refreshed Norfolk All Age Autism Strategy 2024 to 2029 (see appendix A) meets the requirement under the statutory guidance for the Autism Act 2009 for local areas to develop and implement an autism strategy.

2.2 This strategy was co-produced with autistic people, parents/carers and those who work with autistic people. It sets out the NAPB's vision for improving the lives of autistic people in Norfolk, and the priorities which partner organisations will work on over the next five years, to achieve this vision. A summary of the Norfolk All Age Autism strategy (see appendix B) has also been developed.

2.3 The NAPB set up an Autism Strategy Reference Group. This group included autistic people, members of the NAPB and statutory bodies working together to oversee the refresh of the strategy.

2.4 In addition to asking the HWB to adopt the strategy, the NAPB is also asking partner organisations to endorse the strategy, agree to their logos being added to it and agree to work with the NAPB to develop a delivery plan.

2.5 Following endorsement of the strategy by the HWB, the NAPB will publish the final version and will start to work with partners to develop the plan. The plan will set out the key actions that partner organisations will take towards achieving the priorities of the strategy. It will be updated each year from 2025 to 2029 and will be monitored by the NAPB. By January 2029, the NAPB will start work to refresh this strategy for 2030 onwards.

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Norfolk's All Age Autism Strategy

June 2024 to 2029

NORFOLK AUTISM PARTNERSHIP

Norfolk All Age Autism Partnership

A partnership of autistic people, parents, carers, voluntary and statutory organisations working together to achieve an autism-friendly Norfolk.

LOGOS WILL BE ADDED HERE

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Contents

Foreword and acknowledgements

This is Norfolk's refreshed strategy for improving the lives of autistic people living in Norfolk. It builds on and replaces the Norfolk All Age Autism Strategy for 2019 to 2024, 'My Autism, Our Lives, Our Norfolk'.

'My Autism, Our Lives, Our Norfolk' called for a greater understanding of autism, so that autistic people can live fulfilling and rewarding lives. The Norfolk Autism Partnership Board (NAPB) works to improve services and support for autistic people of all ages. In 2019 the NAPB was facilitated by Norfolk County Council, but it is now supported by an independent organisation, giving it greater autonomy. We have seen some real improvements in Norfolk since 2019, such as autism awareness training available to everyone, which was co-produced by autistic people. And the NAPB's website is expanding all the time and is a valuable source of information for autistic people and their families.

The Covid pandemic had a major impact on many autistic people, making it harder for people to get support.[1] But we also learned some valuable lessons from the pandemic, such as the benefits of flexible working and new ways of providing support online.

Much more needs to be done to improve autistic people's lives in Norfolk. Autistic people and their families have told us that understanding of autism still needs to improve in society and across public services. They told us that improvements are particularly needed within mental health and other health services. Autism is not a mental illness, but it is estimated that 70 to 80% of autistic people experience mental ill health, and suicide is one of the leading causes of death.[2] Waiting times for an autism assessment have increased, with people waiting too long for an assessment. Autistic people and their families tell us that they are not getting the support they need due to the inequalities in services they experience. We also know that an inability to record and report accurate autism data both nationally and locally creates a real challenge to effective planning of appropriate services and support for those with a primary need of autism.

[1] Left stranded: our new report into the impact of coronavirus (autism.org.uk)
[2] Autism and mental health.

This strategy aims to build on the ambitions of 'My Autism, Our Lives, Our Norfolk'. It sets out what autistic people, their parents/carers and those supporting them have told us is important to them, and the changes that are needed to improve the lives of autistic people in Norfolk. It is co-produced by the NAPB, which includes people of all ages with lived experience of autism, including parents/carers. It also includes people from a wide variety of partner organisations such as individuals working in healthcare, social care, education, voluntary organisations, the police and Healthwatch. Everyone involved with the NAPB is committed to improving the life opportunities of all autistic people living in Norfolk.

This strategy uses the term 'autistic people'. This is because autistic members of the NAPB said that they prefer 'identity first' language ('autistic people' rather than 'people with autism'). Identity first language reflects the view of many autistic people that their autism is part of who they are, not something separate. However we recognise that there is no single way of describing autism that is universally accepted and preferred by everyone.[3]

Acknowledgement and special thanks to the following:

- The Autism Strategy Reference Group members for their hard work to develop this strategy and their creativity and innovative thinking.

- All members of the NAPB, past and present, who give their time, skills and experience. Their valuable contribution to improving services and support for autistic people of all ages is acknowledged.

- Those who completed the autism strategy questionnaire or attended a group or forum to refresh the strategy. All those who took part have had a major impact on this strategy by sharing their experiences and ideas.

[3]Which term should be used to describe autism?

Our vision

'My Autism, Our Lives, Our Norfolk' and this refreshed strategy set out a vision for the future:

Our Vision:

All autistic people, their parents/carers are accepted, understood and treated as equal members of the community. That there is a greater awareness and understanding of autism by people that live and work in Norfolk. That this understanding will enable autistic people to have the same opportunities as everyone else to live a fulfilling and rewarding life and achieve their life's ambitions.

This refreshed strategy sets out the areas which the Norfolk Autism Partnership will work on over the next five years, from 2024 to 2029 to achieve this vision. We will do this by working together to achieve the six priorities that autistic people have told us are important:

These six priorities are linked to the priorities of the national strategy for autistic children, young people and adults: 2021 to 2026. The national strategy sets out the government's vision of the changes needed at a national level to improve autistic people's lives.

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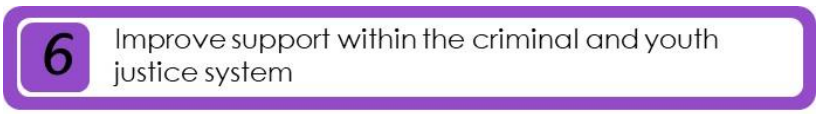
By 2029, we want Norfolk to be a much more autism inclusive county, where Norfolk's autistic population are included in society, and feel safe and welcomed. We want to improve the understanding of autism within the general public, and among those providing support and services to autistic people.

By 2029, we want autistic children and young people to get the right support so that every child and young person in Norfolk can flourish. We want transitions into adulthood to improve so that young people can live well in their communities, find work or continue in education.

By 2029, we want more autistic adults to be in employment. We want autistic people's experience of being in work to have improved, and for employers to be more confident about hiring and supporting autistic workers.

By 2029, we want autistic people to be able to access the health support they need to live healthier lives. We want to see improved health outcomes and a reduction in the gap in life expectancy that currently exists for autistic people.

By 2029, we want autistic people to be able to live well in their communities. We want improvements in support to mean that fewer autistic people reach crisis point. When autistic people spend time in hospital, we want them to be able to return home or move to suitable accomodation with the right support as soon as they are ready.



By 2029, we want autistic people who come into contact with the criminal and youth justice system to get the support that they need. Through early intervention, we want fewer autistic people to become victims of crime or to be convicted of a crime. We also want those who have been convicted of a crime to get the additional support they may need to fully engage with their sentence and rehabilitation.

Background

Why do we need a new autism strategy?

'My Autism, Our Lives, Our Norfolk' was a five year strategy from 2019 to 2024. The Norfolk Autism Partnership Board (NAPB) started work to refresh the strategy in June 2023. We want this refreshed strategy to build on 'My Autism, Our Lives, Our Norfolk'. It reflects the improvements that have happened since 2019, and the changes that autistic people in Norfolk have told us they want to see over the next five years, from 2024 to 2029. We also want to make sure that the refreshed strategy reflects changes in national guidance and policies, so that our local priorities and actions can be as effective as possible.

The Autism Act (2009) was the first national legislation and guidance specifically aimed at autistic people. In 2015, the government provided statutory guidance on implementing the Autism Act.[4] This set out local authorities' and NHS organisations' duties to support autistic adults, and to have a local Autism Partnership Board in place. This led to the Norfolk Autism Partnership Board being set up in November 2017.

The statutory guidance also placed a duty on the government to produce and regularly review a national autism strategy to meet the needs of autistic adults in England. The most recent national strategy includes children and young people for the first time, as well as adults.[5] This national strategy reflects many of the priority areas that were included in 'My Autism, Our Lives, Our Norfolk', such as employment, transitions, better community services and the justice system.

In refreshing this strategy, we also need to take account of other local strategies which may be relevant for autistic people. These strategies include the learning disability, SEND and alternative provision, carers, suicide prevention and eating disorders strategies. Some of these local strategies are also in the process of being refreshed, so we have talked to people working on these other strategies. We talked to them to make sure that we are all working together to achieve the same priorities.

[4] Statutory guidance for Local Authorities and NHS organisations to support implementation of the Adult Autism Strategy (publishing.service.gov.uk)
[5] National strategy for autistic children young people and adults 2021 to 2026 - GOV.UK (www.gov.uk)

Who is this strategy for?

This strategy is for autistic people of all ages, their parents, carers and families, those supporting them and anyone who has an interest in autism in Norfolk.

Autism is a lifelong developmental difference that affects how people communicate and how they experience the world around them.[6] While autistic people share some similar characteristics, it is important to understand that everyone is unique, and autistic people have a variety of strengths as well as needs. Autism is not a learning disability or mental health condition, but autistic people can have co-occurring conditions such as a learning disability or health condition. Some autistic people are able to live independent lives, while others require specialist care and support.

The National Strategy reports that about one in 100 people are autistic, and that there are around 700,000 autistic adults and children in the UK.[7] However, a recent study by researchers at University College London suggest that a more realistic estimate is that between 1 to 3% of people are autistic, and that there are over 1.2 million autistic people in the UK.[8] This means, based on Norfolk's population there could be about 27,400 autistic people living in Norfolk.[9] And based on the birthrate in 2021, there could be 237 autistic babies born each year in Norfolk.[10]

Approach to refresh the strategy

In June 2023, the Norfolk Autism Partnership Board (NAPB) set up an Autism Strategy Reference Group (the Strategy Group). This group included autistic people, members of the NAPB and statutory bodies working together to oversee the refresh of the strategy.

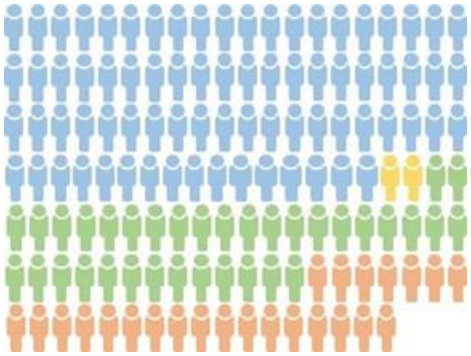
> "Being part of the Autism Strategy Reference Group enabled me to feel part of a caring community dedicated to making positive change for autistic people in Norfolk."
> Autism Strategy Group Member

[6] https://www.autism.org.uk/advice-and-guidance/what-is-autism
[7] The national strategy for autistic children, young people and adults: 2021 to 2026 - GOV.UK (www.gov.uk)
[8] https://www.ucl.ac.uk/news/2023/jun/number-autistic-people-england-may-be-twice-high-previously-thought
[9] https://www.norfolkinsight.org.uk/wp-content/uploads/2023/08/Norfolk_Population_Overview_August_2023.pdf
[10] Norfolk Population Overview (norfolkinsight.org.uk)

The Strategy Group designed a 'You Said, We Did' document. This explained what has changed since 2019 in response to 'My Autism, Our Lives, Our Norfolk'. It also explained what partner organisations already plan to do to improve the lives of autistic people beyond 2024. An autistic member of the Strategy Group created an animation to provide this information in a different format, and an Easy Read version was also created. The Strategy Group designed and tested a questionnaire, to find out what is important to autistic people, their parents/carers and supporters. All of these communications were checked against the Autism Friendly Top Tips guide to make sure they were autism friendly.

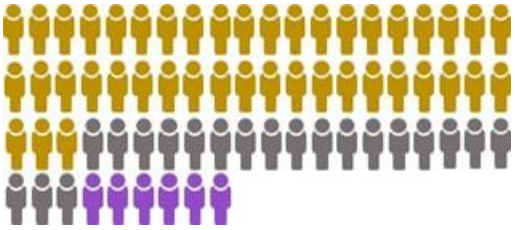
The Norfolk Autism Partnership (NAP) hosted a webpage to share the 'You Said, We Did' communications and the questionnaire, which could be completed online or as a workbook. They wrote to all members of the NAP to encourage people to take part, and shared details through partner organisations, voluntary groups and libraries across Norfolk. The questionnaire was completed by 137 people in total:

76 autistic adults (blue),
2 autistic young people (aged under 18) (yellow),
35 parents/carers or family members (green), and
24 professionals/other respondents (orange).



The Strategy Group arranged further activities in January and February 2024, to give people the opportunity to say more about what is important to them. A mix of online sessions and in-person sessions in Norfolk libraries were held. 69 people took part:

43 people through an online session (gold),
20 people through a library session (grey), and
6 people in a workshop for autistic prisoners at Norwich Prison (purple).



The views we gathered through the questionnaire and the sessions led to the six priorities listed on page 6. 574 individual comments were noted from the questionnaire and sessions and were grouped into key themes. These key themes are reflected throughout this strategy in the sections headed 'What is important to people?'

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1 Improve understanding and inclusion of autism

By 2029, we want Norfolk to be a much more autism inclusive county, where Norfolk's autistic population are included in society, and feel safe and welcomed. We want to improve the understanding of autism within the general public, and among those providing support and services to autistic people.

What we know nationally

The national strategy reports that awareness of autism has increased, since the introduction of the Autism Act in 2009. It is estimated that 99.5% of the public are now aware of autism.[11] Although there is more awareness, there is still a significant lack of understanding about autism among the public, including what it means to be autistic and the diversity of autism. Just 24% of autistic adults and 26% of family members think public understanding has improved since the introduction of the Autism Act.[12]

The Equality Act 2010 places a legal requirement on public services to eliminate discrimination and advance equality of opportunities for disabled people. It also requires service providers, employers and businesses to provide reasonable adjustments for disabled people. This includes autistic people, with or without a diagnosis, provided that their autism has a substantial effect on their ability to carry out day to day activities.[13]

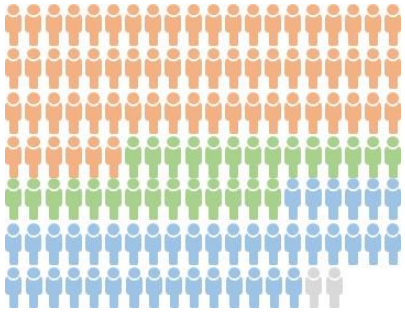
Many public sector services and other organisations are taking steps to become more autism inclusive. However, autistic people still face stigma and prejudice when accessing services or just going about their daily lives.[14] Many autistic people feel excluded from public spaces because these can be overwhelming, busy or noisy and because staff or the public may react negatively to autistic people. The national strategy also identifies that transport is a key issue and is central to autistic people and their families being included in their community and being able to find employment. Many autistic people find public transport inaccessible because of how anxiety-inducing, noisy and busy it can be.

[11] The national strategy for autistic children, young people and adults: 2021 to 2026 - GOV.UK (www.gov.uk)
[12] APPGA-Autism-Act-Inquiry-Report.pdf (pearsfoundation.org.uk)
[13] Check if you're protected from disability discrimination - Citizens Advice
[14] The Autistica Attitudes Index | Autistica

What we know in Norfolk

'My Autism, Our Lives, Our Norfolk' included autism awareness as a priority for 2019 to 2024. Our new priority for this strategy reflects the need to move on from awareness to better understanding and inclusion.
Our questionnaire asked people whether they thought that autistic people are more included within their communities now, compared with 2019.

48% said they were unsure (orange),
21% said they are more included (green),
30% said they are not more included (blue),
1% did not answer the question (grey).

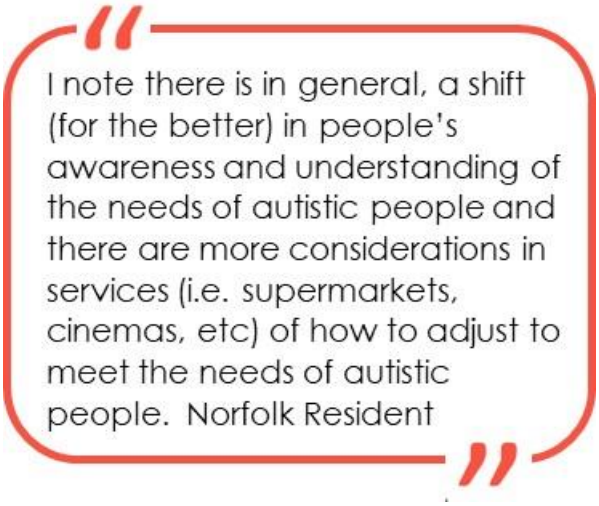


Autism awareness e-learning is available free of charge to anyone via the Norfolk Autism Partnership website. There is also a more detailed one day 'Understanding Autism' course. The Norfolk Autism Partnership co-produced, designed and created both courses with the help of Norfolk County Council and Norfolk and Suffolk NHS Foundation Trust. The courses have been quality checked and endorsed by the University of East Anglia and are annually updated.

People told us that although there is more awareness of autism, there is still a lot to be done to improve the understanding of autism within society, and in public services. In particular, autistic people raised concerns about the lack of autism awareness among staff in primary care, including GP surgeries, and the need for mandatory training to address this. They also talked about the need for better understanding among employers, as well as in schools and a wide range of other settings.

People said that there is a need for clear information about support for autistic people in Norfolk. They also told us about the importance of autistic people working with services to create information and training, and of advocacy to support people when needed. And they told us that safe spaces are needed in the community and in hospitals.

What is important to people



Better understanding of autism in society

- Many people said that autism training for employers or for those providing services in community such as opticians, solicitors and hairdressers is needed. Training could also help family members of autistic people.

- People said there needs to be more understanding of autism among the general public. This includes understanding of meltdowns and shutdowns, so that people respond in a way that is helpful.

- People said that autism should be recognised as a different way of thinking to break down stereotypes.

- People said that autism should be celebrated in society. This includes having positive role models and using celebrities.

- People said that leisure services and social groups which are open to everyone (such as Scouts and Brownies) need to make adjustments so that autistic people can take part more easily.

- People said that autism friendly transport needs to be widely available, so that autistic people can get out and about, particularly if they live in rural areas.

- People said that autism alert cards should be promoted, so that autistic people can choose to use them, and the general public have a better understanding of what they can do to support autistic people.

- People said there could be a kitemark scheme to recognise organisations which are supporting autistic people well.

Understanding of autism in public services

- Many people said that more training is needed for staff in settings such as schools, the police, job centres and prisons, to improve the understanding of autism. This includes making sure that staff put training into practice, and that training is mandatory. This will make sure that all staff who work with autistic people have the right skills and knowledge.

- Many people said that it is important to make reasonable adjustments based on the needs of the autistic person, regardless of whether they have a diagnosis. For example, providing a quiet place in hospitals and allowing more time to explain things. People said that reasonable adjustments should be made in schools based on the child's needs, rather than requiring a diagnosis.

- Many people said that there should be more training for staff in health and social care services. They said it is important that clinical and administrative staff in hospitals, GP surgeries, dentists and mental health services undertake the right level of training for their role.

- People said that it is important that professionals understand sensory differences (such as different ways of perceiving pain), and that they understand demand avoidance and the impact of previous trauma.

- People said there are examples of good practice in healthcare settings and schools. This good practice should be shared widely so that other services can learn from them.

Information and Resources

- Many people said that a Norfolk directory of autism support should be created, so that autistic people and their families know what is available, and how to access it.

Co-production

- People said that co-production is important. They said that information for autistic people should be co-produced, and that autistic people should be fully involved in creating the plan to deliver this strategy and monitoring it. They also said that autistic people should be involved in creating training courses (such as the free autism awareness e-learning) and that it is important for autism training to be co-presented by autistic people.

- People said that the Norfolk Autism Partnership Board should reach out to younger people, to make sure that they are represented on the Board.

Advocacy

- People said that independent advocacy should be available whenever autistic people need it. This could be to support them when accessing services such as health and social care or when applying for benefits.

Safe spaces

- People said there is a need for safe places in the community and in hospitals. These could also provide a quiet place for autistic people when they need it.

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2 Improve access to education and support transitions into adulthood

By 2029, we want autistic children and young people to get the right support so that every child and young person in Norfolk can flourish. We want transitions into adulthood to improve so that young people can live well in their communities, find work or continue in education.

What we know nationally

The national strategy tells us that a growing number of children and young people are being diagnosed as autistic, with special educational needs data suggesting that 1.8% of all pupils in England now have an autism diagnosis.[15] In spite of this, many autistic children and young people are still having poor experiences at school and are struggling in the transition to adult life. The national strategy highlights evidence that autistic children and young people often struggle to get support they need through the Special Educational Needs and Disabilities (SEND) system, including being able to access support early enough from health and social care, as well as education. In addition, staff often lack the skills needed to put in place the right plans and support for autistic young people.[16]

What we know in Norfolk

The Norfolk Joint Strategic Needs Assessment for children and young people with SEND published in May 2022 found that 49% of children and young people (1267 children) on the Norfolk Register of Disabled Children in 2019 were autistic.[17] The JSNA also identified that the most common primary need for children in special schools is Autistic Spectrum Disorder, although the proportion is lower than the national figure (28.7% of special school pupils in Norfolk, compared to 32.4% in England).

Norfolk now has two specialist autism schools: The Wherry School in Norwich which opened in 2017, and the Duke of Lancaster school in Fakenham which opened in January 2022. Two new specialist schools are planned for 2026: a school for children with communication and interaction needs in Downham Market, and a school for children with complex needs in Great Yarmouth. Norfolk also has 13 autism specialist resource bases (SRBs) attached to mainstream schools, but the JSNA found that there are not enough places available for autistic children and young people.

[15] Special educational needs in England, Academic year 2022/23 – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)
[16] The national strategy for autistic children, young people and adults: 2021 to 2026 - GOV.UK (www.gov.uk)
[17] Norfolk Joint Strategic Needs Assessment for children and young people with SEND

Norfolk County Council set up a Preparing for Adult Life team in 2020 to support young people who are likely to need support from Adult Social Services. The proportion of young people turning 18 and supported by the team whose primary need is autism has increased each year, rising from 13% in 2021 to 2022 to 26% in 2023 to 2024.[18]

People told us that the support for autistic children and young people in education settings needs to be improved, along with better communication with families. They also said that better support is needed for those who are not in school as some parents are not home educating through choice, but because a school cannot meet their child's needs. And people said that improvements need to be made for the transition into adulthood.

Our plans to achieve this priority need to reflect the SEND and Alternative Provision Strategy. We will identify where actions planned as a result of that strategy will help us to achieve the priorities within this refreshed strategy.

What is important to people

> Better planning for this transition period, thinking about aspirations, developing independence skills and access to mental health support/support with creating and maintaining healthy relationships. Norfolk Resident

> My son has no idea how to move forward after college and is very stressed about what the future may bring. Norfolk Resident

Support in schools, colleges and other education settings

- People said that good quality support in mainstream schools, colleges and universities is important. This includes support continuing from one setting to another (for example, primary to secondary school). It also includes understanding of autistic young people's mental health and sensory needs, and support for those with lower level needs, not just those with complex needs.

- People said that better resources are needed to enable teachers to support autistic students. These should also be shared with parents for a consistent approach.

[18]Data provided by Norfolk County Council.

- People said that schools and colleges could learn from each other by sharing good practice.

- People said that it can be very difficult to access an Education Health and Care Plan (EHCP) for those who need it, and the wait to get an EHCP should be reduced. People said that schools and colleges should be held to account if they do not provide the support listed in an EHCP.

- People said that more specialist schools for autistic students are needed, as well as better access to remote learning for those who are struggling to attend school. People said that more flexibility could enable young people to access college courses when they are ready for them, rather than being limited by their age.

- People said that autistic children and young people should get support in schools to enable them to make and keep friends. People also said that bullying within schools needs to be better addressed.

Communication

- People said that the voices of parents and children needs to be heard in education settings, as parents can feel that they are not listened to.

- People said that autistic young people need more support to learn to speak for themselves as they become adults. They said families need better information about how they can support their child to make their own decisions, and what happens if the young person is not able to make a decision for themselves.

Support for home educating families, and young people who are not in school

- People said it would be helpful if resources used by schools could be shared with families, so that they can use them as well.

Transitions into adulthood

- People said autistic young people need support to make the transition from school to college, and from education to work. This includes schools and colleges knowing about options for young people to move on to.

- People said that careers advice should focus on the autistic young person's strengths and their hopes for the future.

- People said that planning for the transition into adulthood should start in Year 9 for all autistic young people, not just those with an EHCP.

- People said that continuity is important in transitions within health care, social care and education, so that autistic young people do not suddenly lose support, or find they are being supported in a very different way.

- People said that waiting times for support from the Preparing for Adult Life Team need to be reduced, so that they can get involved earlier.

3 Support adults into employment

By 2029, we want more autistic adults to be in employment. We want autistic people's experience of being in work to have improved, and for employers to be more confident about hiring and supporting autistic workers.

What we know nationally

The national strategy tells us that there is a significant employment gap for autistic people. The Buckland Review of Autism Employment (published in February 2024) identified that only around 3 in 10 working age autistic people are in employment.[19] This compares with around 5 in 10 for all disabled people and 8 in 10 for non-disabled people. Autistic people also face the largest pay gap of all disability groups, receiving a third less than non-disabled people on average. Autistic graduates are twice as likely to be unemployed after 15 months than non-disabled graduates and are more likely to be overqualified for the job they have.

Barriers to work for autistic people identified by the Buckland Review include poor preparation by employers, unfair hiring practices, unclear processes and outdated attitudes. Once in a job, many autistic people do not receive the support or adjustments they need. Only around 35% of autistic employees are fully open about being autistic at work, and the most common time for employees to disclose their autism is after starting a job. This highlights a persistent and well-founded fear of discrimination during the recruitment process.

What we know in Norfolk

Using the estimated figures for the number of autistic people in Norfolk referred to above, there could be about 14,200 autistic people aged 18 to 64 in Norfolk.[20] If only 3 in 10 autistic people of working age are employed, then there could be almost 10,000 autistic people of working age who are not in employment in Norfolk.

New employment schemes to support people with long-term conditions, including autistic people, have been established since 2019. These include the Local Supported Employment programme (available from late 2022 until March 2025) and Working Well Norfolk. There is also the Norfolk Employment Service for people supported by Adult Social Services. In addition, the Universal Support Scheme, funded by the Department of Work and Pensions, is currently being rolled out across the country. This is likely to come to Norfolk in late 2024 or early 2025.

[19] Buckland Review of Autism Employment
[20] Data shared by Norfolk County Council

People have told us that more needs to be done to support autistic people to get and keep a job and to support employers of autistic people. They also told us that there need to be more routes into employment and education for autistic adults.

What is important to people

Getting a job

- People said that autistic people need support to access employment based on their strengths and interests.

- People said that there are many alternatives to traditional employment which could be considered. These include apprenticeships, supported internships, self-employment, part-time or flexible working, and paid peer support roles. Being able to work or study from home also creates more opportunities for some autistic people.

- People said that recruitment processes should be adapted so that they are based on autistic people's strengths and an understanding of the challenges they experience. For example, doing a job trial rather than a traditional interview.

Keeping a job

- People said that employers could provide a mentor for autistic employees when appropriate. Having one person to go to would make it easier for many autistic people to maintain their job.

- People said that more support should be given to autistic employees to help them to manage stress and issues at work. Autistic people sometimes feel that Human Resources processes around absence do not recognise their needs.

- People said that autism friendly information on employment rights would be helpful. This would help autistic employees to know what support they can expect their employer to provide, and what their employer is legally required to do.

- People said that bullying in the workplace should be addressed.

- People said that autistic people should be made aware of the support available through the Access to Work scheme.

Support for employers

- People said that there should be more information and support available to employers to help them recruit and support autistic employees.

- People said employers could share good practice with each other and be encouraged to sign up to the Disability Confident scheme. The needs of autistic people could be specifically considered, for example as a separate kitemark.

Routes into employment and education for adults

- People said that there should be more supported employment settings for autistic people who need a higher level of support.

- People said that volunteering and work experience could provide more routes into work for autistic people.

- People said there should be more targeted support for autistic people who are on benefits, to support them to get into work.

- People said that support should be available to enable autistic adults to access education throughout their life.

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4 Tackle health inequalities for autistic people

By 2029, we want autistic people to be able to access the health support they need to live healthier lives. We want to see improved health outcomes and a reduction in the gap in life expectancy that currently exists for autistic people.

What we know nationally

The national strategy highlights that many people are waiting a long time for an autism diagnostic assessment. NHS data shows that in December 2023 over 170,000 people were waiting for an autism assessment in England, a 47% increase from the previous year.[21]

The national strategy also tells us that autistic people have poorer physical health outcomes and a lower life expectancy than the general population.[22] Many possible reasons for this gap have been suggested, including poor understanding of autism among health and care staff, which can lead to signs of illness being overlooked. Without the right understanding, autistic people can miss out on adjustments needed for them to engage in medical appointments, which can lead to distressing experiences and avoiding seeking medical attention.

It is estimated that 70 to 80% of autistic people experience mental ill health. This could include anxiety, depression, eating disorders or psychosis.[23] It is recognised that there are not enough of the right type of community services, and not enough mental health professionals who properly understand autism.[24]

Autism annual health checks are currently being piloted in other parts of England, to tackle the causes of poor health in autistic people and improve their physical and mental health.[25] These health checks already exist for people with learning disabilities, and there is evidence that they can improve health outcomes.[26] They are not yet available for autistic people who do not have a learning disability in Norfolk. Autistica is working with NHS England to carry out research into the effectiveness of these checks for autistic people and has created a Health Checks Plan to ensure every autistic person is offered an annual health check by 2030.

[21] News item Autism assessment waiting times
[22] Premature death of autistic people in the UK investigated for the first time | UCL News - UCL – University College London
[23] Challenges autistic people face | Autistica
[24] Mental Health (autism.org.uk)
[25] Autistica releases plan to ensure every autistic adult is offered a yearly, tailored health check by 2030 | Autistica
[26] Better Health and Care for All (nihr.ac.uk)

The learning from lives and deaths – people with a learning disability and autistic people (LeDeR) programme was expanded in January 2022 to include autistic adults who do not have a learning disability. The number of LeDeR reviews for autistic people without a learning disability completed in 2022 was small, and awareness of the programme needs to be increased. The annual report found that suicide was the leading cause of death for autistic adults referred for a review.[27] The national suicide prevention in England: 5-year cross-sector strategy identifies autistic people as a priority group, reflecting the evidence that autistic people are up to seven times more likely to die by suicide than others, with a need for action to address this.[28]

What we know in Norfolk

People have told us that more needs to be done to tackle health inequalities in Norfolk.

The NHS publishes statistics relating to waiting times for autism assessments on the NHS Digital website. However, not all diagnostic services report in this way, meaning that this data is not always accurate for Norfolk. While improvements to the accuracy of the NHS Digital data are being made, commissioners report statistics to the NAPB. In January 2024, it was reported that there were 9290 children (aged under 18) waiting for a neurodevelopmental assessment in Norfolk and Waveney. And there were 954 adults in Norfolk waiting for an autism diagnostic assessment.

Norfolk's situation mirrors that across England, with waiting lists at unsustainable levels. Diagnostic services for both adults and children are unable to meet the NICE guidance stating that no one should wait longer than 13 weeks for their first appointment,[29] or the NHS 18 week 'Referral to Treatment' target.[30] Actions to reduce the waiting time for an adult autism assessment were taken in 2022 to 2023, using one off funding to complete 1119 assessments. Similar funding has been allocated for children's neurodevelopmental assessments, and this work is underway. This one off funding has helped temporarily, but increasing numbers of people being referred for assessment means that waiting times are increasing. If referrals continue at their present rate and action is not taken, the waiting times will continue to increase each month.

[27] Learning from Lives and Deaths - people with a learning disability and autistic people (LeDeR) - King's College London (kcl.ac.uk)
[28] Suicide and autism | Autistica
[29] Autism assessment waiting times
[30] NHS England » Referral to treatment

In most cases, people have a right to choose an alternative service to complete their autism assessment, provided that service is approved by the NHS.[31] However, many people (including professionals) are not aware of this option.

People told us that more needs to be done to improve the support available before and after a diagnosis, and throughout life. There is some support available, such as advice and guidance from Family Action for parents and carers of children waiting for a neurodevelopmental assessment, or who have recently been diagnosed with autism or ADHD. Some sessions of post diagnostic support are also now available for adults who have been diagnosed, and a resource pack is available online. There is a Living Well with Autism course which was co-produced with people with lived experience of autism, available through the Recovery College run by Norfolk and Suffolk Foundation Trust.

However, people told us that there is not enough support while waiting for a diagnosis and limited support available post diagnosis. They told us that support needs to be improved before and after diagnosis, and that ongoing support, including therapy adapted to meet their needs, should be available. People also told us that there is a lack of clinical support for issues such as sensory needs and communication.

More also needs to be done to improve mental health support across Norfolk to prevent autistic people from reaching a crisis, and for those in a crisis. People talked about the need to improve mental health services, to ensure that they are appropriate for autistic people and that mental health support is not refused due to them being autistic. People told us they are not able to access mental health support when they need it. They also talked about the difficulties resulting from a misdiagnosis (when autism is not recognised), but also how autism may overlap or be overshadowed by other conditions. This can make it hard for autistic people to have their needs met, and for professionals to offer the right support.

The local suicide prevention strategy is currently being refreshed, and recognises that autistic people are a priority group. Our plans to achieve this priority need to reflect the local suicide prevention strategy. We will work with Public Health and other organisations to consider how the actions in our strategy plan can link to the local suicide prevention strategy and improve support for autistic people.

[31] Patient choice at the point of referral - Norfolk & Waveney Integrated Care System (ICS (improvinglivesnw.org.uk)

Our plans also need to take into account the local Eating Disorders Strategy, as research suggests that autistic people may be more likely to experience eating disorders.[32] We will identify where actions planned as a result of that strategy will help us to achieve the priorities within this strategy.

What is important to people

> ASD affects the whole experience of healthcare, and the long wait times and difficulty getting diagnosed is a significant barrier to accessing the correct healthcare and resources.
> Norfolk Resident

> People are waiting too long for a diagnosis that can put people off a diagnosis when it is needed.
> Norfolk Resident

Diagnosis

- Many people said that waiting times for an autism diagnosis should be reduced.
- People said that the tools used for diagnostic assessment should be appropriate for all groups, such as women and girls, and that it is important that staff keep up to date as the understanding of autism changes.
- People said that pre and post diagnostic information and support are important. This includes information and support around regulating emotions, understanding masking and sensory differences.
- People said that there needs to be more awareness that when autism has not been recognised, this can lead to misdiagnosis of other conditions. Misdiagnosis can lead to inappropriate medication.
- People said that the diagnostic pathways need to be improved for adults who may need assessments for more than one condition, such as autism and ADHD.
- People said that a private diagnosis was not accepted by their GP in some cases, and it should be.

[32] Eating disorders (autism.org.uk)

Health services

- People said that autism annual health checks would be very helpful. These have been piloted in some parts of the country but are not yet available in Norfolk.

- People said that My health passports need to be more widely promoted and followed by health professionals.

- People said that there needs to be better access to specialist health services such as Speech and Language Therapy, sensory integration assessments and support for ARFID (Avoidant Restrictive Food Intake Disorder).

- People said the support offered by the Learning Disability and Autism Nurses in the acute hospitals needs to be better known about, and that it would be helpful if it was available out of hours.

Mental health services

- People said that mental health support for autistic people needs to be more available. This includes therapy and counselling being adapted so that they are appropriate for autistic people.

- People said that better support is needed to stop autistic people going into crisis. People also said that more support should be available when autistic people are in crisis.

- People said that crisis telephone support should be available for autistic people and that there should be an option to speak to someone with expertise in autism.

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5 Build the right support in the community

By 2029, we want autistic people to be able to live well in their communities. We want improvements in support to mean that fewer autistic people reach crisis point. When autistic people spend time in hospital, we want them to be able to return home or move to suitable accommodation with the right support as soon as they are ready.

What we know nationally

The Building the Right Support national plan was updated in 2022, and states that all autistic people should be able to live full lives in their community, in their home, with access to the care that is right for them, when and where they need it.[33] Too many autistic people (particularly teenagers and young adults) are still being admitted into inpatient hospital settings, often because they struggle to access community support (including social care, mental health and housing support) before their needs escalate.[34]

In February 2024, NHS data shows that there were 2,045 autistic people and people with learning disabilities in mental health hospitals in England.[35] 67% of these people are autistic. There are 210 under 18 year olds in inpatient units who are autistic or have a learning disability, and 93% of them are autistic. There has been some progress in moving people with learning disabilities out of hospitals and into the community. However, the number of autistic people who do not have a learning disability detained in mental health hospitals has increased by 100% since 2015.[36]

What we know in Norfolk

NHS data indicates that there were 35 people with learning disabilities and autistic people in inpatient settings in Norfolk and Waveney in February 2024.[37] As a proportion of the population, this is slightly below the average for England. This number included 15 autistic people, 5 autistic people who also had a learning disability and 15 people with learning disabilities.

[33] Building the Right Support Action Plan - GOV.UK (www.gov.uk)
[34] The national strategy for autistic children, young people and adults: 2021 to 2026 - GOV.UK (www.gov.uk)
[35] Assuring Transformation NHS data
[36] Number of autistic people in mental health hospitals: latest data (autism.org.uk)
[37] NHS Assuring Transformation data: Learning disability services monthly statistics from Assuring Transformation dataset: Data tables - NHS England Digital

The Norfolk and Waveney Integrated Care System requested a Building the Right Support peer review in 2022 to look at how services for autistic people and people with learning disabilities could be improved. This involved professionals and people with lived experience from other areas visiting Norfolk and Waveney and giving feedback about the support and services available. The peer review highlighted the need to address the inequalities in services that are experienced by autistic people. Building The Right Support covers both autistic people and people with learning disability both nationally and locally. Looking separately at the needs of autistic people could provide a clearer focus, to help address the recognised inequalities in services.

Some new services for autistic people have been established in Norfolk since 2019. These include a new short-term adult social care service for adults with emerging social care needs, which was set up in January 2024. Titan travel training has been extended to autistic adults known to Adult Social Services, and some assistive technology gadgets and apps can be provided for autistic adults living in their own homes.[38] And an award-winning care phone was rolled out by Adult Social Services during the pandemic, supporting people (including autistic people) to keep in touch with loved ones and professionals who supported them.[39] Curators of Change are working with Norfolk County Council to create a Real Care Deal for Norfolk, with the intention of providing a more ethical approach to how Adult Social Services works with people and providers.

Community support available to everyone has also improved, with autism social groups now being held in libraries across Norfolk.[40] These groups support autistic people to meet others, to help reduce loneliness and isolation. Information about the groups is available on the Norfolk Autism Partnership's 'What's On?' webpage and in local libraries.

People have told us that much more needs to be done to improve the support available in the community. They told us that early intervention is important, to prevent people's needs from escalating. They talked about the need for ongoing support for autistic people, and improvements to social care services. And they told us about the importance of housing and independent living.

Carers of autistic people also find it hard to get the support they need. A survey of carers, carried out by Carers Voice Norfolk and Waveney during the development of the All Age Carers Strategy, found that 62% of carers of autistic people had found it difficult to get the support they need. This rose to 77% for those carers who were also autistic themselves.

[38] Assistive technology - Norfolk County Council
[39] Adult Social Care digital initiative scoops silver at prestigious national awards - Norfolk County Council
[40] Data provided by Norfolk Autism Partnership Board

Our plans to achieve this priority need to reflect the All Age Carers Strategy, and other local strategies which are relevant to support for autistic people in the community, such as the Learning Disability Plan. We will identify where actions planned as a result of those strategies will help us to achieve the priorities within this strategy.

What is important to people

> Life at home, relationships – support for neurodiverse spectrum couples and help to have a healthy relationship and family life.
> Norfolk Resident

> More support directed towards autistic adults. Not everyone will seek out the support.
> Norfolk Resident

Early intervention

- People said that there should be more social groups for autistic people, to prevent loneliness and provide opportunities to meet others. This includes groups in smaller places as well as large towns and a mix of in person and online groups.
- People said there is a need for support to help autistic people understand themselves. This includes support with managing their own mental health and support for late diagnosed adults.
- People said that peer support would enable autistic people to support each other. A start-up pack could enable autistic people to set up new social and support groups.
- People said that parents, carers and families need more support.
- People said autistic people could benefit from support to identify and set up assistive technology (gadgets and apps that can help people to live independently).

Support for autistic people

- Many people said that a drop-in service available to all autistic people is needed. This would mean people could get occasional support when they need it. Several ideas were suggested for this, such as using hubs in the community, or a bus that travels around.

- People said that guidance about positive relationships is needed. This includes making friends, how to have healthy relationships, and awareness of scams, financial exploitation, and domestic abuse.

- People said that support is needed to manage life changes and transitions. This includes moving home, getting a new job, becoming a parent and bereavement.

- People said that it would be helpful to have one consistent person to go to. And when services are working with people, it is helpful for them to check in regularly with the autistic person.

Social care services

- People said that professionals should take a whole family approach. This includes considering siblings and their needs.

- People said that more respite options are needed to support family carers.

- People said that waiting times for allocation to a social care worker should be reduced.

- People said improvements to communication and the approach taken for an Adult Social Services assessment are needed.

- People said that more flexibility would help families to use Short Breaks funding at times that work for them, and that it can be hard to provide the evidence required to access support.

Housing and independent living

- People said that autistic people need support to develop the skills for independent living. They said that people may appear to function really well in some areas, but still need support in others. This needs to start early, but also be available throughout the life span.

- People said that more information about independent living options is needed.

6 Improve support within the criminal and youth justice system

By 2029, we want autistic people who come into contact with the criminal and youth justice system to get the support that they need. Through early intervention, we want fewer autistic people to become victims of crime or to be convicted of a crime. We also want those who have been convicted of a crime to get the additional support they may need to fully engage with their sentence and rehabilitation.

What we know nationally

Autistic people are over-represented within the criminal justice system as victims, witnesses and defendants. However, they often have poor experiences when they come into contact with the criminal justice system.[41] This can be because of poor understanding of autism among professionals, and challenges with getting the reasonable adjustments they need to support them. [42] There is also evidence that autistic people who are in contact with the criminal justice system often struggle to get the health and social care services they may need.

Research in 2017 found that 9% of a sample of prison inmates were likely to be autistic[43] and it is recognised that neurodivergent young people are also over-represented in the youth justice system.[44]

There is evidence that autistic people are often not provided with reasonable adjustments in police stations or courts, or with an appropriate adult to support them (even when their diagnosis was known to police). When autistic people are involved in a trial, research has found that it is common for barristers, judges and magistrates to say or do something that suggests they do not have an adequate understanding of autism.[45]

[41] AGGPA inquiry
[42] Identification and support of autistic individuals within the UK Criminal Justice System: a practical approach based upon professional consensus with input from lived experience (careknowledge.com)
[43] Neurodevelopmental disorders in prison inmates
[44] Neurodiversity – a whole-child approach for youth justice (justiceinspectorates.gov.uk)
[45] Autistic defendants are being failed by the criminal justice system | University of Cambridge

What we know in Norfolk

Local data confirms that the proportion of autistic people within the criminal justice system is higher than the general population, even though the data only includes those with a diagnosis. 3% of prisoners accessing prison healthcare in the East of England region have a diagnosis of autism. [46]

The three prisons in Norfolk all now have Neurodiversity Support Managers, who provide support for autistic prisoners. Autistic prisoners told us that this support is highly valued.

Norfolk Constabulary has brought in sensory boxes to support autistic people in police stations, and any autistic people in custody should see the Liaison and Diversion Service who help to identify appropriate support. This includes provision of appropriate adults to support autistic people through the process.

Norfolk Youth Justice Service (NYJS) was awarded the Youth Justice Special Educational Needs and Disability Quality Mark in February 2023, for partnerships securing better outcomes for children and young people with SEND in the youth justice system. NYJS in partnership with Norfolk Constabulary and Norfolk Children's Services operates a diversion scheme, which successfully works to divert children away from the formal criminal justice system. The NYJS health team is a multi-disciplinary team of health professionals providing support to children, families and professionals within the service.

People have told us that more needs to be done to improve support in the criminal and youth justice systems. They talked about the importance of early intervention and the need for support in police stations and courts, and in prison. They also told us about the importance of support for autistic people when they are released from prison.

What is important to people

> "More awareness and support for reoffending programmes tailored for autistic people. Ensuring probation staff are trained to stop recall being the first option when someone with autism is struggling and can instead support them better. Norfolk Resident"

> "Some autistic people are coerced into criminal activity due to a variety of factors that is not a deliberate intention or awareness of hurting others, with lack of autism awareness from professionals. Norfolk Resident"

[46] Data shared by NHS England (East of England)

Early intervention

- People said that the right support early on could help to prevent a situation from getting much worse. This includes how the police approach an autistic person, to make sure they ask questions in the right way.

- People said that autistic young people and adults are vulnerable to exploitation and need support to prevent this.

- People said there is a need for support to understand good citizenship and appropriate behaviour.

- People said that those who may be autistic and are subject to Community Sentence Treatment Requirements (CSTRs) need more support, to prevent them from re-offending.

Support in police stations and court

- People said there is a need for advocacy to support autistic people with communication and to help them understand what is happening. This includes the availability of appropriate adults to support autistic people in police stations.

- People said that more needs to be done to make reasonable adjustments for autistic people, particularly in courts.

- People said that autism friendly information about processes in court and police stations is needed.

Support while in prison

- People said that autistic prisoners need more support, including reasonable adjustments to make the environment more appropriate.

- People said that more support is needed for autistic prisoners to develop work skills and get a job on release.

- People said that there should be autism friendly programmes for offenders.

Support on release from prison

- People said that autistic prisoners need support when they leave prison. Autistic prisoners sometimes miss out on probation support due to reaching the end of their sentence through being recalled.

- People said that licence conditions should be clear and unambiguous. They said that autism friendly information in approved premises could help autistic people to understand the rules and what they can and cannot do. This could also include approved premises which are specifically for autistic people.

Making the vision a reality

This strategy should be read alongside the NAPB's strategy plan, which can be found on their website. The year one plan will be developed with partner organisations from July 2024, and will be updated each year from 2025 to 2029.

The plan for each year will set out the key actions that partner organisations will take towards achieving the priorities of this strategy. The NAPB will put in place a working group which will include autistic people to oversee the development of the plan and to monitor it.

By January 2029, the NAPB will start work to refresh this strategy for 2030 onwards.

Glossary

Co-production: this is an equal relationship between people who use services and the people responsible for services. They work together, from the start to the end of a project.

Education Health and Care Plan (EHCP): a plan for a child or young person aged up to 25 who has complex special educational needs and disabilities. It sets out the support they need to achieve their best outcomes.

Easy Read: a way of making written information easier to understand by using simple language and illustrating the information with pictures.

Healthwatch: a statutory agency whose role is to monitor NHS services on behalf of the public and make its finding public.

Independent advocacy: independent advocates support people to speak up for themselves or give their views. They are independent because they do not work for the organisations that they are supporting people to talk to.

Integrated Care System: integrated care systems were set up by the Health and Care Act 2022. The Norfolk and Waveney Integrated Care System is a partnership of local health and social care organisations.

Kitemark scheme: an official scheme which awards a mark of quality and reliability to organisations which meet a required standard.

National Institute for Health and Care Excellence (NICE): this organisation provides evidence based recommendations for the health and social care sector, developed by independent committees.

Norfolk Autism Partnership (NAP): a partnership of autistic people, parents, carers, voluntary and statutory organisations working together to achieve an autism-friendly Norfolk. More information is available on the NAP's website: Home - Norfolk Autism Partnership.

Norfolk Autism Partnership Board (NAPB): the Board which manages the Norfolk Autism Partnership. Members of the Board include autistic people, parents/carers and representatives of voluntary and statutory organisations in Norfolk. The Board meets every two months.

Preparing for Adult Life (PfAL) team: this team is responsible for ensuring young people make a smooth transition into Adult Social Services. They work with young people who are likely to need support from Adult Social Services when they turn 18.

Reasonable adjustments: the Equality Act (2010) requires employers, businesses and service providers to make reasonable adjustments so that their services are accessible to everyone. For example, by being flexible about appointment times, or providing a quiet place to wait.

Special Educational Needs and Disabilities (SEND): usually used in the context of children and young people up to the age of 25 years.

Specialist Resource Base (SRB): these provide children and young people with the extra support they need within a mainstream school. Autism SRBs are specifically for autistic children and young people.

NORFOLK AUTISM PARTNERSHIP

NORFOLK'S ALL AGE AUTISM STRATEGY

JUNE 2024 TO 2029

SUMMARY

NORFOLK AUTISM PARTNERSHIP

A partnership of autistic people, parents, carers, and voluntary and statutory organisations working together to achieve an autism-friendly Norfolk.

Foreword

This is a summary of the refreshed strategy.

It builds on and replaces the Norfolk All Age Autism Strategy for 2019 to 2024, 'My Autism, Our Lives, Our Norfolk'.

This strategy is for autistic people of all ages, their parents, carers and families, those supporting them and anyone who has an interest in autism in Norfolk.

This refreshed strategy builds on 'My Autism, Our Lives, Our Norfolk' which was a five-year strategy from 2019 to 2024.

This strategy reflects the improvements that have happened since 2019, and the changes that autistic people in Norfolk have told us they want to see over the next five years, from 2024 to 2029.

The refreshed strategy also reflects changes in national guidance and policies, so that our local priorities and actions can be as effective as possible. It takes account of other local strategies that may be relevant for autistic people.

700,000 autistic adults and children in the UK
1 in 100 people are autistic

Introduction and vision

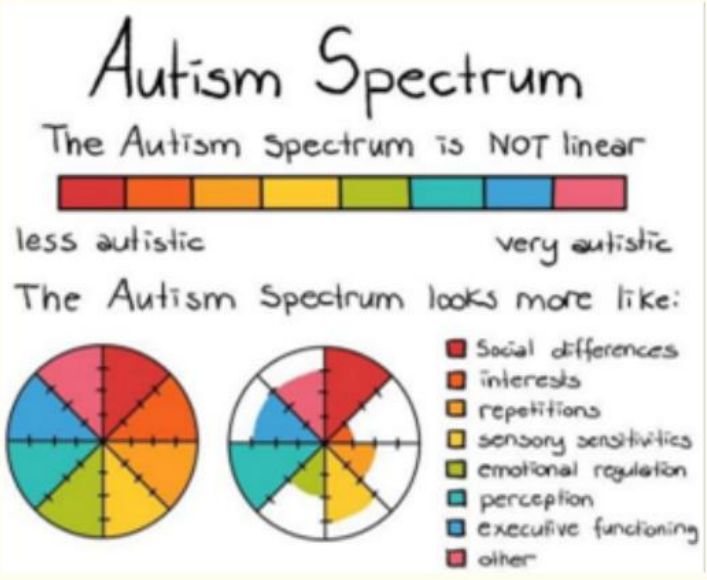
'My Autism, Our Lives, Our Norfolk' and this refreshed strategy set out a vision for the future.

Our Vision

All autistic people, their parents/carers are accepted, understood and treated as equal members of the community.

That there is a greater awareness and understanding of autism by people that live and work in Norfolk.

That this understanding will enable autistic people to have the same opportunities as everyone else to live a fulfilling and rewarding life and achieve their life's ambitions.



This strategy uses the term 'autistic people'. Autistic members of the NAPB said that they prefer 'identity first' language ('autistic people' rather than 'people with autism'). Identity first language reflects the view of many autistic people that their autism is part of who they are, not something separate.

Autism is a lifelong developmental difference that affects how people communicate and how they experience the world around them

The priorities

These are the areas the Norfolk Autism Partnership will work on to achieve the vision.

This summary includes the key themes that people said are important to them, for each of these priorities.

1. Improve understanding and inclusion of autism
2. Improve access to education and support transitions into adulthood
3. Support adults into employment
4. Tackle health inequalities for autistic people
5. Build the right support in the community
6. Improve support within the criminal and youth justice system

To find out more information you can read the full version of the strategy.

This says more about what is happening nationally and locally, and what people said is important.

1 Improve understanding and inclusion of autism

21% of Norfolk autistic people felt more included in their communities compared to 2019

24% of autistic adults in the UK think public understanding has improved

By 2029, we want Norfolk to be a much more autism-inclusive county, where Norfolk's autistic population are included in society, feel safe and welcome.

We want to improve understanding of autism within the general public, and among those providing support and services to autistic people.

> Awareness seems to have increased, but I don't feel like it has translated to real inclusion.
>
> Norfolk Resident

> I note there is in general, a shift (for the better) in people's awareness and understanding of the needs of autistic people and there are more considerations in services (i.e. supermarkets, cinemas, etc) of how to adjust to meet the needs of autistic people.
>
> Norfolk Resident

People said these themes are important to them:

Better understanding of autism within society

Better understanding of autism within public services

A Norfolk autism directory of support

Autistic people fully involved in planning, delivery and monitoring of the strategy

Independent advocacy available

A quiet space available within communities and hospitals

2 Improve access to education and support transitions into adulthood

2 new autism schools and 13 autism specialist resource bases

More specialist resource base provision needs to be developed

By 2029, we want autistic children and young people to get the right support so that they can flourish in education.

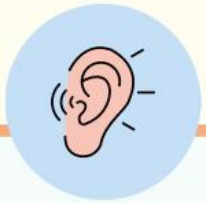
We want transitions into adulthood to improve so that young people can live well in their communities, find work or continue in education.

> My son has no idea how to move forward after college and is very stressed about what the future may bring.
>
> Norfolk Resident

> Better planning for this transition period, thinking about aspirations, developing independence skills and access to mental health support/ support with creating and maintaining healthy relationships.
>
> Norfolk Resident

People said these themes are important to them:

Support in schools, colleges and other education settings



Listening to parents, children and young people

Support for home educating families and young people who are not in school

More support for transition to adulthood

3 Support adults into employment

3 in 10

autistic people of working age are employed nationally

10,000

autistic people of working age living in Norfolk are estimated to not be in employment

By 2029, we want more autistic adults to be in employment.

We want autistic people's experience of being in work to have improved, and for employers to be more confident about hiring and supporting autistic workers.

> Many autistic people find themselves stuck in volunteering or unhealthy work environments. I think a priority needs to be to support us to find paid, sustainable employment...
>
> Norfolk Resident

> ... support for adults when they are already in employment...
>
> Norfolk Resident

People said these themes are important to them:

Support to get a job

Support to keep a job

Support for employers

Routes into employment and education for adults

4 Tackle health inequalities for autistic people

954

adults are waiting for an autism assessment in Norfolk

9290

children and young people are waiting for a neurodevelopmental assessment in Norfolk and Waveney

By 2029, we want autistic people to be able to access the health support they need to live healthier lives.

We want to see improved health outcomes and a reduction in the gap in life expectancy that currently exists for autistic people.

> ASD affects the whole experience of healthcare, and the long wait times and difficulty getting diagnosed is a significant barrier to accessing the correct healthcare and resources.
>
> Norfolk Resident

> People are waiting too long for a diagnosis that can put people off a diagnosis when it is needed.
>
> Norfolk Resident

People said these themes are important to them:

Reduce the waiting time for a diagnosis, and provide more information and support

Better access to health services, through annual health checks, health passports and specialist services

Better access to mental health services and support to prevent people going into crisis

5 Build the right support in the community

By 2029, we want autistic people to be able to live well in their communities.

We want improvements in support to mean that fewer autistic people reach crisis point.

When autistic people spend time in hospital, we want them to be able to return home or move to suitable accommodation with the right support as soon as they are ready.

> Life at home, relationships - support for neurodiverse spectrum couples and help to have a healthy relationship and family life.
>
> Norfolk Resident

> More support directed towards autistic adults. Not everyone will seek out the support.
>
> Norfolk Resident

People said these themes are important to them:

Early intervention such as more autism social groups, support to understand yourself and peer support

Support for autistic people such as a drop-in service and autism friendly guidance and advice

Improve social care support for autistic people

Support to develop independent living skills and information about housing options

6 Improve support within the criminal and youth justice system

By 2029, we want autistic people who come into contact with the criminal and youth justice system to get the support that they need.

Through early intervention, we want fewer autistic people to become victims of crime or to be convicted of a crime.

We want those who have been convicted of a crime to get the support they need to fully engage with their sentence and rehabilitation.

> More awareness and support for reoffending programmes tailored for autistic people. Ensuring probation staff are trained to stop recall being the first option when someone with autism is struggling and can instead support them better.
>
> Norfolk Resident

> Some autistic people are coerced into criminal activity due to a variety of factors that is not a deliberate intention or awareness of hurting others, with lack of autism awareness from professionals.
>
> Norfolk Resident

People said these themes are important to them:

Early intervention and support to prevent situations from getting worse

Support in police stations and courts

Support while in prison

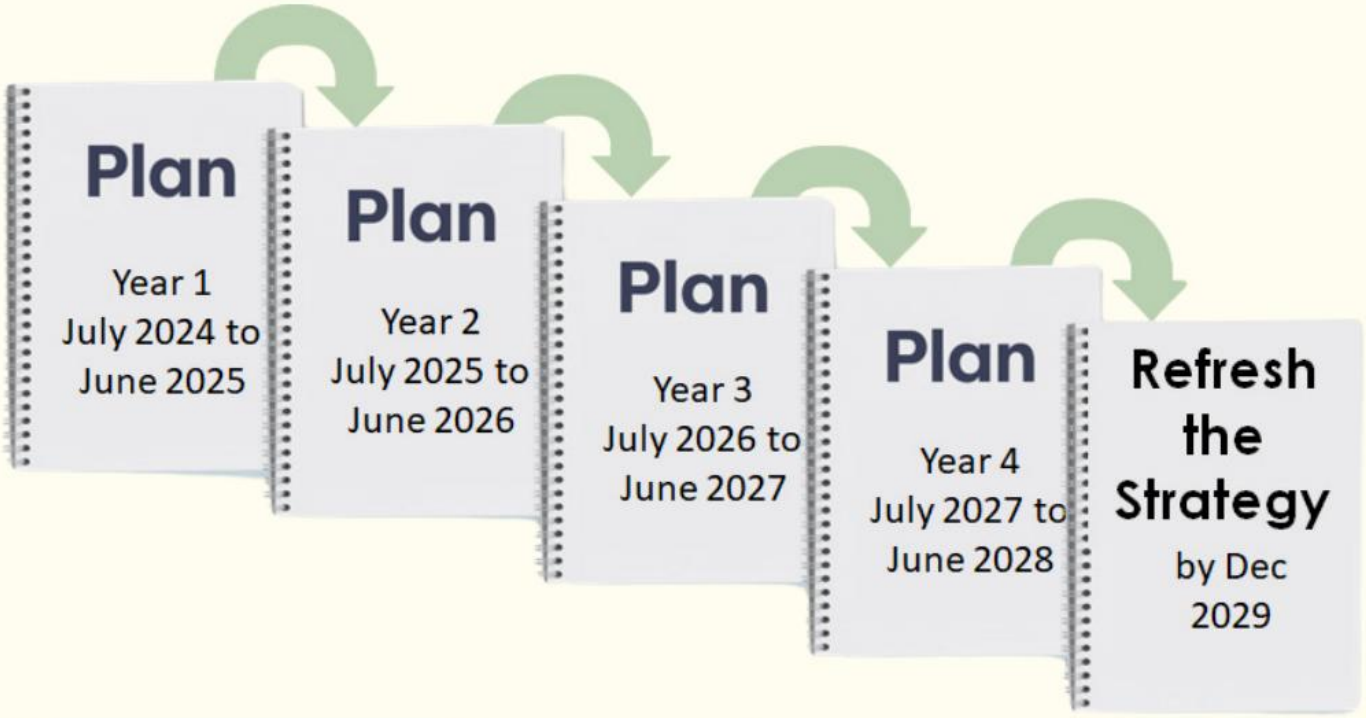
Support on release from prison

Putting the strategy into action

The plan sets out the key actions that we will take towards achieving the priorities of the strategy.

A new plan will be agreed each year.

The NAPB will monitor the plan and whether partner organisations are doing what they have said they will do.



To find out how this strategy will be put into practice, you can read the plan.

> **Will there be visibility on how funding is spent?**
>
> **Norfolk Resident**

> **Who will monitor how and when the strategy is implemented?**
>
> **Norfolk Resident**

How we refreshed the strategy

This strategy is co-produced by the Norfolk Autism Partnership Board (NAPB), which includes people with lived experience of autism of all ages, including parents/carers.

July to Dec 2023
Set up an Autism Strategy Group made up of autistic people to oversee the refresh of the strategy

Oct to Nov 2023
Documents, questionnaire and workbook available through the Norfolk Autism Partnership website

July to Sept 2023
Autism Strategy Group designed and tested

- a document, animation and easy reads to share what the strategy achieved over the last 5 years and what partners plan to do over the next 5 years
- an online questionnaire and workbook, to find out what is important to people
- a webpage to share the communications
- a plan of how to encourage people to take part

Being part of the Autism Strategy Reference Group enabled me to feel part of a caring community dedicated to making positive change for autistic people in Norfolk.

Autism Strategy Group Member

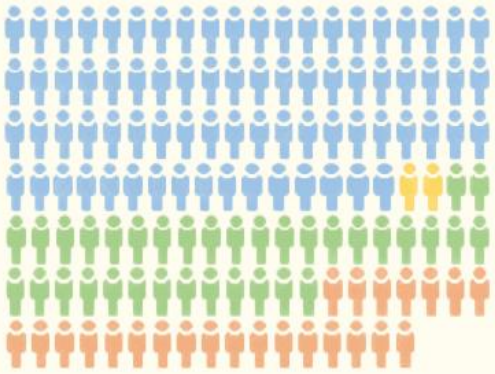
Mar to Apr 2024
Autism Strategy Group analysed the feedback to agree the Norfolk All Age Autism Strategy's key priorities and wrote the strategy and plan

Jan to Feb 2024
Autism Strategy Group arranged activities to share and understand better what people said is important and check if anything is missing

May to June 2024
Shared the strategy with Board members and partners

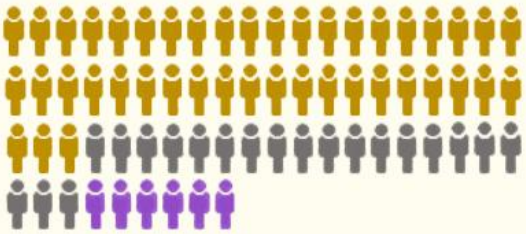
Who was involved?

574 individual comments were recorded and analysed from those people who completed the questionnaire in October 2024, and those who took part in online and face to face sessions held in January and February 2024.



The questionnaire was completed by 137 people:

- **76 autistic adults (blue)**
- **2 autistic young people - aged under 18 (yellow)**
- **35 parents/carers or family members (green)**
- **24 professionals/other respondents (orange)**



69 people took part in individual and group sessions:

- **43 people through an online session (gold)**
- **20 people through a library session (grey)**
- **6 people in a workshop for autistic prisoners at Norwich Prison (purple)**

Acknowledgements

Acknowledgement and special thanks to the following:

- **The Autism Strategy Reference Group members for their hard work to develop this strategy and their creativity and innovative thinking.**

- **All members of the NAPB, past and present, who give their time, skills and experience. Their valuable contribution to improving services and support for autistic people of all ages is acknowledged.**

- **Those who completed the autism strategy questionnaire or attended a group or forum to refresh the strategy. All those who took part have had a major impact on this strategy by sharing their experiences and ideas.**

NORFOLK AUTISM PARTNERSHIP

NORFOLK'S ALL AGE AUTISM STRATEGY

SUMMARY DOCUMENT

JUNE 2024 TO 2029

A partnership of autistic people, parents, carers, voluntary and statutory organisations working together to achieve an autism-friendly Norfolk.

Norfolk and Waveney Integrated Care Partnership

Item No: 7

Report title: Amendments to the Integrated Care Partnership Terms of Reference

Date of meeting: 12 June 2024

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

Reason for the Report

There have been changes to the membership of the Integrated Care Partnership (ICP), so it has become necessary to make amendments to the Terms of Reference (ToRs).

Report summary

The ICP came into being under the Health and Care Act 2022 on 1 July 2022. ToRs were produced as part of the Governance arrangements for the ICP and to align with the Governance for the Health and Wellbeing Board due to the meetings being held consecutively with the same membership represented at both meetings. There have been recent changes to the membership of the ICP with the inclusion of the University of East Anglia representative with voting rights and the Chair of the Health Overview and Scrutiny committee with non-voting rights, so it has become necessary to make amendments to add the new members to the list contained within the ICP ToRs. It is also good Governance to review the ToRs yearly and the ToRs have been reviewed with an amendment to Section 12 to include the reference to Steering Groups to enable future system work to be taken forward together.

Recommendations

The ICP is asked to:

a) Agree to the revised version of the Integrated Care Partnership Terms of Reference.

1. Background

1.1 The ToRs for the ICP were agreed at the meeting on 21 July 2022 and since then our Integrated Care system has been taking shape across Norfolk and Waveney. It is good practice to review the Governance and Membership of the ICP yearly and there have been recent changes which have prompted the need to revise the ToRs.

2. Revised Terms of Reference

2.1 The revised Terms of Reference for the ICP are attached at **Appendix A.**

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

Name: Debbie Bartlett Tel:01603 303390 Email: debbie.bartlett@norfolk.gov.uk

Norfolk and Waveney Integrated Care Partnership (ICP)

Terms of Reference and Procedure Rules

1. Context and Role of the Integrated Care Partnership

The role of the Integrated Care Partnership (ICP) in Norfolk and Waveney is to promote the close collaboration of the health and care system, building on the existing Norfolk Health and Wellbeing Board and other partnerships with the expanded geography that includes Waveney, to ensure better health and care outcomes for all our residents.

It provides a forum for stakeholders to come together as equal partners to discuss and resolve crosscutting issues. The ICP is a statutory committee of both the Integrated Care Board and Norfolk and Suffolk County Council's under the Health and Care Act 2022, it plays a central role in the planning and improvement of health and care in Norfolk and Waveney and will support place-based partnerships**.**

It drives and enhances integrated approaches and collaborative behaviours at every level and promotes an ethos of working in partnership with people and communities, and between organisations to address challenges that the health and care system cannot address alone.

Together, the ICP will generate an Integrated Care Strategy to improve health and care outcomes and experiences for our residents, for which all partners will be accountable.

2. Principles

The Norfolk and Waveney ICP will operate under these guiding principles:

1. Partnership of equals – to find consensus and make decisions including working though difficult issues, where appropriate.
2. Collective model of accountability – partners hold each other mutually accountable for shared and individual organisational contributions to objectives.
3. Improving outcomes for communities – including improving health and wellbeing, supporting people to live more independent lives, reducing health inequalities, and tackling the underlying social determinants.
4. Collaboration and integration – a culture of broad collaborations and integration at every level of the system to improve outcomes and reduce duplication and inefficiency.
5. Co-production and inclusivity – create a learning system which makes decisions based on evidence and insight.

3. Membership

The Membership of the ICP mirrors the existing Norfolk Health and Wellbeing Board, with additional membership to consider Waveney and place partnerships. Whilst it is important for the ICP to engage with a wide range of stakeholders and understand the differing viewpoints across the system and communities, membership will be kept to a productive level.

The membership for the Norfolk and Waveney ICP is attached at appendix A.

4. Appointment of Chair

The Chair of the ICP will be selected from among the members of the ICP and agreed jointly by the ICB, and Norfolk and Suffolk Local Authorities.

This appointment process will take place at the start of the meeting with an officer informing members of the need to elect a chair. Nominations will then be called and then seconded. If more than one nomination is received this will be dealt with by way of a majority vote of those present. If

only one nomination is forthcoming the officer will then ask for any objections. If objections are received, a vote will take place which will be carried by a majority vote by those present. Once this process takes place and the nomination is passed, the Chair then commences the meeting. If the nomination is rejected, the whole process will commence again until agreement by majority of those present is reached.

The Chair will be appointed at the first meeting of the ICP and annually at a meeting of the ICP thereafter.

The Chair will be expected to:

- be able to build and foster strong relationships in the system
- have a collaborative leadership style
- be committed to innovation and transformation
- have expertise in delivery of health and care outcomes
- be able to influence and drive delivery and change

The ICP will appoint three Vice Chairs drawn from its membership. These will also be appointed at the first meeting of the ICP and annually thereafter.

5. Duties and Responsibilities

The ICP is a core part of the Norfolk and Waveney Integrated Care System, driving their direction and priorities.

The ICP will be rooted in the needs of people, communities, and places.

The ICP will help to develop and oversee population health strategies to improve health outcomes and experiences.

The ICP will support integrated approaches and subsidiarity.

The ICP will take an open and inclusive approach to strategy development and leadership, involving communities and partners to utilise local data and insights.

The ICP will work to embed safeguarding as everyday business across the Norfolk and Waveney Integrated Care System.

The ICP will develop an Integrated Care Strategy which the ICB, Norfolk and Suffolk County Council’s will be required by law to have regard to when making decisions, commissioning, and delivering services.

The ICP is expected to highlight where coordination is needed on health and care issues and challenge partners to deliver the action required. These include, but are not limited to, helping people live more independent, healthier lives and safer lives for longer, free from abuse and harm, taking a holistic view of people’s interactions with services across the system and the different pathways within it, addressing inequalities in health and wellbeing outcomes; experiences and access to health services; improving the wider social determinants that drive these inequalities, including employment, housing, education environment, safeguarding, and reducing offending; improving the life chances and health outcomes of babies, children and young people, and improving people’s overall wellbeing and preventing ill-health.

The ICP will provide a forum for agreeing collective objectives, enable place-based partnerships and delivery to thrive alongside opportunities for connected scaled activity to address population health challenges.

The ICP will set the strategic directions and workplans for organisational, financial, clinical, and informational integration, as well as other types.

6. Authority, Accountability, Reporting and Voting Arrangements

The ICP is tasked with developing a strategy to address the Health, Social Care and Public Health needs of their system, and of being a forum to support partnership working. The ICB and Local Authorities will have regard to ICP Strategies when making decisions. The ICP has no executive powers, other than those specifically delegated in these terms of reference. Individual members will be able to act with the level of authority and the powers granted to them by way of their constituent bodies' policies and make decisions on that basis. The ICP is able to discuss and agree recommendations for approval by the constituent members' statutory bodies. Its role is primarily one of oversight and collective co-ordination.

The aim will be for decisions of the ICP to be achieved by consensus decision making. Voting will not be used, except as a tool to measure support, or otherwise, for a proposal. In such a case, a vote in favour would be non-binding. The Chair will work to establish unanimity as the basis for all decisions.

Meetings of the ICP will be open to the public unless the matter falls within one of the categories of information, outlined in Appendix B. In this instance, the ICP may determine public participation will be withdrawn for that item.

Meetings will be live streamed and recorded, to be made available to the public afterwards.

Minutes of the meeting will be taken and approved at the next meeting of the ICP.

Final minutes will be made available on the websites of the ICB, Norfolk and Suffolk County Councils.

7. Attendance

Members are expected to attend 75% of meetings held each year. It is expected that members will prioritise these meetings.

Where it is not possible for a member to attend, they may nominate a named deputy to attend meetings in their absence and must notify the Secretariat, at norfolkandwaveneyicp@norfolk.gov.uk, who that person will be.

Members and those presenting must attend meetings in person.

The quorum, as described at section 8, must be adhered to for all meetings, including urgent meetings.

Attendance will be recorded within the minutes of each meeting and monitored annually.

8. Quorum

A quorum will be reached when at least the Chair and four members from different partnership organisations are present.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no recommendations for decision by the constituent member bodies may be taken.

In the unlikely event that a member has been disqualified from participating in the discussion of an item on the agenda, for example by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

Nominated deputies attending a meeting on behalf of a member may count towards the quorum.

9. Notice and Frequency of Meeting

Generally, meetings will be held four times a year but more frequently if required for specific matters.

As a matter of routine, an annual schedule of meetings will be prepared and distributed to all members. In other specific instances, or in cases where the date or time of a meeting needs to be changed, notice shall be sent electronically to members at least five working days before the meeting. Exceptions to this would be in the case of emergencies or the need to conduct urgent business.

An agenda and any supporting papers specifying the business proposed to be transacted shall be delivered to each member and made available to the public five working days before the meeting, potential exception being in the case of emergencies or the need to conduct urgent business. Supporting papers, shall accompany the agenda.

Secretariat support to the ICP will be provided by Norfolk County Council.

10. Public Questions

The public are entitled to ask questions at meetings of the ICP and questions should be put in writing and sent by email at least three working days before the meeting. If the question relates to urgent matters, and it has the consent of the Chair to whom the question is to be put, this should be sent by 4pm on the day before the meeting.

Questions should be sent to the Chair, at norfolkandwaveneyicp@norfolk.gov.uk, and will be answered as appropriate, either at the meeting or in writing.

The Chair on behalf of the ICP may reject a question if it:

a) is not about a matter for which the ICP has collective responsibility or particularly affects the ICP; or

b) is defamatory, frivolous, or offensive or has been the subject of a similar question in the last six months or the same as one already submitted under this provision.

Who may ask a question and about what

A person resident in Norfolk and Waveney, or who is a non-domestic ratepayer in Norfolk and Waveney, or who pays Council Tax in Norfolk and Waveney, may ask at a public meeting of the ICP through the Chair any question within the terms of reference of the ICP about a matter for which the ICP has collective responsibility or particularly affects the ICP. This does not include questions for individual ICP members where responsibility for the matter sits with the individual organisation.

Rules about questions:

Number of questions – At any public ICP meeting, the number of questions which can be asked will be limited to one question per person plus a supplementary. No more than one question plus a supplementary may be asked on behalf of any one organisation. No person shall be entitled to ask in total under this provision more than one question, and a supplementary, to the ICP in any six-month period.

Other restrictions – Questions are subject to a maximum word limit of 110 words. Questions that are in excess of 110 words will be disqualified. The total time for public questions will be limited to 15 minutes. Questions will be put in the order in which they are received.

Supplementary questions – One supplementary question may be asked without notice and should be brief (fewer than 75 words and take less than 20 seconds to put). It should relate directly to the original question or the reply. The Chair may reject any supplementary question which s/he does not consider compliant with this requirement.

Rules about responses:

The Chair shall exercise his/her discretion as to the response given to the question and any supplementary.

Not attending – If the person asking the question indicates they will not be attending the ICP meeting, a written response will be sent to the questioner.

Attending – If the person asking the question has indicated they will attend, response to the questions will be made available at the start of the meeting and copies of the questions and answers will be available to all in attendance. The responses to questions will not be read out at the meeting.

Supplementary questions – The Chair may give an oral response to a supplementary question or may require another Member of the ICP or Officer in attendance to answer it. If an oral answer cannot be conveniently given, a written response will be sent to the questioner within seven working days of the meeting.

Written response – If the person who has given notice of the question is not present at the meeting, or if any questions remain unanswered within the 15 minutes allowed for questions, a written response will be sent within seven working days of the meeting.

Rejection of a question

A question may be rejected if it:

a) is not about a matter for which the ICP has collective responsibility or particularly affects the ICP; or
b) is defamatory, frivolous, or offensive or has been the subject of a similar question in the last six months or the same as one already submitted under this provision; or
c) requires the disclosure of confidential or exempt information, as defined in the Access to Information Procedure Rules.

11. Managing Conflicts of Interest

A conflict of interest may be defined as “a set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold”.

The ICP specifically recognises and acknowledges that its members have legal responsibilities to the organisations which they represent and that this may give rise to conflicts of interest being present. However, discussions at the meetings are to be focussed on the needs of the Norfolk and Waveney population and health and care. Therefore, members will not be excluded from engaging in discussions that will benefit the system as a whole.

Members of the ICP shall adopt the following approach for managing any actual or potential material conflicts of interest:

- To operate in line with their organisational governance framework for managing conflicts of interest/probity and decision making.
- For the Chair to take overall responsibility for managing conflicts of interest within meetings as they arise.
- To work in line with the ICS system objectives, principles, and behaviours.
- Members are to ensure they advise of instances where the register of members interest for the Norfolk and Waveney system requires updating in relation to any interests that they have.

In advance of every ICP meeting consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This action will be led by the Chair with support from their governance advisor.

At the beginning of each meeting of the ICP, members and attendees will be required to declare any interests that relate specifically to a particular item under consideration. If the existence of an interest becomes apparent during a meeting, this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting.

Elected members will be bound by their own codes of conduct and provisions for declaration of interests.

12. Steering and Working groups

To assist with performing its role and responsibilities, the ICP is authorised to establish steering or working groups and to determine the membership, role, and remit for each steering or working group. Any steering or working group established by the ICP will report directly to it.

13. Other Boards

As a key part of the health and care system the ICP will seek active engagement and collaboration with the Norfolk and Waveney ICB, Norfolk and Suffolk Health and Wellbeing Boards, Place Boards, Health and Wellbeing Partnerships, Safeguarding Adults Boards, Safeguarding Childrens Partnerships, County Community Safety Partnerships, Autism Partnership Boards, and the Learning Disabilities Partnership Boards.

14. Review

The ICP will review these terms of reference at least annually or more regularly if needed, considering policy changes in respect of the Integrated Care System.

Appendix A

Membership of the Integrated Care Partnership

1. Borough Council of King's Lynn & West Norfolk
2. Breckland District Council
3. Broadland District Council
4. Cambridgeshire Community Services NHS Trust
5. Chair of the Voluntary Sector Assembly
6. East Coast Community Healthcare CIC
7. East of England Ambulance Trust
8. East Suffolk Council
9. Great Yarmouth Borough Council
10. Healthwatch
11. James Paget University Hospital NHS Trust
12. Norfolk Care Association
13. Norfolk Community Health & Care NHS Trust
14. Norfolk Constabulary
15. Norfolk County Council, Cabinet member for Adult Social Care
16. Norfolk County Council, Cabinet Member for Public Health and Wellbeing
17. Norfolk County Council, Cabinet member for Childrens Services and Education
18. Norfolk County Council, Director of Public Health
19. Norfolk County Council, Executive Director Adult Social Services
20. Norfolk County Council, Executive Director Children’s Services
21. Norfolk County Council, Chief Executive Officer (nominee)
22. Norfolk & Norwich University Hospital NHS Trust
23. Norfolk & Suffolk NHS Foundation Trust
24. Norfolk & Waveney ICB, Chair
25. Norfolk & Waveney ICB, Chief Executive Officer
26. North Norfolk District Council
27. Norwich City Council
28. Police and Crime Commissioner
29. Place Board Chairs for each Place Board area
30. Primary Care representatives (1)
31. Primary Care representatives (2)
32. Primary Care representatives (3)

33. Primary Care representatives (4)
34. Primary Care representatives (5)
35. Queen Elizabeth Hospital NHS Trust
36. South Norfolk District Council
37. Suffolk County Council, Cabinet Member for Adult Care
38. Suffolk County Council, officer representative
39. Voluntary sector representatives (1)
40. Voluntary sector representatives (2)
41. University of East Anglia representative
42. Chair of Health Overview and Scrutiny committee (non-voting rights)

Appendix B

Categories of Information

Information relating to any individual.

Information which is likely to reveal the identity of an individual.

Information relating to financial or business affairs of any particular person (including the authority holding that information).

Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour relations matter arising.

Information relating to any action taken or to be taken in connection with the prevention, investigation, or prosecution of crime.

Norfolk and Waveney Integrated Care Partnership

Item No: 8

Report title: Health Inequalities Strategic Framework for Action

Date of meeting: 12 June 2024

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

Reason for the Report
To present the final Norfolk and Waveney ICS Health Inequalities Framework for Action for agreement, provide a progress update and agree a governance approach to provide overall oversight to implement the Framework.

Report summary
This report sets out recommendations for 'how we organise ourselves' to best deliver the now published Health Inequalities Framework for Action (Appendix A), in line with the identified Guiding Principles. These recommendations include:

- The overall Framework and initial 10 actions are to be overseen by a Strategic Steering Group which is created as a working group reporting to the ICP, that is supported by a partnership Coordination Group who will develop and provide the tools to the system to support implementation.
- The Health Inequalities Oversight Group (HIOG), which is led by the ICB, to lead the Healthcare Inequalities action plan development, alongside the five Place Boards.
- The Health Improvement Transformation Group (HITG), which is led by NCC Public Health, to lead the Lifestyle Factors action plan development, alongside the eight Health and Wellbeing Partnerships.
- A new leadership group to be established by the ICP to lead the Living and Working Conditions action plan development.

Recommendations
The ICP is asked to:

a) Partners agree and endorse the Norfolk and Waveney ICS Health Inequalities Strategic Framework for Action, including the first 10 actions for the first year and agree to take this through their own organisations governance arrangements to reflect this in their own strategies.
b) Commit their respective organisations to supporting implementation.
c) Agree to the establishment of the Strategic Steering Group as a working group of the ICP and support the proposed governance arrangements for overall Integrated Care System oversight and coordination.
d) All partners, including VCSE partners, lead the development of the Living and Working Conditions Group and provide an update on progress at Septembers 2024 ICP meeting.

1. Background

1.1 In March 2024 the ICP endorsed a draft ICS Health Inequalities Strategic Framework for Action (Framework) and committed to supporting its implementation. This Framework has been published and is outlined as an objective in the Joint Forward Plan.

1.2 The Framework 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.

1.3 The Framework development was led by Norfolk and Waveney Integrated Care Board and Norfolk County Council Public Health, and its production was coordinated by a small multi-agency 'Taskforce' to facilitate a whole-system approach.

1.4 System leaders have reflected on the approach undertaken to date and acknowledge the benefits of integrated, multi-agency working to develop the Framework. There is appetite to build on this experience and the success of a distributed leadership approach as we move into implementation, developing our ways of working to further support continued collaboration.

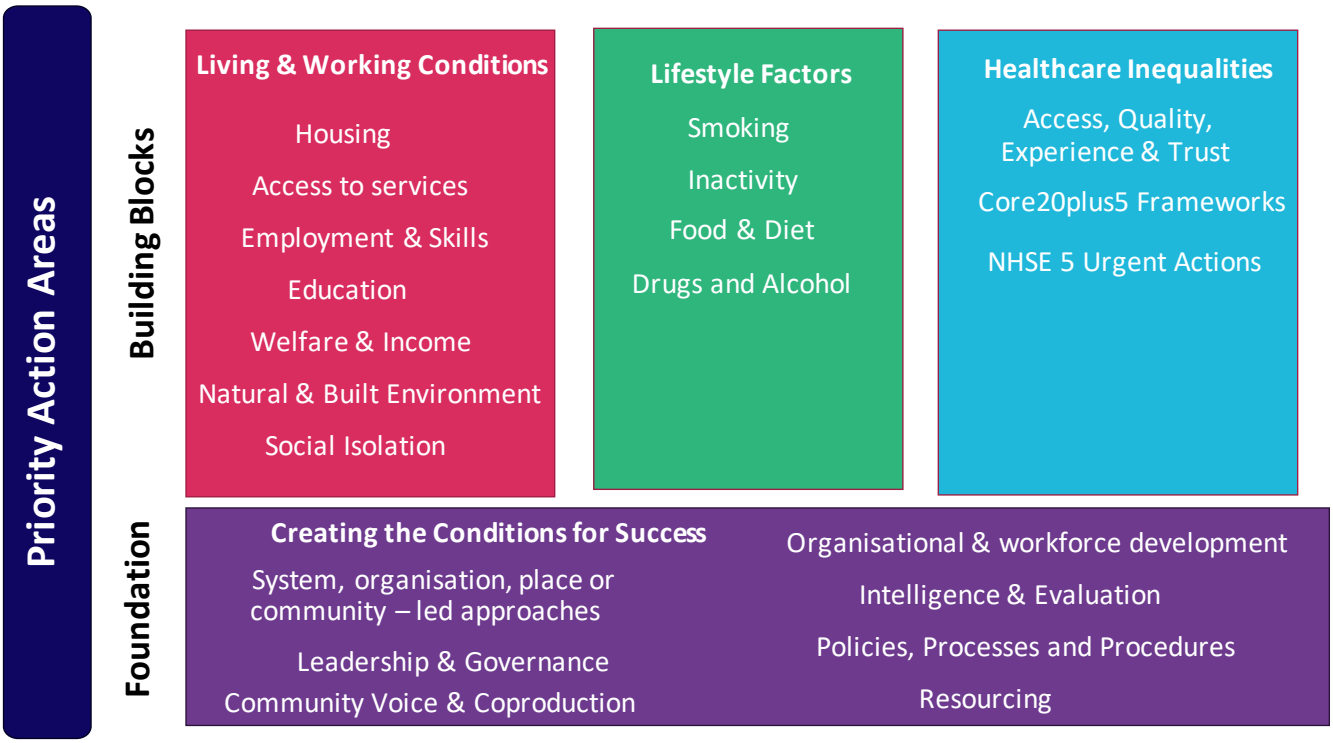
2. Norfolk and Waveney ICS Health Inequalities Framework for Action

2.1 Following feedback from the draft, the Framework has now been finalised and published and you can view the Health Inequalities Framework for Action in detail on improvinglivesnw.org.

2.2 The Framework contains 10 clear actions for the first 12 months of implementation, which focus on how we 'Create the Conditions for Success'.

2.3 Our initial focus has been on how we 'organise ourselves' as a system to best implement this ambitious framework, taking into consideration our place-based governance arrangements, as well as the strengths, strategic levers, and spheres of influence all of ICS partners.

2.4 We have 3 'building blocks' outlined in the Framework as outlined below:



2.5 It is recommended that we establish **leadership groups** for each of our building blocks for action, to be led by different parts of our Integrated Care System and enable a distributed leadership approach in line with our Guiding Principles.

2.6 **Healthcare Inequalities** is to be led by the Integrated Care Board via the Healthcare Inequalities Oversight Group (HIOG). This is an already established group with cross-

system representation and is overseen by Exec SRO Mark Burgis, Executive Director of Patients & Communities, NWICB. This group will work predominantly alongside the five Place Boards to improve access, outcomes, experience and trust relating to healthcare inequalities and drive implementation of the Core20plus5 frameworks. Go to NHS England to learn more about The Core20plus5 frameworks.

2.7 **Lifestyle Factors** is to be led by Norfolk County Council Public Health via the Health Improvement Transformation Group (HITG). This is an already established group that focuses on primary prevention and is overseen by the SRO for prevention, Stuart Lines, Director of Public Health, Norfolk County Council. Suffolk County Council are an active member of the group to ensure system-wide coverage. This group will work predominantly alongside the eight Health & Wellbeing Partnerships to support health improvement, with a focus on reducing inequalities.

2.8 Terms of Reference for the Health Improvement Transformation Group and Healthcare Inequalities Oversight Group are currently under review and will be brought to the September 2024 meeting for review and agreement.

2.9 **Living and Working Conditions** is a new group which is yet to be established, which will focus on the wider determinants of health working alongside the Health and Wellbeing Partnerships. An SRO needs to be identified for this group, in line with the actions in the framework and Terms of Reference established.

2.10 The ICP is asked to lead the development of the Living and Working Conditions Group (LWCG) and to bring a proposed Terms of Reference to the September 2024 meeting for review and agreement. The Strategic Steering Group to lead on this work.

2.11 Further to the development of the leadership groups to drive action around the building blocks, it is recommended that an overall Strategic Steering Group be established as a working group of the ICP, to enable continued distributed leadership and alignment of the three working groups.

2.12 The initial Taskforce has scoped out several leadership options as outlined below:

Option 1	Option 2	Option 3	Option 4
One organisation mandated to lead on behalf of ICS.	One ‘taskforce’ or ‘coordination group’ to drive implementation on behalf of ICS.	Strategic Steering Group to be established, supported by Coordination Group.	No overall oversight of implementation, actions to be delivered via 3 leadership groups.

2.13 The recommended option is **Option 3** which sees a Strategic Steering Group initiated to oversee implementation of the Framework.

2.14 The Strategic Steering Group would provide overall leadership for the implementation of the first 10 actions identified in the Framework, proving assurance to the ICP and enabling clear accountability.

2.15 The Strategic Steering Group would consist of the identified SRO’s, Chairs and Vice-Chairs of HIOG, HITG and LWCG. Any gaps in system representation would be considered and filled, to ensure the Steering Group is representative of our ICS.

2.16 The Steering Group would be supported by a Coordination group, an ‘action orientated’ group made up of those with dedicated capacity and responsibility for health inequalities, such as the ICB Head of Health Inequalities and Public Health inequalities policy leads.

2.17 The Coordination Group would have responsibility for developing and providing tools to leadership groups and place-based structures to enable implementation of the first 10 actions.

2.18 For example, the development of the communications and Pledge resources, development of the suite of tools to support implementation, an overall Outcomes Framework and the self-assessment processes.

2.19 It is recommended that the Steering Group and Coordination Group approach are piloted for the first 12 months of implementation and reviewed in June 2024.

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

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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

A clinical view

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. 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 recognising our key issues and 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. cost of living, housing quality, community life, discrimination

Inequalities between who?

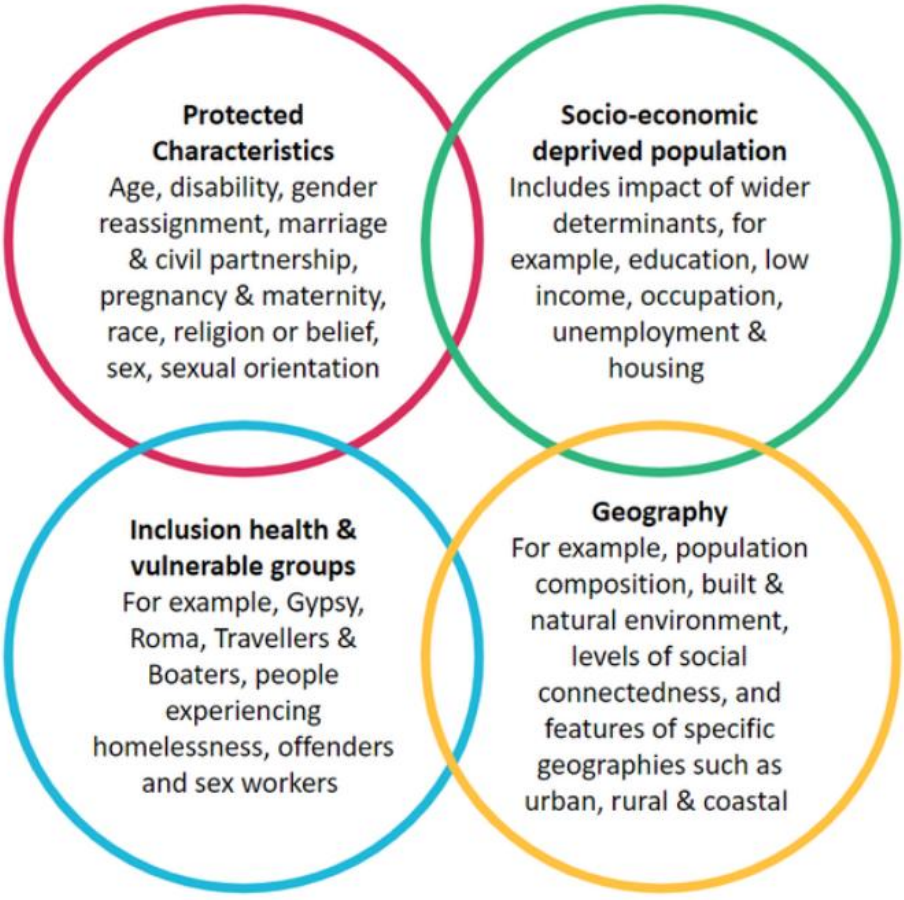


Figure 1:

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 make up our health and decisions on our health, as well as those things we can't influence on our own.

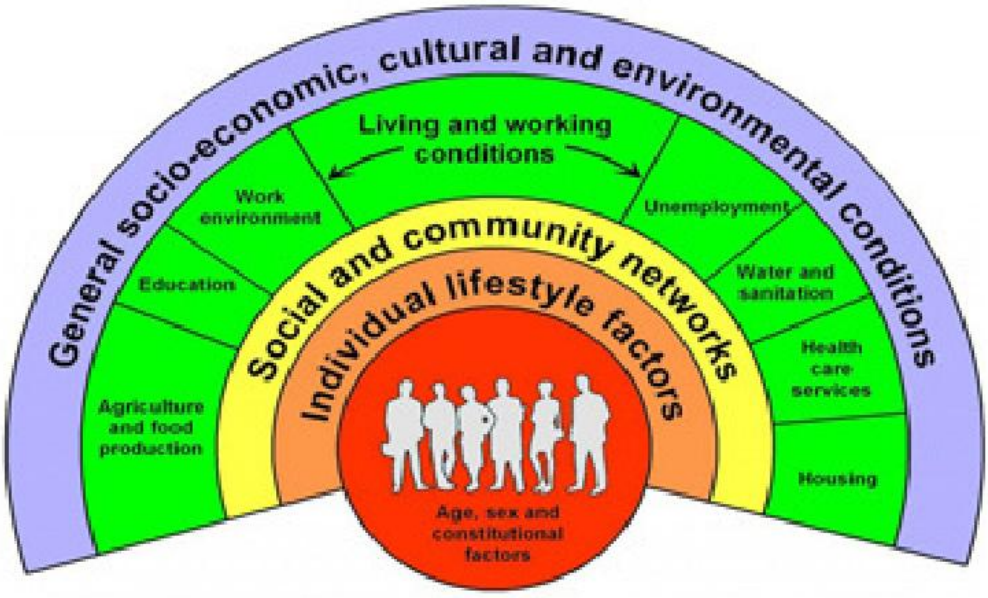


Figure 2: Dahlgren and Whitehead (1991)

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, tackling racism, 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 are 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.

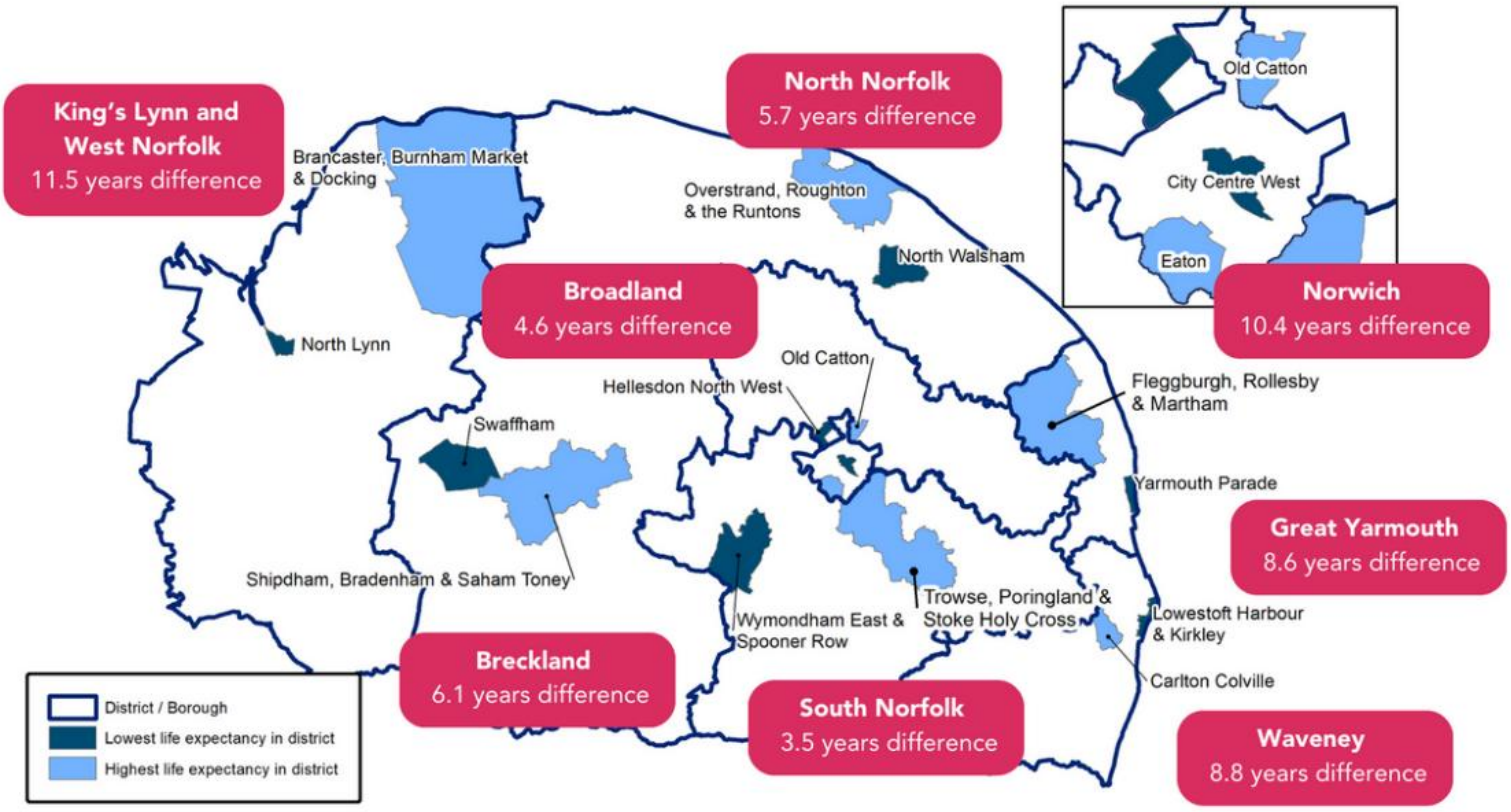


Figure 3:

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.

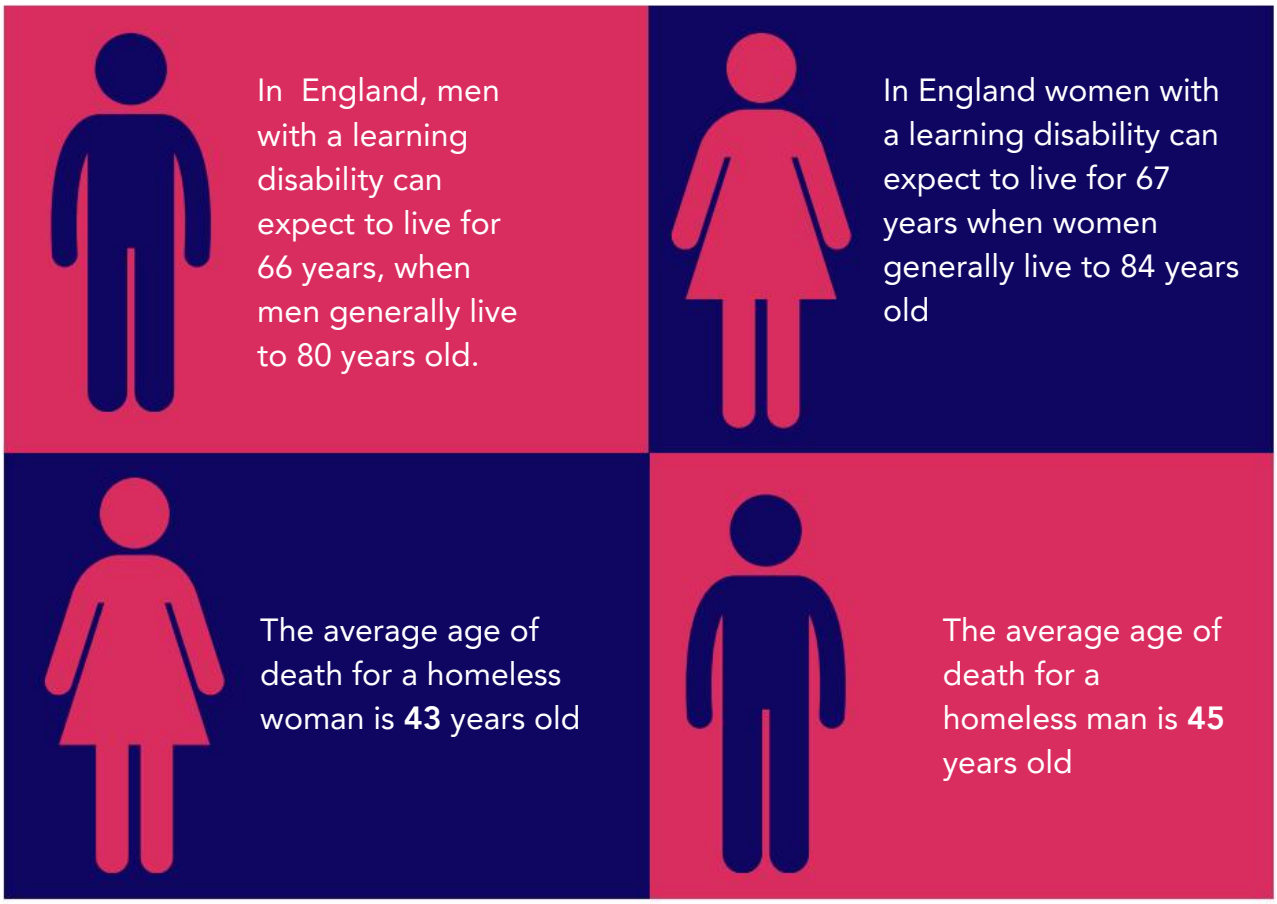


Figure 4:

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 outcomes in our communities, we also want to make sure that we are listening to those who are seldom heard, and that people are able to speak for themselves. To help write this framework, we have asked people who experience health inequalities directly, what the issues are that affect them the most.

Community Voices

Using your feedback to improve care

We have targeted these conversations towards the groups that experience the greatest differences in health outcomes, working with our trusted communicators across sectors through our Community Voices programme.

These conversations highlight how important it is to understand how residents who experience health inequalities live and work, those factors that influence their health behaviours and what makes it difficult or possible to access services.
The summary below highlights 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 causes of disease begin long before someone sees a health professional as outlined below. This image clearly shows the '**building blocks'** for good health.

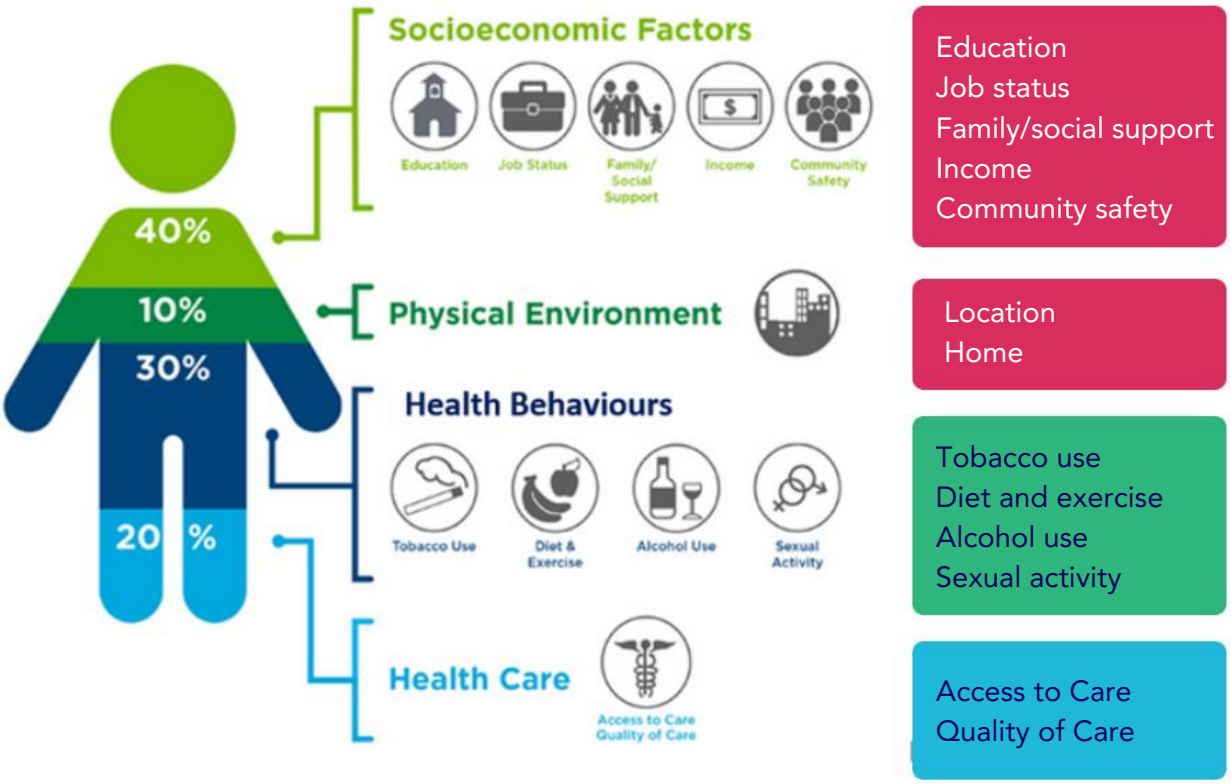


Figure 5: Determinants of health

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 - we have 42 of these in Norfolk & Waveney.

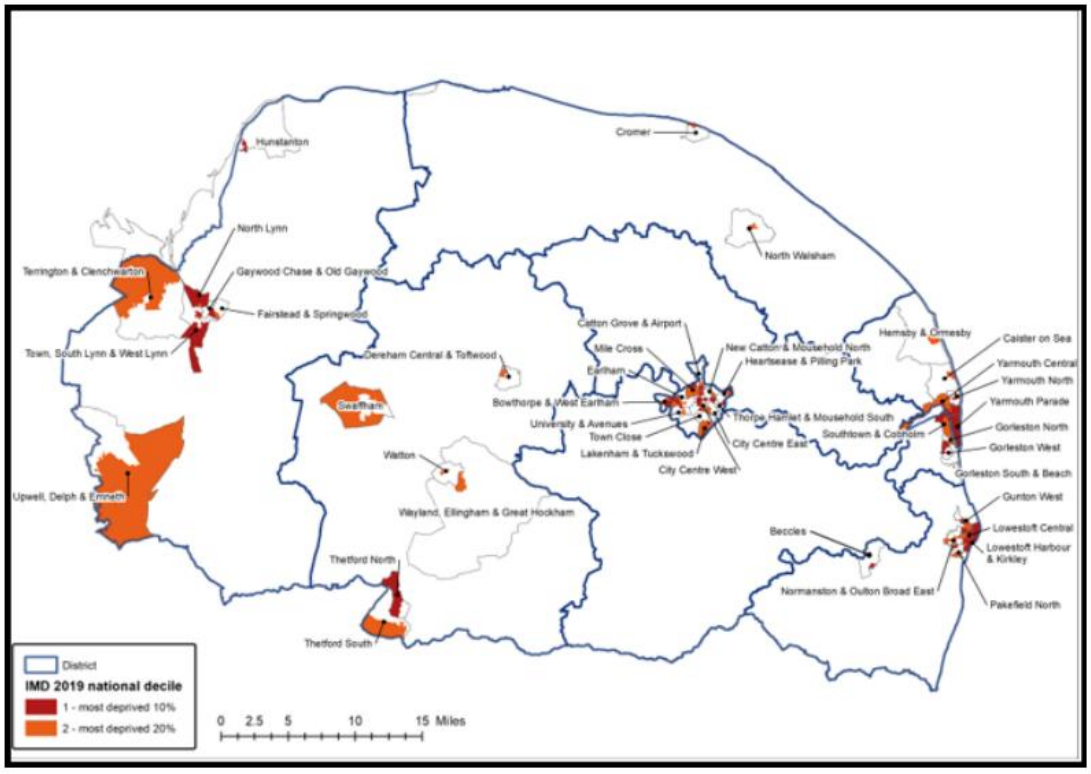


Figure 6: District ward Core20

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, neurodiversity 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 about the adult framework here and more about the children and young people framework 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:

- 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.
- Understand that not taking action early has a negative financial impact on organisations, and worse health outcomes for residents.

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, collaboration and enduring focus.

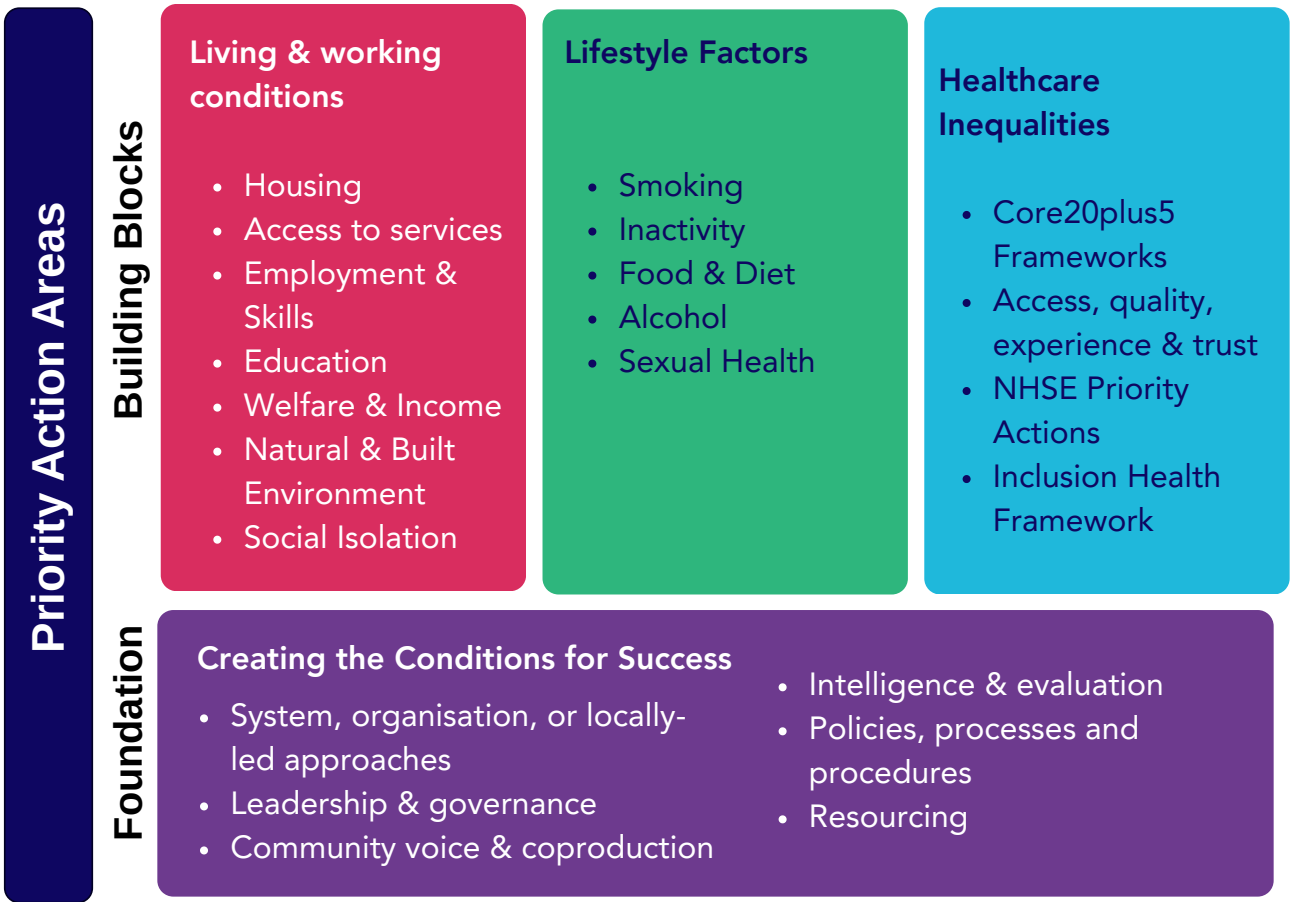
We will understand who is accessing our services, who isn't and why in order to act.

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 well-being of a community depends on many things, including education, housing, employment, and access to good healthcare. These factors can affect a person's health throughout their life and can also contribute to health inequalities. (Marmot, 2010). They are also often linked. For example, someone who is unemployed may have a harder time finding good housing and may not have access to healthy food or green spaces.

To address these issues, we need to focus on spending money where it is needed most, to make sure everyone has the same chance at good health. This means investing in the root causes of health inequalities and making sure resources are distributed where there is need. (The King's Fund, 2022).

This may very well be at place level in order to meet local need, and be delivered by organisations and people who know the place and community best.

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 too much 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 groups or people to get access. 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.

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 and with our communities.

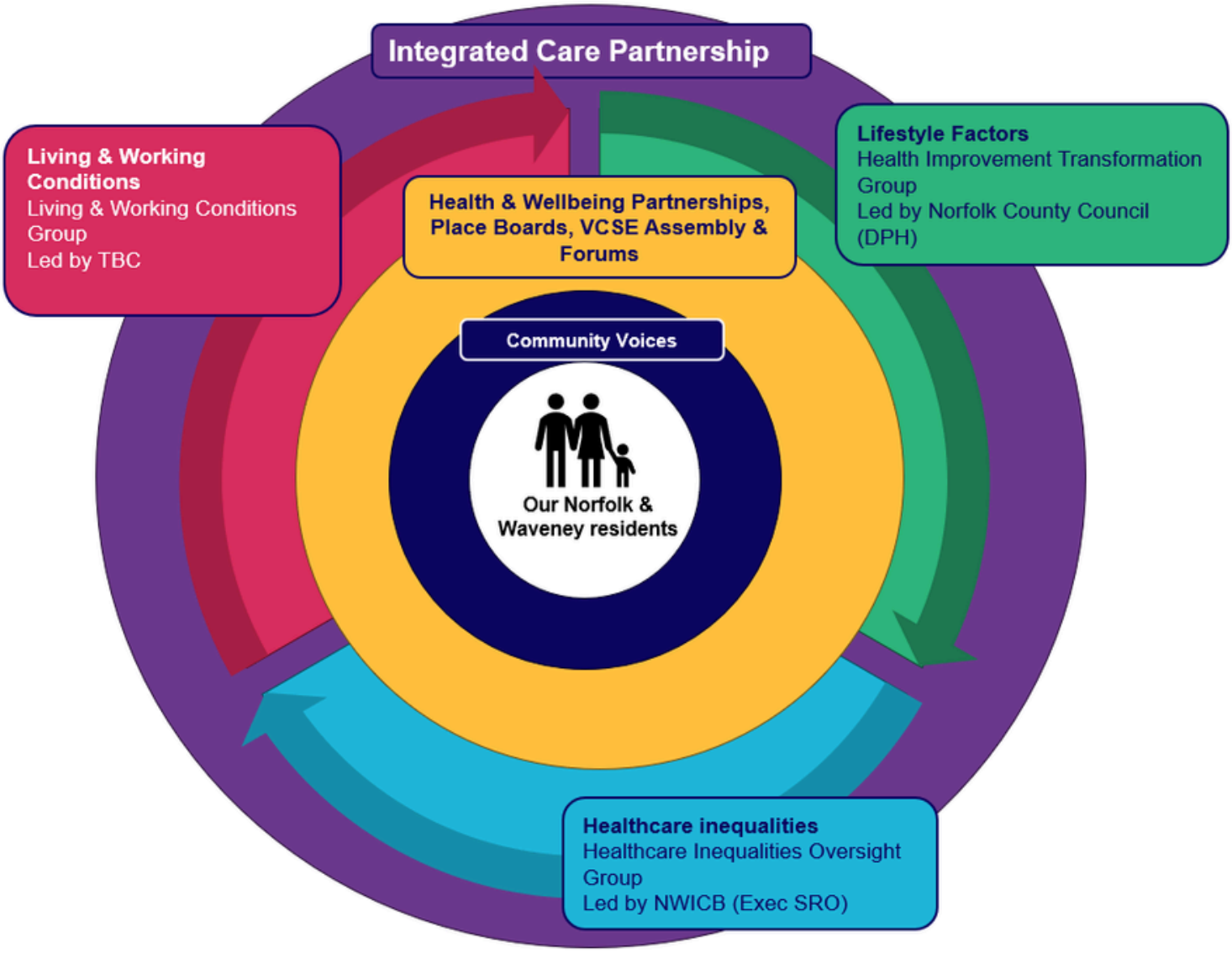
Navigating our different duties, relationships, structures and priorities is going to be difficult. However, this is the chance to work more closely with communities, understanding better how we can do differently, and leading more effectively.

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, city, borough and county councils, Voluntary Community & Social Enterprise (VCSE) sector, the NHS and the independent sector.

Our Norfolk & Waveney Integrated Care Partnership brings together health and social care providers, local government, the VCSE sector and other partners. It will provide oversight and ensure the Health Inequalities Framework is delivered.

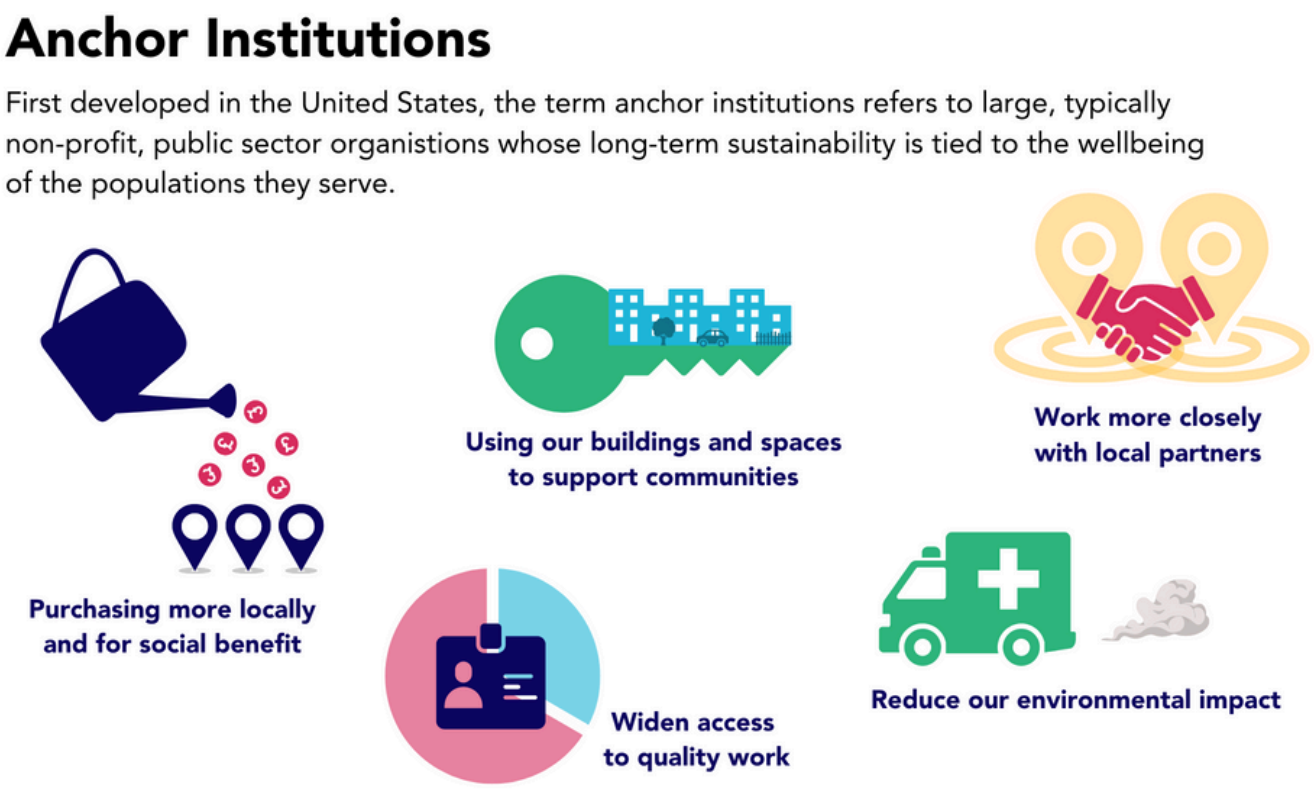

Integrated Care Partnership
Living & Working Conditions
Living & Working Conditions Group
Led by TBC
Lifestyle Factors
Health Improvement Transformation Group
Led by Norfolk County Council (DPH)
Health & Wellbeing Partnerships, Place Boards, VCSE Assembly & Forums
Community Voices
Our Norfolk & Waveney residents
Healthcare inequalities
Healthcare Inequalities Oversight Group
Led by NWICB (Exec SRO)

Action 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 (see below diagram).
- Through good quality equality impact assessments, complaints procedures or by embedding a requirement for social value in contracts.
- A commitment to training and learning.
- 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, an organisation working alongside NHSE, 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. local services and people have a good idea of what works for them, and how it is best to go about making change happen. 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. This might not be the same everywhere as every place is different.

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 plays an important role in addressing health inequalities.

The VCSE sector is a vibrant and creative sector that can lead the way to finding solutions to local health issues. Rooted in communities with established relationships in place, the sector has long been acting as 'trusted communicators' highlighting community need and assets. The sector offers the opportunity for better connection to those who experience the worst health disadvantage. The Covid 19 Pandemic response also reinforced that the VCSE sector able to shift focus, respond quickly and help meet immediate need.

The VCSE sector are powerful partners needed to succeed in transforming health inequalities, promoting community wellbeing and ensuring equitable access to healthcare. In order to do this successfully more needs to be done to empower organisations in the sector. Therefore, this framework for action commits member organisations to the development of a VCSE partnering work programme, as well as the continued development of a VCSE Assembly that complements what is already in place.

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 will establish and further develop three 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**
- Health Improvement Transformation Group to drive action relating to **Lifestyle Factors**
- Population Health & inequalities Board to drive action relating to **Healthcare Inequalities**

Further to these groups we will establish a Health Inequalities Coordination Group overseen by a Strategic Steering Group and made up of system partners that seeks to drive implementation of the overall strategy with particular emphasis on **Creating the Conditions for Success.**

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 1 April 2025. The Taskforce will be responsible for making sure these actions happen.

Action 1	Action 2	Action 3
Communications & Pledges We will continue our 'Health Inequalities Conversation' and roll out a programme which includes commitments and accountability.	**Governance** We will identify named Senior Responsible Officers/Leaders, Organisational Leads, Clinical leads and Health inequalities champions.	**VCSE Integration** We will further develop the VCSE Assembly, integrate the VCSE sector into all parts of our planning & decision making and support volunteering.
Action 4	**Action 5**	**Action 6**
Action Plans We will produce action plans for each of our building blocks, using existing assets and with our place and system structures working closely together.	**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.	**Organisational Development** Including a suite of tools and training, a learning centre to share good practice and case studies, and a health inequalities champions network.
Action 7	**Action 8**	**Action 9**
Resources Mapping the flow of health inequalities resources & spend across organisations to further develop the business case for investment.	**Intelligence** Implement our Population Health Management Strategy, so that we get better at collecting and using data and insights	**Monitoring** A Health Inequalities Outcomes Framework developed with clear metrics and targets identified to keep us on track

Action 10
Participation Develop a common approach to engaging our 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.

Key commitments

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

Report title: Driving Integration Through Digital, Data and Technology including the Impact and potential risks in respect of the landline to digital switchover and 3G switch off

Date of meeting: 12 June 2024

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

Reason for the Report

This paper is to provide an update on how we continue to work collaboratively as a system to enable data sharing and some of the progress that has been made since our last update on 6th March. It also provides an overview of the landline to digital switchover and the 3G switch off, the potential impacts and risks for our residents and the actions which are being taken to communicate and reduce them.

Report summary

This report and appendix provides an update on how we have progressed some of the outcomes that were discussed at the ICP Development Session in January. It also gives an update on how we are communicating with staff, customers and residents of Norfolk about the digital switch in light of the UK's telephone network being upgraded over the next year and a half. By the end of 2025 the old analogue copper telephone landline network will be switched to digital, meaning that all phone calls will go through the internet, and everyone will require broadband to make landline phone calls. This means that people who use technology and who are reliant on analogue telephone connections may need to upgrade their devices.

Recommendations

The ICP is asked to:

a) Note the updates on the progress taken around the collaboration as a system and raise any potential gaps or priorities to further inform the plan.
b) Review, comment, and advise on the potential impact and actions which are being taken to mitigate the risks associated with the digital switch.
c) Agree how best to identify and communicate this potential impact to vulnerable customers.
d) Agree how best to communicate to staff and colleagues.

1. Background

1.1 This paper is brought to the ICP to update on how we are working collaboratively as a system to enable data sharing and what we are doing to drive integration through our digital, data and technology systems (DDaT). The report provides information regarding the digital roadmap for further integration and sharing, the Norfolk and Waveney Shared Care Record, the Data Hub and the Electronic Patient Record. It also highlights changes afoot following references at previous meetings to the forthcoming telecommunications changes and their potential impact.

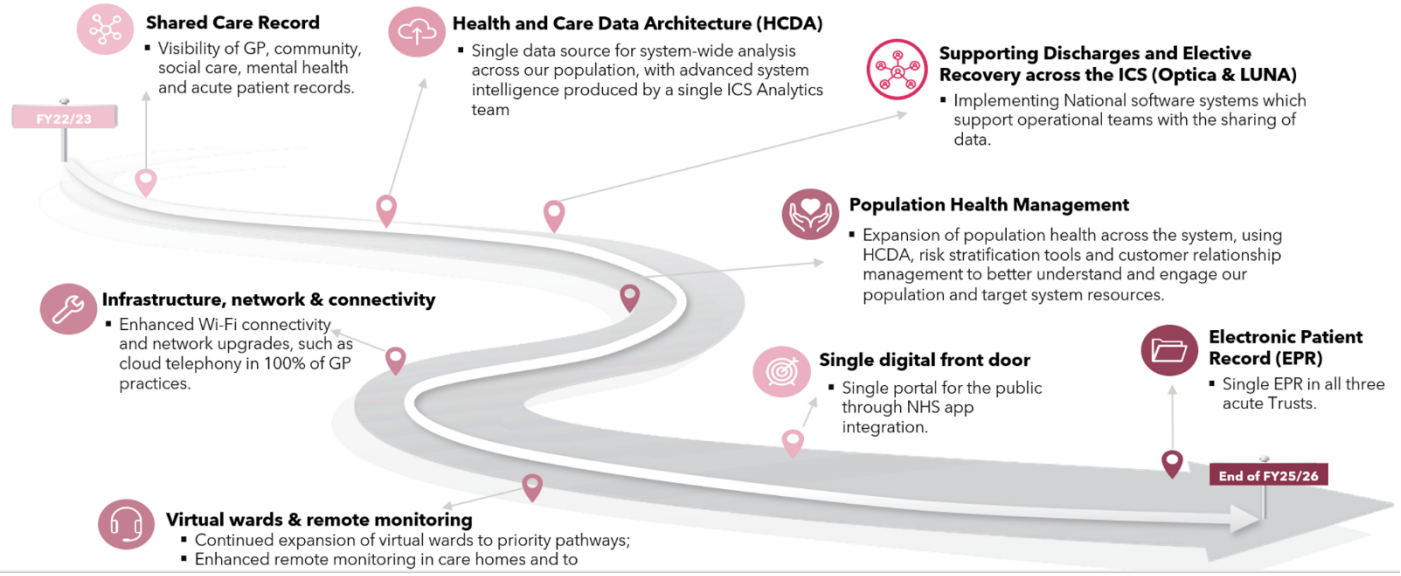
2. Update on the Digital Overview

2.1 **Digital Road Map:** Norfolk and Waveney continue to deliver the agreed ICS Digital roadmap (see image below). This sets out the delivery of a number of significant projects and programmes and this takes us (currently) through to the end of 2025/26.

2.2 The Digital strategy and roadmap will be refreshed in the Autumn of 2024 to continuously reflect the changing system transformation priorities and available funding levels.

Digital Transformation Strategic Roadmap

Digital will enable transformation across all care settings, including outpatients.



2.3 **The Norfolk & Waveney Shared Care Record** roll out phases 1 and 2 are complete, with the record now accessible in Norfolk County Council, all three Acute Hospitals, the community providers, Norfolk & Suffolk Foundation Trust, NHS 111, GP Practices and Out of Hours services. All of these organisations, apart from the community providers, are also contributing data to the record, which is being accessed by an average of 4,000 staff a week for 30,000 citizens.

2.4 A Social Prescribing system, Joy, has been purchased and will be rolled out across Norfolk & Waveney. This will enable delivery of the Shared Care Record to the VCSE sector, as well as improving the uptake of social prescribing pathways and ultimately improving people's lives. The project is currently in discovery phase and the team are actively working with PCNs and social prescribing partners on baseline work, such as populating directories of service.

2.5 Remote observation technology has been rolled out to 40 care homes in Norfolk & Waveney and is being expanded to 40 more. The ability for remote observations gives clinicians at the GP Practice or in the 111 or Out of Hours setting, better information to assist decision making and means that residents can receive care at home where appropriate. We are also exploring ways of flowing data from the Adult Digital Social Care Record to be available to system partners.

2.6 **The data hub** (formerly HCDA) provides a system wide platform for the linkage and sharing of data across all ICS partner organisations. We recognise that a citizens story is told across multiple organisations and it is therefore the intention that the data hub will bring them together, linking them into a single story. This will allow systems and providers access to better intelligence.

2.7 As we have discussed previously, we recognise that navigating the data security and information governance processes are complicated and on occasions have been a blocker. As well as developing the infrastructure, an overarching set of agreements has now been developed to remove this burden. This includes:

a. An overarching data sharing framework agreement and Data Processing Agreement. These set out the conditions that organisations need to adhere to when sharing data
b. An overarching Data Protection Impact assessment (DPIA). This describes and mitigates for any identified risks.
c. The Data Security and Protection Toolkit (DSPT). This helps providers to check and improve how they keep people's data safe.
d. Sublicencing - this allows organisations to make use of nationally processed NHS data.

2.8 A joint controller group has also been established and each partner organisation is represented. The following use cases are either under review, or have been approved:

- Public Health - Access to the data hub for Norfolk and Suffolk County Council Public Health teams – agreement has been given for the public health informatics team to have full access to the data hub allowing them to make use of the plethora of NHS data sets which have previously not been accessible to them.
- Workforce Data – Approval for all secondary care NHS organisations to share their full workforce data sets with the data hub. This will allow us to build a single data model across the secondary care system and use workforce intelligence for better triangulation of capacity and demand and for planning purposes.
- Identification of patient cohorts for specific interventions.

2.9 We also want to explore how social care can access this information to support demand management in the future.

2.10 **Electronic Patient Record (EPR):** Norfolk and Waveney Acute Hospitals are currently classed by NHSE as 'Group 0' which is the lowest level of digital maturity. The three acute Trusts have formed the Acute Hospital Collaborative (N&WAHC) with a programme to invest in a single, shared, integrated Electronic Patient Record (EPR) system across the three acute hospitals:
  - James Paget University Hospitals NHS Foundation Trust (JPUH).
  - Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH).
  - The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEHKL).

2.11 The procurement work has concluded and resulted in the Meditech system being selected. The remaining approvals work centres around gaining national confirmation of the funding. The Full Business Case (FBC) has now been reviewed by the NHS England (NHSE) East of England Regional Team with input from finance teams and additional expertise on digital being provided by Regional Digital Transformation Team, Medical Directorate and NHS England.

2.12 The FBC will require approval from Treasury in May 2024 with a planned 'go live' for the system in April 2026.

2.13 NSFT is also looking to implement a new Electronic Patient Record (EPR), the current Lorenzo system has been in use at NSFT since May 2015, prior to which four separate systems and paper records were used. The current Lorenzo contract expires in May 2025 with the option to extend for a further 12 or 24 months under the current terms. Work to get the FBC agreed to support this replacement is ongoing and a new EPR is also scheduled to go live during March / April 2026.

3. Public Switched Telephone Network (PSTN) Landline to Digital switchover and 3G switch off

3.1 Government and the telecommunications regulator Ofcom have taken the view that the removal of legacy technologies and migration to digital landlines and 4/5G mobile are industry led. As a result, they had little involvement in the changes until some high profile cases brought the risks to light. Subsequently they have instigated agreements with telephony providers which should help to safeguard vulnerable residents during the transition from the old PSTN network and also in the event of a power outage. Local authorities and health and care providers can also help by raising awareness and supporting vulnerable residents, in particular those who use telecare services.

3.2 By the start of 2027 the old analogue copper telephone landline network will be switched to digital, meaning that all phone calls will go through the internet, and everyone will require broadband to make landline phone calls. The migration process is already underway and effecting Norfolk residents.

3.3 The mobile providers have also decided to switch off their 3G networks to make room for the more advanced 4G and 5G services, giving customers faster and more reliable access. Work will be completed by 2024.

3.4 The majority of mobile phones in use will be unaffected, however if an older device is used that doesn't have 4G or 5G signal then this will need to be replaced as they will no longer work for data. They will still however be able to make and receive phone calls and text messages using the 2G network.

3.5 There is a potential risk to a resident that uses a service that relies on a landline connection as they may be impacted. These are services such as Telecare Services, Fire, Burglar and Personal alarms.

3.6 Norfolk County Council have been promoting these changes to its residents and staff as part of a wider communications campaign and although the switchover date has very recently changed from 2025 to 2027, we will continue with our communications campaign.

3.7 An article about both of these changes was in the spring 2024 'Your Norfolk' magazines which goes to all of our residents. It informed them of what the changes were, when it was happening, what they needed to do and where to find further information about this.

3.8 For further Information about both the landline to digital switchover and the 3G switch off visit norfolk.gov.uk/Digital.

3.9 An NCC internal communications campaign is due to start May 17 to ensure all of our staff are aware of the changes and potential impacts for both them and customers that they work with. A variety of communication methods will be used from our weekly 'Friday Takeaway' to leaders Blogs, Manager and Member briefings. More detailed information is also available to all of our staff via our intranet 'myNet'.

3.10 Our Assistive Technology team will be mailing a flyer/leaflet to all known vulnerable people who use assistive technology which explains the changes and impacts to them (see Appendix A).

3.11 We have now signed a Data Sharing Agreement with BT to ensure that we can provide information regarding vulnerable people and will also be meeting with other suppliers over the coming months.

3.12 Information is shared regularly with our partners from Health, Local Authorities and the VCSE via the Digital Inclusion Programme board.

3.13 Councillor Jane James, Cabinet Member for Corporate Services and Innovation has spoken on the local radio on several occasions regarding both changes.

3.14 The council will also be using the Norfolk Show to highlight these changes.

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

Name: Geoff Connell Tel: 01603 307779 Email: Geoff.connell@norfolk.gov.uk

Norfolk County Council

Important changes to your Telephone Line

As a community alarm (pendant) user, who has received additional sensors linked to the community alarm from our Assistive Technology Team, you need to be aware of an important change.

Your **telephone line provider** (BT, Virgin Media, Sky, etc.) will be contacting you by mail to **notify you that your connection will change to a new digital line** before the end of 2025.

- You may already have been contacted.
- You may have already changed to a digital line.
- Or you may not hear anything until closer to the deadline of the end of 2025.

When you are contacted by your telephone line provider, please do not ignore the communication.

You should identify yourself to your telephone line provider as a community alarm (pendant) user.

The provider can explain extra support to ensure your telephone and community alarm are reconnected to the new digital line and working correctly.

If necessary, they can delay your new connection until nearer the deadline at the end of 2025.

How this affects your Community Alarm

Your community alarm provider may have already been in contact to notify you of the digital change, or to change your community alarm to a digital device.

- You may already have a digital device, and no change is required.

You should test your pendant at least once a month.

You should notify the alarm centre if you have been given a date for your telephone line to change to digital and test the pendant if this has already occurred.

If you have any concerns about this change, or the validity of any communication you receive, please contact either your telephone line provider, your community alarm provider (by phone or by using the pendant button), or the Assistive Technology Team.

If you have additional sensors linked to your community alarm these will not work if your alarm has been changed to a digital device.

If you are unsure or have recently had your alarm changed, please contact the Assistive Technology Team.

Norfolk County Council

If you have any concerns about this change, or the validity of any communication you receive, please contact either your telephone line provider, your community alarm provider (by phone or by using the pendant button), or the **Assistive Technology Team on 01603 223766**