Patients and Communities Committee

Mon 22 May 2023, 15:00 - 17:00

Virtual

Agenda

15:00 - 15:00
0 min

Chair's welcome and apologies for absence

Aliona Derrett

00. Patients and Communities Committee Agenda 22.05.23 FINAL (2).pdf (2 pages)

15:00 - 15:00
0 min

Declarations of Interest

Aliona Derrett

To declare any interests specific to agenda items
For noting

02. ICB Patients and Comm Committtee - May 23 V2.pdf (2 pages)

15:00 - 15:00
0 min

Minutes from previous meeting and matters arising

Aliona Derrett

To approve minutes of the previous meeting (27.3.23)
For approval

03. NW ICB Patients Communities Committee Minutes 27.3.23 AD edits.pdf (11 pages)

15:00 - 15:00
0 min

Action log

Aliona Derrett

To note any outstanding actions from the previous meeting not yet completed
For review, update and approval

04. Action Log (2).pdf (1 pages)

15:00 - 15:00
0 min

Joint Forward Plan

Andrew Palmer and Rebecca Champion

- The Patients and Communities Committee will discuss the Joint Forward Plan *(Andrew Palmer)*
- Engagement exercise outcomes *(Rebecca Champion)*

For discussion and noting

05. Cover sheet PC CTTEE_JFP.pdf (3 pages)
05.1 Patients & Communities Committee - JFP.pdf (13 pages)
05.2 NW First Draft JFP - 15.5.23.pdf (182 pages)

Parker Rachael
16/05/2023 10:51:02

15:00 - 15:00
0 min

Healthwatch Updates

Alex Stewart and Andy Yacoub

For discussion and noting

15:00 - 15:00
0 min

Complaints Report

Jon Punt

- Update on the action from the last meeting to make changes to our organisation wide complaints and feedback policy

For discussion and noting

07. May 2023 P&C Committee report - 22-23 Q4 activity and new policy.pdf (5 pages)
07. NHS N&W ICB Complaints Handling Policy Procedure proposed - V3.pdf (15 pages)

15:00 - 15:00
0 min

Urgent and Emergency Care Update

Mark Burgis

- An update on work taking place across UEC to improve outcomes and patient experience

For discussion and noting

08. Patients and Communities Committee UEC Update May 23.pdf (9 pages)

15:00 - 15:00
0 min

Spotlight on: Children and Young People

Rebecca Hulme

- Each meeting, there will be a focus on one of seven corporate and wider system priorities

For discussion and noting

15:00 - 15:00
0 min

People and Communities Approach Update

Rebecca Champion

- New projects
- Engagement and co-production activities

For discussion and noting

10. 2023.05.22 P&C Approach_UPDATE Draft v1.pdf (7 pages)

15:00 - 15:00
0 min

Any Other Business

Aliona Derrett

i. Population Health and Inequalities Board – Assurances and Escalations Report

11.1 2023.04.18_PHI Board Assurance-Escalationsv2.pdf (2 pages)

Parker Rachael
16/05/2023 10:51:02

Improving lives together
Norfolk and Waveney Integrated Care System

Meeting of the NHS Norfolk and Waveney ICB Patients & Communities Committee

Monday 22 May 2023, 1500-1700hrs

Meeting to be held via MS Teams

Item	Time	Agenda Item	Lead
1	15:00	**Chair's welcome and apologies for absence**	Chair
2	15:05	**Declarations of Interest** To declare any interests specific to agenda items *For noting*	Chair
3	15:10	**Minutes from previous meeting and matters arising** To approve minutes of the previous meeting (27.3.23) *For approval*	Chair
4	15:15	**Action log** To note any outstanding actions from the previous meeting not yet completed *For review, update and approval*	Chair
5	15:20	**Joint Forward Plan** • The Patients and Communities Committee will discuss the Joint Forward Plan • Engagement exercise outcomes *For discussion and noting*	Andrew Palmer Rebecca Champion
6	15:50	**Healthwatch Updates** *For discussion and noting*	Alex Stewart Andy Yacoub
7	16:00	**Complaints report** • Update on the action from the last meeting to make changes to our organisation wide complaints and feedback policy *For discussion and noting*	Jon Punt
8	16:15	**Urgent and Emergency Care Update** • An update on work taking place across UEC to improve outcomes and patient experience *For discussion and noting*	Mark Burgis
9	16:25	**Spotlight on: Children and Young People** • Each meeting, there will be a focus on one of seven corporate and wider system priorities *For discussion and noting*	Rebecca Hulme
.10	16:50	**People and Communities Approach update** • New projects • Engagement and co-production activities *For discussion and noting*	Rebecca Champion
.11	16:55	**Any other business** i. Population Health and Inequalities Board – Assurances and Escalations report	Chair
Date, time and venue of next meeting: Monday 24 July 2023, 1500-1700hrs via MS Teams			

Parker Rachael 16/05/2023 15:51:02

Item	Time	Agenda Item	Lead
Any queries or items for the next agenda please contact: rachael.parker9@nhs.net			

Parker Rachael
16/05/2023 10:51:02

NHS Norfolk and Waveney Integrated Care Board (ICB)
Register of Interests

Declared interests of the Patients and Communities Committee

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Aliona Derrett	Non-Executive Member, Norfolk and Waveney ICB	Norfolk and Norwich University Hospitals NHS FT				Indirect	My son-in-law, Richard Wharton, is a consultant surgeon at NNUHFT	2004	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Hear for Norfolk	X			Direct	I am the Chief Executive of Hear for Norfolk (Norfolk Deaf Association). The charity holds contracts with the N&W ICB.	2010	Present	
		Derrett Consultancy Ltd	X			Direct	I am the Director of Derrett Consultancy Ltd.	2018	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Norfolk and Waveney MIND				Indirect	My husband, Robin Derrett, is the HR Director at Norfolk & Waveney MIND. MIND holds contracts with the N&W ICB	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		MoldovaDAR Ltd	X			Direct	I am Director of MoldovaDAR Ltd	Ongoing		Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
Catherine Armor	Non-Executive Member, Norfolk and Waveney ICB	Brundall Medical Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Norwich University of the Arts			X	Direct	Deputy Chair of Council, Norwich University of the Arts	2019	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Evolution Academy Trust			X	Direct	Trustee, Evolution Academy Trust	2022	Present	
		Cambridge University Press		X		Direct	Trustee, Cambridge University Press Pension Schemes	Ongoing		
		East of England Ambulance Service NHS Trust	N/A			Indirect	Daughter-in-law is Technician for East of England Ambulance Service NHS Trust	Ongoing		
Paula Boyce	A representative from the Health and Wellbeing Partnerships	Great Yarmouth Borough Council	X			Direct	Employee of Great Yarmouth Borough Council	2023	Present	To be raised at all meetings to discuss prescribing or similar subject. Risk to be discussed on an individual basis. Individual to be prepared to leave the meeting if necessary.
		Emmaus, Norfolk and Waveney			X	Direct	Trustee and Board member of registered homeless charity Emmaus, Norfolk and Waveney	2023	Present	
Mark Burgis	Executive Director of Patients and Communities, Norfolk and Waveney ICB	Drayton Medical Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Castle Partnership				Indirect	Partner is a practice nurse at Castle Partnership	Ongoing		
Suzanne Meredith	Deputy Director of Public Health, Norfolk County Council	Norfolk County Council		X		Direct	Deputy Director of Public Health, Norfolk County Council	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
Emma Ratzer	Partner Member - VCSE	Access Community Trust	X			Direct	I am the Chief Executive Officer of Access Community Trust, an organisation which holds contracts with NWICB	2009	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Community Access Trust
		VCSE Assembly			X	Direct	I am CEO of a voluntary sector organisation operating in NWCCG and Independent Chair of NWVCSE Assembly	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.

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Alex Stewart	Chief Executive, Healthwatch Norfolk	TBC								
Dr Frankie Swords	Executive Medical Director, Norfolk and Waveney ICB	Norfolk and Norwich University Hospitals NHS FT		X		Direct	Honorary Consultant Physician and Endocrinologist at Norfolk and Norwich University Hospitals NHS FT (1 day a week)	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		N/A			X	Direct	Ad-hoc Clinical Advisor of multiple patient charities - Addison Self Help Group - Pituitary Patient Support Group - Turner syndrome Society	2008	Present	
		Long Stratton Medical Partnership			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		British Medical Association		X		Direct	Member of the BMA	Ongoing		Inform Chair and will not take part in any discussions or decisions relating to BMA
		N/A				Indirect	Husband is a counsellor and undertakes voluntary work with 2 VCSE providers in N&W MIND and Emerging Futures	2008	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services
Tracy Williams	Health Inequalities Advisor	Bacon Road Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		One Norwich Practices	X			Direct	Employed 10 hours a week by One	Jul-20	Present	For any related items, individual would not
		Norfolk and Waveney training hub	X			Direct	One day a week session as clinical adviser for the Norfolk and Waveney training hub	Jul-21	Present	All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc
		Health inequalities and CYP N&W ICB	X			Direct	Clinical lead for Health inequalities and CYP N&W ICB , Attend Quality and Safety Committee and ICP Partnership/H&WB Board	Aug-22	Present	All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc
		Queens Nursing Institute		X		Direct	Member of the Queens Nursing Institute	2012	Present	All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc
		Royal College of Nursing		X		Direct	Member of the RCN	1987	Present	All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc
		Homeless and Health Inclusion		X		Direct	Member of the Faculty of Homeless and Health Inclusion awarded an Honorary fellowship March 2022	2021	Present	All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc
		Norfolk and Norwich University Hospitals NHS FT				Indirect	Sister employed registered nurse at NNUH	2000	Present	All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc
		Norfolk and Norwich University Hospitals NHS FT				Indirect	Brother employed in an administration role at NNUH	2021	Present	All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc
Andy Yacoub	Chief Executive, Healthwatch Suffolk	Nothing to Declare	N/A				N/A	N/A		N/A

Parker Rachael
16/03/2023 10:51:02

NHS Norfolk and Waveney Integrated Care Board

DRAFT Minutes of the Patients and Communities meeting

Held on Monday 27 March 2023

Meeting in Public

Committee members present:

- Aliona Derrett (AD), Non-Executive Director and Chair of the Patients and Communities Committee, NHS Norfolk and Waveney Integrated Care Board
- Mark Burgis (MB), Executive Director of Patients and Communities, NHS Norfolk and Waveney Integrated Care Board
- Karen Watts (KW), Director of Nursing and Quality, NHS Norfolk and Waveney Integrated Care Board *(representing Tricia D'Orsi)*
- Dr Frankie Swords (FS), Executive Medical Director, NHS Norfolk and Waveney Integrated Care Board
- Suzanne Meredith (SM), Deputy Director of Public Health, Norfolk County Council
- Cathy Armor (CA), Non-Executive Director, NHS Norfolk and Waveney Integrated Care Board
- Judith Sharpe (JS), Deputy Chief Executive, Heathwatch Norfolk *(representing Alex Stewart)*
- Andy Yacoub, (AY) Chief Executive Officer, Healthwatch Suffolk
- Paula Boyce (PB), Strategic Director, Great Yarmouth Borough Council and representing the eight Norfolk and Waveney Health and Wellbeing Partnerships
- Tracy Williams (TW), Clinical Lead for Health Inequalities and Children, Young People and Maternity, NHS Norfolk and Waveney Integrated Care Board

Participants and observers in attendance:

- Paul Hemingway (PH), Associate Director of Communication and Engagement, NHS Norfolk & Waveney Integrated Care Board (for item 7)
- Rebecca Champion (RC), Senior Communications and Engagement Manager – Partnerships, NHS Norfolk and Waveney Integrated Care Board (for item 5)
- Roy Weston, Associate Director of Contracting and Procurement, NHS Norfolk and Waveney Integrated Care Board (for item 8)
- Mark Payne (MP), Deputy Head of Mental Health, NHS Norfolk and Waveney Integrated Care Board (for item 11)
- Samantha Holmes (SH), Head of Co Production and Involvement, Rethink Mental Illness (for item 11)
- Morgana Ebe (ME), Expert by Experience (for item 11)
- Adrian Grant (AG), Expert by Experience (for item 11)

Attending to support the meeting:

- Rachael Parker (RP), Executive Assistant, NHS Norfolk and Waveney Integrated Care Board (Minutes)

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16/05/2023 10:51:02

1.	**Chairs welcome and apologies for absence**	
	Aliona Derrett (AD) welcomed everyone to the second meeting of the Patients and Communities Committee. Apologies for absence had been received from Dr Jeanine Smirl and Tricia D'Orsi, however Karen Watts (KW) was attending the meeting on behalf of Tricia. Alex Stewart had also given apologies and was being represented by Judith Sharpe, Deputy Chief Executive of Healthwatch Norfolk.	
2.	**Declarations of Interest**	
	None declared	
3.	**Agree Minutes from the Previous meeting and Matters Arising**	
	The minutes were reviewed and approved as an accurate account of the meeting. <u>Matter Arising</u> AD had reflected on how to be more creative in the way we deliver some of the services that we have received complaints for, and consider all possible options to ensure that we still delivery on our priorities. AD and Mark Burgis (MB) agreed to discuss outside of this meeting. **Action:** **AD and MB to discuss complaints and options to ensure priorities are delivered**	**Action**
4.	**Action Log**	
	The action log was reviewed. Several updates had been provided in advance of the meeting and some actions were agenda items for this meeting. Two actions (no. 3 and 4) were not due until the next meeting. In respect of action two around co-production, Rebecca Champion (RC) suggested, as this was likely to be an ongoing discussion, that it was removed from the action log and RC would update as and when required. AD agreed with this but felt it should not be removed until after the next meeting when there will be a deep dive on co-production	
5.	**Terms of Reference**	
	AD explained that the comments received at the last meeting had been incorporated in the Terms of Reference (ToR) and if members had no further comments then the ToR can be approved. Dr Frankie Swords (FS) commented felt that a quorum of 10 was too many and suggested that the meeting would still go ahead with fewer than 10 people. AD agreed to review this element of the ToR. The committee approved the ToR subject to the quoracy being confirmed. AD advised the ToR will be reviewed annually or sooner if there are substantial changes to consider.	

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	Decision: **01 Committee agreed ToR subject to confirmation of quoracy**	**Decision**
6.	**Complaints Report**	
	Mark Burgis (MB) provided a verbal update on behalf of Jon Punt (ICB Complaints Manager). The agreed action from the last meeting in reference to complaints was to consider how the complaints process for patients and communities can be improved, as well as seeking solutions for the other concerns and issues raised. It was noted that Jon Punt would be bringing a paper to May's meeting which will update on the changes to the complaints process MB shared the following which Jon Punt (JP) will expand on more fully at May's meeting: There is a necessity to amend the complaints process from 1 July 2023 onwards, given that the full delegation of primary care complaints will happen on this date. Therefore we will bring a proposed amended policy to the May 2023 committee meeting for consideration. Thought will be given as to how the Ombudsman's new complaints handling standards may be incorporated into this policy, or whether this will require a much wider piece of work. For reference, geographical neighbours have not adopted these standards as yet either and it is not mandated that we do so, so it may be better to fully embed primary care complaints into the team before considering the new standards. Since raising at the last meeting about the theme of housebound patients finding it difficult to obtain information on when they would receive their COVID Boosters, Jon Punt had met with the vaccination team. An agreement was sought to produce further comms for primary care ahead of the potential spring and autumn booster campaigns, which will hopefully mean much more clarity for patients. Since the last meeting the ICB has been liaising regularly with NHS England as part of a task and finish group around the delegation of primary care complaints. NHSE have now confirmed the complaints resource that will be transferring over (1 band 5 WTE and 1 band 6 WTE) and a commitment to regular monitoring of volumes post delegation, as there are some question marks around how NHSE's contact centre will hand-off queries and whether questions/concerns/queries will naturally gravitate to ICBs anyway, meaning higher volumes of calls and emails for the ICB's front door to deal with. Since the last meeting the backlog of older complaints has reduced, which has been a result of the team working with service areas regularly to obtain information. Jon Punt proposed solidifying this process and potentially regularly reporting into SMT around outstanding complaints that are either approaching the target date for response or are already overdue. AD thanked MB for sharing the update and asked that he pass on ADs thanks to Jon Punt for preparing it. AD invited questions from the committee. Paula Boyce (BP) commented that it was exciting the ICS was being charged with commissioning these additional services but questioned how the delegation to Place Boards will work in relation to patients and communities? MB responded that work is still ongoing but at a recent system meeting of Chief Executives of the main providers and ICB colleagues, there was a real commitment	

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	to support developments at place and the direction of travel to boost and empower place. In terms of confirming delegated budgets, there is a long way to go but it is very live and happening now. AD provided some observational feedback from patients who she had recently been talking to who were trying to raise complaints about a number or providers. Patients were given email addresses to raise complaints via but they do not have access to the internet. AD encouraged that we think about alternative ways for people to raise their complaints not just by email. MB agreed with AD and offered to take this as an action for JP to incorporate an update in the paper he is producing for the next meeting. **Action:** **MB to ask JP to include an update on ways in which patients can raise complaints, in paper due at May's meeting**	**Action**
7.	**Lived experience committee members update**	
	Paul Hemingway (PH) advised that since the last meeting the pack that was presented at the meeting in January has been tweaked considerably and feedback, both from committee members and via email and other conversations, has been incorporated. The pack is now on the ICS website and has also been circulated to partner organisations, stakeholders and members of the VCSE sector and many others, to see their views on the process as well as for seeking their views on how we can make the process open, easy and accessible. PH and Rebecca Champion (RC) will be meeting some individuals over the next few weeks for more granular formal conversations and once all the feedback has been received from that, the pack will be formalised and recruitment can begin but in a very informal and widely engaging way. The roles will not be advertised on NHSjobs it will simply be an accessible pack that is distributed across Norfolk and Waveney by the ICB, via Trusts, providers and the VCSE sector. Expressions of interest will be invited and the intention will be that we will try to complete the exercise within the next few months and in a very staged and specific way, with a view to the members joining the committee at the absolute latest in July. In terms of remuneration for the lived experience members, PH advised there is work ongoing within the ICB and working with partners across the system, looking at having a standard volunteer expenses and co-production policy, to ensure that people are compensated for their time and in line with the wider ICS system expenses procedure which will be co-designed with partners across the system. AD thanked PH for the update and remarked it was good to know we are taking a system approach to compensating the lived experience members. AD invited questions from the committee. Cathy Armor (CA) commented that whilst she understood there was a need to follow process, she was curious as to why the recruitment process was so long given we started in January? PH responded that he hoped people will be recruited before July but we do need to be mindful that we want to capture a wide ranging audience and some people might need more support than others to be able to actually join the committee, or support with papers. PH continued that what we're also mindul of is that we're not necessarily going out to recruit two people but a wider pool to ensure that all ages and perspectives were included.	

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	RC added that the ICB hasn't done this type of recruitment before so we want to do it properly, and the nature of co-production is that if you take people along from the start it takes much longer.	
8.	**Commissioning and contracting in NHS Norfolk and Waveney**	
	Roy Weston (RW), Associate Director of Contracting and Procurement for the ICB attended to provide a brief update to the committee on the commissioning and contracting of healthcare services by the ICB following its creation. A presentation circulated with the meeting papers was taken as read. AD thanked RW for the presentation. AD commented that the VCSE Assembly will be a very good mechanism for engaging with the sector in terms of planning and contracting. AD highlighted two areas of pertinence in relation to contracts, the first area is that we need to start moving into outcomes based commissioning and contracting, building into the procurement the requirement for providers to demonstrate how they are going to make a difference to our communities, and the improvements in population health they will be achieving. AD encouraged that outcomes and impact measuring processess and indicators are included from the outset. The second question related to the current contracting and in particular what percentage of existing contracts are based on Payment by Result approach (PBR) and how many are Block Contracts. RW responded that outcome based commissioning and contracts are being looked at and there's more work going on currently about the ICB role being one of commissioning services that deliver improvements in the health of our population. RW continued that there is a degree of trust involved in that because if you commission for outcomes you have to be confident that the provider will be delivering those outcomes, and traditionally we've been more focussed on some of the mechanics about how services get delivered. So there's the coproduction piece where we're working with providers about how services should be delivered but the measure that we will be performance managing organsations against will be more and more about outcomes and improvements of the health our population, but that will be a gradual process due to the amount of change involved. In response to ADs point about activity or payment by results based payments, RW commented it was a mixed economy, it always has and will continue to be. For example, the NHS nationally is very focussed on delivering elective recovery – dealing with the waiting lists of patients waiting for elective care in hospitals. To incentivise that, all our hospital providers will be paid for activity (surgical interventions) they deliver in 23/24, rather than a block arrangement which it has been for the past three years. RW felt that once the elective recovery has been delivered there will be shift away from activity based payment back to more of an outcome based arrangement. Mark Burgis (MB) thanked RW for the helpful update and acknowledged the complexities around contracting today and that current rules haven't caught up with the way we're working now. In particular, around co-production and working as a system, but that actually makes it quite difficult as well. MB asked whether there is any sign of that changing in the near future. RW agreed with MB's observation and was pleased to advise that there is a change in sight. Changes to the procurement for healthcare services have been going through Parliament for some time now, and the latest is that by July we are expecting a provider selection regime to come into effect. This is a different procurement regime which will enable contracts to be awarded to providers we are confident are able to deliver services and we have	

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	worked with to develop new services. We are hoping the provider selection regime will make collaboration easier to deliver. Suzanne Meredith (SM) queried, in relation to commissioning services to meet the need of the local population, whether the contracting and procurement team undertake formal health needs assessment as part of that work, and do they link up with the joint strategic needs assessment as there's a possibility that SM and RW teams can link together to form some health needs assessments that fit with the commissioning pipeline. RW responded that his main focus is on procurement and the contracts that follow, however health needs assessments are always taken into account when commissioning services. Furthermore, there is now much closer working with local authorities when looking at the health needs of the population and how we can delivery health improvement. AD added a final request to RW that we avoid a postcode lottery when planning services and to keep in mind that whilst we want to have a targeted approach we must not lose sight of conditions which are not geographically or community needs driven. RW agreed and added that one of the fundamental roles of the ICB now as a strategic commissioner is to ensure that we have consistent access to services across the whole of the system, the place level work is more about ensuring in delivering those we recognise the needs of local populations as well.	
9.	**Inequalities overview and update**	
	Tracy Williams (TW), Clinical Lead for Health Inequalities and Children, Young People and Maternity for the ICB, provided an update on the ICBs work in respect of Health Inequalities continuing from the Population Health Management introduction paper at the last meeting. The update highlighted key achievements and initiatives in place, and noted challenges and ambitions in working to drive improvements in reducing health inequalities in our local system. AD thanked TW for the update and noted the interesting work that is taking place across many areas. AD asked TW whether the health inequalities strategy could be circulated so we can see what's included and where we're heading. In relation to the Wellness on Wheels bus (WoW), AD observed there are other mobile services delivered across Norfolk and it will be good to bring those projects together as they can support each other and some are targetting the same areas as the WoW bus. TW advised that the health inequalities strategy was a feature of the Joint Forward Plan (JFP) for both health and inequalities and population health management, and although it was currently work in progress, it could certainly be brought to a future committee meeting. In respect of the outreach programmes, TW agreed these should be joined up and was happy to have discussions on how this could work. FS advised that the Population Health Management and Health Inequalities Board launches in March, which will oversee the development of the strategy which will then come to the Patients and Communities Committee for sign off. FS further advised, in relation to ADs comment about integrating mobile services with the WoW bus, that the Place Boards, as they develop and embed further, will be taking on local leadership for health inequalities in their area and will have local oversight of the services available in their locality. FS continued that although the inclusion health groups are, to some degree, nationally set, Norfolk and Waveney hasn't formally defined it's Plus communities yet, which it will need to do. TW's presentation pulled out some very obvious examples	

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	e.g. rural communities which is a particular issue for our system, and this is a really key piece of work for us. TW added that from the PHM work that Public Health has been undertaking, we do know, from a children and young people perspective, that children in care and those children that are carers are going to be Plus groups. CA thanked TW for the insightful update and asked, in relation to the WoW bus, about the uptake of the initiatives? TW responded that it was more about quality, not quantity and connecting with people who don't necessarily trust our services. It offers opportunities for social prescribing, for example the cost of living crisis, and being able to signpost appropriately. There has been some really good feedback and there is ongoing evaluation of the programme too. MB commented that, in relation to the strength of the Place agenda around health inequalities, some of the best work being seen is being delivered in Place. The work with the district councils, with local people, and the voluntary sector are some of the best schemes and will be critical and key for the future. MB reiterated a point TW made in her presentation that Health Inequalities is everyone's business and we must keep pushing that. **Forward Planner:** **Health Inequalities Strategy, WoW bus programme and HI Case studies – T Williams**	
10.	**Healthwatch updates**	
	AD began by acknowledging that in addition to Healthwatch Norfolk, Healthwatch Suffolk is also represented on the committee thus ensuring that both areas within Norfolk and Waveney ICB and ICS are covered. AD welcomed both Judith Sharpe (JS) (Healthwatch Norfolk) and Andy Yacoub (AY) (Healthwatch Suffolk). JS and AY had already provided a brief overview of work currently being undertaken across Norfolk and Suffolk which was taken as read. JS highlighted that the three big concerns that Healthwatch hear from the public about the most are primary care, dentistry and pharmacy services. JS asked a specific question to the committee about how the Patients and Communities Committee will be kept informed of relevant decisions in other committees, such as changes in primary care commissioning, that would affect patients and communities? FS explained that the Patients and Communities Committee is the link as FS, MB and AD are linked to the ICB Board, the Quality and Safety Committee and the Primary Care Commissioning Committee. FS asked JS about digital tools, in particular Healthwatch Norfolk using digital tools to help people with hearing difficulties, and how do we reach out to people with digital exclusion. Can Healthwatch share any learning from this e.g. using libraries or community centres to help people access information digitally. JS responded that the specific piece of work relating to digital tools is a three year project and will have three separate topics. The first was about access to primary care for people with hearing loss, the outcome was a host of recommenations and a charter for GPs in terms of helping them help patients with hearing loss. There is also work looking at increasing patient understanding of the Shared Care Record and there is also work that Healthwatch England have done about accessible information standards, in terms of making information accessible to all people in different formats when they have various impairments or where English is not their first language. There are	

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	recommendations and reports available to help in this area and JS offered to share these. AD added that Clinical Commissioning Groups (CCGs) prior to becoming ICBs were promoting accessible information standards and have provided training to support the implementation of these standards to ensure provider's compliance. As an ICB it may be something we look at to see what the compliance is and what improvements may need to take place. AY gave an overview of the work that Healthwatch Suffolk is currently undertaking. AD thanked AY for the update. AD requested that the presentation of future reporting is presented as summaries of the key findings and recommendations to the committee. AD thanked both Healthwatch Norfolk and Healthwatch Suffolk for all the work they are doing, representing the voice of our local population. AD added that we need to listen and take into account the findings and recommendations to ensure it influences what we are doing.	
11.	**Spotlight on: Mental Health Transformation**	
	AD began by reminding members that each committee meeting will focus on one of the ICBs seven corporate priorities. The focus for today's meeting is Mental Health Transformation. Mark Payne (MP) began by introducing Samantha Holmes (SH) from Rethink, and Morgana Ebe (ME) and Adrian Grant (AG) who are both experts by experience. MP explained that the NHS Long Term Plan set out a bold vision for transforming community mental health care for adults. We're now two years into the transformation journey, working in partnerships with local voluntary organisation, local authorities and experts by experience, to provide more options for people to get the right help in the right way for them, but there's still a long way to go. The experts by experience who are supported by Rethink are integral to the plan and decision making. SH explained that Rethink Mental Illness facilitates coproduction and involvement on the adult mental health transformation programme. SH shared details about the mental health transformation coproduction model which brings flow, lived experience information or data from a wide range of people in the community through community conversations, particularly those who are currently under served and experiencing highest health inequalities. The community conversations feed into a reference group made up of experts by experience who review and consider the priorities and recommendations to be made to the Mental Health Partnership Board. SH introduced Morgana Ebe (ME), an expert by experience leader. ME is an expert by experience and a member of the Norfolk and Waveney Reference Group, mainly working in the eating disorders workstream. ME highlighted some recent improvements particularly around collaboration with Trusts and reference groups in other counties, and the national effort to coordinate service provision. ME highlighted eating disorders which are less well known such as ARFID (Avoidant Restrictive Food Intake Disorders) which is very much up and coming in terms of what service provision has been made. ME explained that she has a background in advocacy and social justice, and having the opportunity to tell her story and influence change was significant in her decision to become an expert by experience. ME	

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	explained that quite often people have a real mistrust of the system, they are reluctant to tell their story because they feel that's putting too much effort in and there can be a lot of back and forth. ME feels it is important to show the system what people on the ground are actually experiencing. Adrian Grant (AG) is also an expert by experience. AG shared that he is autistic and has experienced mental ill health, including crisis, since childhood and throughout adult life. AG shared a statistic that it is estimated about 80% of autisitic people also experience poor mental health and a range of other conditions and difficulties. AG has used mental health services throughout his life, and like many people, regularly slips between services or gets shunted between services, constantly repeating his condition to new and different people and this is one of the reasons he wanted to get involved. The reason why many experts by experience want to be involved is to try and shape mental health services to become more holistic and integrated. AG has been involved for just over a year and has been impressed by the motivation and everyone trying to make changes for the better, for the right reason and with the right information and, importantly, the right people involved. AG shared some of his experiences and examples of how co-production is working in relation to the mental health community transformation programme. As a volunteer expert by experience AG currently chairs the mental health community transformation reference group, he is also a member of the steering group and mental health partnership board and all experts by experience are able to join these groups, and the fact that experts by experience are part of these groups in itself is progress; there is a very wide collective of experts sharing their experience and wider networks. AG feels this is fantastic progress in achieving coproduction in Norfolk for mental health services, bringing to the table an extremely comprehensive and rich volume of opinions and experience from people that actually use the services and whose well-being depends on them. AG was keen to stress that all experts by experience are volunteers and not employed by any organisation, they do it because they are passionate about the subject. A final comment from AG was that we probably should congratulate ourselves for our achievements in making coproduction in mental health services start to work in Norfolk and AG genuinely believes it will get better as we move forward. AD thanked SH, ME and AG for making the time to join the meeting and noted it is pleasing to hear that we are beginning the journey of engaging with people with lived experience and listening to what they have to say. AD commented that ME's comment about mistrust of the system resonated with her and the feedback she receives from patients too. AD asked ME, is there was one thing that people working within the system must do to start changing that, what would it be? ME responded that from her own experiences of therapy and dealing with clinicians and other healthcare professionals, there does need to be a willingness for professionals to listen to lived experience more, rather than just reading papers in journals or diagnostic material which can reinforce biases of particular groups. TW thanked AG for his insight and the work he is doing. As a clinician working particularly with inclusion health groups predominantly people who experience homelessness, TW felt that some of the groups she works with have the most quieter voices and would find that kind of approach to coproduction quite challenging so do you have any tops tips on how we can support our quieter voices to be more involved? AG responded that he was familiar with this experience and suggested meetings being held remotely and virtually, creating an atmosphere where the people you're engaging have the freedom to leave the meeting at any moment without any	

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	criticism or judgement. It's about taking small steps to make engagement easier; it's a learning journey for everyone including the people you're engaging with. MB thanked SH, ME and AG and encouraged them to continue challenging the ICB around doing things the right way.	
12.	**People and Communities Approach Update**	
	AD began by acknowledging the work that has been completed for the Community Voices pilot; some very good work took place which has helped us to plan for the future. AD invited Rebecca Champion (RC) to update further. RC referred back to the last meeting where it was noted that the community voices work was a little light on outcomes, and so a draft slide has been produced with the latest data. (RC added that more detailed information is also available which can be shared after the meeting). RC highlighted that as of today (27.3.23) there have been 684 recorded conversations over approximately eight months and from this there were 132 recorded outcomes. However there have been other outcomes and consequences, which are much harder to quantify. RC felt it was interesting that the top two outcomes (at 24 each) were being directed to accessing benefits and accessing community group support, but coming in second is assistance with getting GP appointments and people being helped to register with their GP. Following that is people needing support with housing. It was noted that one outcome resulted in a person not going to court for a council tax summons, which is also a huge achievement. RC reiterated that community Voices is about the voice of communities and is still a pilot. We shouldn't be too focused on numbers as we then start to lose sight of other important aspects. The ultimate vision is to train people across the system to input and feedback about what they hear in their frontline roles, to help gather rich qualitative information. Included in RC's presentation slides is information about the University of East Anglia's (UEA) evaluation of the first phase of the Community Voices project. It is hoped that a much fuller update can be provided at May's meeting. Shelley Ames (SA) added that colleagues at Great Yarmouth Borough Council have been supporting with the analysis of information and the systems impact of this work is potentially very strong. A full time programme manager will be in post shortly which will help to drive the programme forward, and we can take the learning from the pilot and start thinking about how we build this as business as usual. AD invited questions from the committee. FS was delighted to see the outcomes information, in particular the impact it is having on individuals who engaged with Community Voices. FS felt it would be helpful to link in with the work Healthwatch Norfolk and Healthwatch Suffolk are doing around pharmacy, dental and GP access, signposting and simplifying access, and for the next meeting FS would like see some 'you said, we did' examples . AD added that an advantage of the project is that if we have the right concept of delivery and people with the right knowledge delivering it, then people can access support much earlier for whatever challenge they may have.	

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	AD thanked RC and SA for their updates and also offered thanks to the teams in the background who are delivering this work, as it is helping a good number of people with their issues and preventing escalation of need. **Forward Planner:** **'You said, we did' examples to come to July's meeting – R Jakeman and S Ames**	
13.	**Any other business**	
	1. Agree Committee's Objectives for Reporting to the ICB Board AD advised members that the committee is required to provide a regular report to the ICB Board based on it's objectives. AD proposed holding a separate meeting with committee members to discuss the committee objectives and forward plan. AD asked Rachael Parker to organise a suitable date. **Action:** **Development Session to be arranged to agree committee objectives and forward plan**	**Action**
Date, time, and venue of next meeting: Monday 22 May, 1500-1700hrs via MS Teams		

Minutes agreed as accurate record of meeting:

Signed: …… Date: ……...
Chair

DRAFT

Parker Rachael
16/05/2023 10:51:02

Code
RED Overdue
AMBER Update due for next Committee
GREEN Update given
BLUE Action Closed

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Norfolk & Waveney ICB Patients and Communities Committee
Action Log

No	Meeting date added	Description	Owner	Action Required	Action Undertaken / Progress	Due date	Status	Date Closed
2	30.1.23	Co-production	RC	Explore coproduction development opportunities	27.3.23: Update provided. Item to be removed from action log following coproduction deep dive	tbc ~~23.3.23~~		
3	30.1.23	Community Voices	RJ / SA	Summary of actions taken as a result of Community Voices to include learning, what has been done differently, introduced or changed as a result of the feedback	25.4.23: Update coming to July meeting	24.7.23 ~~22.5.23~~		
4	30.1.23	Lived experience representative	PH	Committee members to provide feedback to PH. Reflect at March meeting as to where we are and what adaptations have been made to the current plan to take this forward	The pack has been finalised and shared widely for comment with partner organisations, stakeholders and forums. Comments will then be factored into the final pack. Roles expected to be advertised late March 2023.	22.5.23 ~~23.3.23~~		
5	30.1.23	Complaints	JP	JP to prepare a proposal on improving the complaints process for patients and communities	27.3.23: Update provided. Paper due at May's meeting - MB to ask JP to include details of the ways in which patients can raise complaints	22.5.23		
6	30.1.23	ICS organogram	PH	ICS organogram to be produced to show who does what from the comms and engagement team	This is a work in progress and will be shared once finalised. This is a big task to do this across the ICS. The ICB structure was shared with HWN previously.	May		
8	30.1.23	Include national patient surveys & HW reports in forward planner	PH / RP	Incorporate a calendar for all national patient surveys as well as planned HW reports into the Patients and Communities forward planner	In progress. HWS and HWN will share a list of work underway at any particular time	24.7.23 ~~22.5.23~~		
9	27.3.23	Agree committee objectives and forward plan	RP	Development session to be arranged for committee members to agree objectives and plan	27.4.23: Session arranged on 11.5.23	22.5.23		

Parker Rachael
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Norfolk and Waveney
Integrated Care Board

Agenda item: 5

Subject:	**5-Year Joint Forward Plan**
Presented by:	**Andrew Palmer, Deputy Chief Executive and Director of Performance, Transformation and Strategy, NHS Norfolk & Waveney ICB** **Rebecca Champion, Senior Communications & Engagement Manager – Partnerships, NHS Norfolk & Waveney ICB**
Prepared by:	**Liz Joyce, Head of System Transformation, NHS Norfolk & Waveney ICB** **Rebecca Champion, Senior Communications & Engagement Manager – Partnerships, NHS Norfolk & Waveney ICB**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**22 May 2023**

Purpose of paper:

To update the Patients and Communities Committee on the work to develop the 5-Year Joint Forward Plan (JFP) for Norfolk and Waveney, including the engagement undertaken with local people and communities.

Executive Summary:

Norfolk and Waveney ICS has developed its Integrated Care Strategy, which sets the overall direction for how we will help people in Norfolk and Waveney to live longer, healthier and happier lives. This strategy builds on what you have already told us over the last four years what matters to you and how you would like to see local health and care services develop in the future. The strategy cannot be delivered by any one organisation but needs collaboration across the system.

NHS Norfolk and Waveney Integrated Care Board, working with partner organisations is developing a five-year JFP for health and care services in Norfolk and Waveney. It will set out in more detail how the local NHS and care services will implement our Integrated Care Strategy, through eight ambitions and their underpinning objectives.

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Before developing our plan we felt it was important to check whether what our people and communities have told us over the last few years still holds true, or whether because of the COVID-19 pandemic and everything else that has happened

over the past few years, what's important to local people and what they would like us to be focusing on, has changed. As a result, we undertook an engagement exercise between December 2022 to January 2023 which aimed to give our staff, partner organisations, people and communities across Norfolk and Waveney the opportunity to have their say at an early stage on what is important to them and what they wanted to see in our plan.

The draft JFP is attached in a Part 1 and Part 2 format, together with example Case Studies, some of which will be included in the final JFP. Timescales are set out within the slides which explain next steps, and feedback on the draft JFP is invited.

Report

Please refer to the presentation included in the agenda pack.

Recommendation to the Committee:

To note the progress so far regarding the Norfolk and Waveney Joint Forward Plan, and how the views and ideas of local people and communities have helped shape it.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	As the planning horizon extends to medium-longer term, forecasting with any certainty becomes very difficult. The JFP content has been triangulated with the Medium Term Financial Plan and this is a key requirement prior to submission.
Impact Assessment (environmental and equalities):	Not completed yet
Reputation:	It is important that this plan is realistic, achievable and deliverable
Legal:	This is a statutory requirement for the ICB and NHS Trusts and Foundation Trusts. The JFP is being written in partnership.
Information Governance:	N/A
Resource Required:	There has been a significant time commitment required from ICB members of staff and all the partner organisations
Reference document(s):	Go to England.nhs.uk to read the guidance on developing the joint forward plan.
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

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Governance

Process/Committee approval with date(s) (as appropriate)	Transformation Board 25 May 2023 ICS EMT – provisional date 26 May 2023 ICB Board 27 June 2023 (chairs action) Health and Wellbeing Boards: Norfolk 14 June and Suffolk 18 May 2023

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Norfolk & Waveney ICS

Joint Forward Plan (2023/24 – 2028/29)

Update May 2023

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JFP principles

- Principle 1: Fully aligned with the wider system partnership's ambitions.
- Principle 2: Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments.
- Principle 3: Delivery focused, including specific objectives, trajectories and milestones as appropriate.

What it is and what it isn't ….

The JFP is a delivery plan, that sets out our plan to improve services for our local population by convening and working together

It is a collaborative response to the key things that the public thinks is important, informed by our data

The JFP is not a retrospective look back / description of "business as usual" work, or our response to the NHS Long Term Plan

The JFP should align with ICS Goals and the four priorities identified in the transitional Integrated Care Strategy and Joint Health & Well-Being Strategy for Norfolk & Waveney (2022-23) and the Joint Health & Well-Being Strategy for Suffolk

Where the JFP is describing services delivered in partnership this is clearly set out, and where the response in Waveney is different to Norfolk we have taken this into account

Partners on a Task & Finish group have been involved in writing various chapters as we have gone along, as well as leading on specific chapters such as Provider Collaboratives

The JFP is a legal requirement of ICBs and their partner NHS Trusts. We will need to report progress each year in our annual plans

Demonstration of the broad alignment between JFP content and partners' strategic plans is important

The JFP is building on our existing ICS Strategies – digital being a key enabler to delivery for example

Public Pack 10/07/2023 10:51:02

The draft JFP

The draft JFP is attached for feedback: tracked changes, general comments and factual corrections all welcome

Feedback to be sent via e-mail to: liz.joyce2@nhs.net as soon as possible and by 30th May 2023

Points to note:

1. The audience is the general public (in their role of holding the local NHS to account) and NHS England (JFP is a mandated requirement)
2. **Part 1 – Joint Forward Plan, Part 2 – Legal Duties** - these two parts together form the overall document
3. **Case studies** are to be included throughout the final version of the plan
4. The JFP will be designed using ICS colours, infographics and icons to reduce the word count
5. The eight Ambitions have been well socialised and the detailed Objectives have been developed together with system Boards and groups, with involvement from experts by experience in Mental Health

Parker Rachael
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1. Transforming Mental Health Services

1. Build system resources for early intervention and prevention for people of all ages, including those who experience mental health inequalities. This work will include enhancing and expanding skills and knowledge of mental health across our populations; providing a framework of tools and capacity to support mental wellbeing; and delivering a refreshed suicide prevention strategy.
2. Mobilise mental health system collaboratives to facilitate partnership working and deliver better health outcomes for our residents. The focus of the adult collaborative in year one is to improve support for older people living with dementia, delirium and depression which also has alignment with the Ambition Transforming Care in Later Life.
3. Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'integrated front door' so all requests for advice, guidance and help are accepted, and support provided to navigate the system and meet the presenting level of need. This will be developed in line with the Thrive principles, with children and young people at the centre of delivery with resources wrapped around them, enabling them to Flourish.
4. See the whole person for who they are, beyond their complex behaviour. Develop pathways that support and promote recovery for people living with multiple and complex needs – with a focus on dual diagnosis and complex emotional needs (CEN)

Parker, Rachael
16/05/2023 20:55:02

2. Improving Urgent & Emergency Care

1. Improve Ambulance Response Times
2. Expand virtual ward services
3. Delivery of the Improving Lives Together Programme, to reduce Length of Stay (LOS) in hospitals

3. Elective Recovery & Improvement	4. Primary Care Resilience & Transformation	5. Improving Productivity & Efficiency
1. Effectively utilise capacity across all Health System Partners 2. Implement digital technology to enable elective recovery	1. Developing our vision to provide a wider range of services closer to home, improving patient outcomes and experience 2. Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.	1. Improve the services we provide by enhancing productivity and value for money, embracing digital innovation and delivering services together where it makes sense to do so.

Parker Rachael
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6. PHM, Reducing Inequalities and Supporting Prevention

Development and delivery of two strategies to support prevention:

- A Population Health Management Strategy, and a Norfolk and Waveney Health Inequalities Strategy to deliver the "Core20plus5" approach

The delivery of three specific work programmes designed to tackle:

- Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people
- Early Cancer Diagnosis – Targeted Lung Health Check Programme
- Cardiovascular disease (CVD) Prevention

Public Reactions
16/07/2021 10:51:02

7. Improving Services for Babies, Children, Young People & Maternity

1. Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach
2. Continued development of our Local Maternity and Neonatal System (LMNS), including the Three Year Maternity Delivery Plan.
3. Reducing health inequalities including an initial focus on asthma, epilepsy and mental health
4. Develop an improved and appropriate offer across Norfolk and Suffolk for Children's Occupational Therapy, to meet their needs

8. Transforming Care in later life

1. To develop a shared vision and strategy with older people that will help us to transform our services to be easy to access and designed and wrapped around the needs of older people.

Timeline of key dates / activities – May to July

Key Dates	Meeting	Activity and Focus
15 May	Draft JFP to be circulated – deadline of 30 May for initial feedback	All Partners, ICB Board members and Suffolk HWB
18 May	Suffolk Health & Well Being Board	Opinion
22 May	Patients & Communities Committee	Review / comment
25 May	Transformation Board	Page turn of JFP – Ambition Leads to be invited to attend this agenda item.
26 May	ICS EMT	Approval / check & challenge
30 May	ICB Board	Sight of near final copy
31 May	Send copy to designer	3 weeks for design
14 June	Norfolk Health & Well Being Board	Opinion
21 June	Final copy back from designer	Completed JFP – fully designed
27 June	ICB Board	Sign off
30 June	N/A	Publish on ICS website, send to NHSE
w/c 3 July	NHS 75th birthday celebrations (5th July)	Launch – look forward using the JFP

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Norfolk and Waveney Integrated Care System

Five-Year Joint Forward Plan Engagement

Patients and Communities Committee 22nd May 2023

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16/05/2023 10:51:02

What have people told us matters to them?

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Our Integrated Care Strategy was built on feedback collected before and during COVID:

- Research on developing our system clinical strategy June 2021
- Engagement on designing a marketing campaign for Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) summer 2020
- Collation of feedback on people's experiences of health and care during the COVID-19 pandemic in September 2020
- Programme of engagement to Develop our five-year plan for health and care in Norfolk and Waveney in 2019
- Engagement to developing our Adult Mental Health Strategy for Norfolk and Waveney 2017-18

Parker Rachael
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https://improvinglivesnw.org.uk/~documents/uncategorized/the-norfolk-and-waveney-integrated-care-strategy

Have people's priorities changed?

We wanted to check if the COVID-19 pandemic and everything else that has happened over the past few years meant that what matters to people has changed. We asked if local people thought our ambitions were still correct.

1. Transforming Mental Health services
2. Improving Urgent and Emergency Care
3. Improving Elective Care
4. Developing a resilient and integrated model of Primary Care
5. Improving Productivity and Efficiency

We were told that **some things were missing**, so we have **added three more** to our list of ambitions:

6. Population Health Management, Reducing Inequalities and Supporting Prevention
7. Improving services for Babies, Children and Young People and developing our Local Maternity and Neonatal System (LMNS)
8. Transforming care in later life

Qualitative Feedback

We received **700** responses. 592 were completed and included qualitative comments. We are still working on our detailed response but here are some of the things people said we need to include in our plan because they are important to the people of Norfolk and Waveney:

- Social care
- GP access
- NHS dentistry
- Lack of flow through the system/disconnected services
- Affordability and staying within budget
- Community care, especially end of life and palliative, as well as primary care
- Early help and prevention
- Mental health provision, especially early and preventative care for children and young people
- Recruitment and retention of staff
- Services for people with extra needs, e.g. Learning Disabilities and Autism, deaf/hearing impaired
- Digital connectivity and exclusion

Parker Rachael
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Example Comments

"Mental health services quickly available for young people, there are many children at junior schools suffering from anxiety. Addressing issues at a younger age & helping them develop coping mechanisms would surely help them through life"

"The current crisis shows that social care is crucial in being able to deliver health care"

"Mental health services have always been the Cinderella service and this must change!"

"Preventing and managing ill health starts in primary [care]."

"Primary and COMMUNITY care should be a priority. Community care support both primary care and front and back door of acute sector."

"There should be more emphasis on prevention rather than cure"

Parker Rachael
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"A properly funded system should mean that all health and social care needs are met."

"I think a top priority should be recruitment. With a skeleton workforce the reality of achieving the reduction of the waiting list, provision of aftercare and provision of emergency response is futile. It is not about pay; it is about workforce and workplace environment."

You can read the full **engagement feedback report** here:

https://improvinglivesnw.org.uk/get-involved/working-with-people-communities/you-said-we-did/norfolk-and-waveney-five-year-joint-forward-plan-2023-2028/

A detailed response and what we will do as a result of what you have told us is being worked on and will be available on this page soon.

Parker Rachael
16/05/2023 10:51:02

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Norfolk and Waveney Integrated Care System

Joint Forward Plan: 2023-2028

First Draft: 15 May 2023
Version 0.4

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Foreword by the Chair and Chief Executive of Norfolk & Waveney ICB

There is nothing more important than our own and our family's health. It's why, as a country, we treasure the NHS and its dedicated staff. But vital though it is, the NHS only accounts for a fraction of our physical and mental health and wellbeing. All the rest depends on other things: genetics, our environment – whether we have decent work, enough money, close family and friends, a warm home, clean air – and our own lifestyles.

The development of our Integrated Care System is a unique opportunity to bring together the many different partners who support the health and wellbeing of Norfolk and Waveney's almost 1.1 million residents: the staff and organisations working in the NHS and social care; local government with its responsibilities for public health, social care, housing, leisure and the environment; the voluntary, community, faith and social enterprise sector; and many others in the public and private sectors.

Of course each of us is the expert in our own lives and we all have a responsibility for our own health and wellbeing. This is why our Integrated Care System has at its heart a constant process of listening to people, learning from their experience and acting on what we hear. We are grateful to all the people and organisations who have helped to shape this plan and told us what matters to them.

Our mission as an Integrated Care System is clear: to help the people of Norfolk and Waveney to lead longer, healthier and happier lives. This plan sets-out how we will work towards this over the next five years. We are not starting from scratch – we will build on what we have achieved over the past few years, including through the COVID-19 pandemic, and the real progress we have made since NHS Norfolk and Waveney and our wider Integrated Care Partnership were established in July 2022.

Over the past year we have tackled the longest waits for planned care and treatments that built-up during the pandemic. We are now providing more preventative care, by using data to identify people who could benefit from a particular course of treatment or support, and then contacting them before problems arise or their condition worsens. And we are reaching out to people though initiatives like our Wellness on Wheels Bus, to make it easier for people to get services, support and information about health conditions and other issues like debt and housing, which really affect people's health and wellbeing.

This plan sets-out our ambitions for the future. It describes how we will make it easier for people to get the care and support they need, when they need it. Whether that is in an emergency, getting an appointment at a GP practice, support in the community, or treatment from a mental health professional. It explains how we will continue our work to tackle waiting lists for planned care and treatments. And it makes clear the actions we will take to improve people's health, wellbeing and care from birth through to later life.

By working together, we can create a healthier Norfolk and Waveney.

Baker Ratcliffe
19/05/2023 07:51:02

Rt Hon. Patricia Hewitt
Chair, NHS Norfolk and Waveney Integrated Care Board

Tracey Bleakley
Chief Executive, NHS Norfolk and Waveney Integrated Care Board

Executive Summary <placeholder for final version>

H&WB Board opinions <placeholder for final version>

Suffolk H&WB Board 18th May
Norfolk H&WB Board 14th June

Parker Rachael
16/05/2023 10:51:02

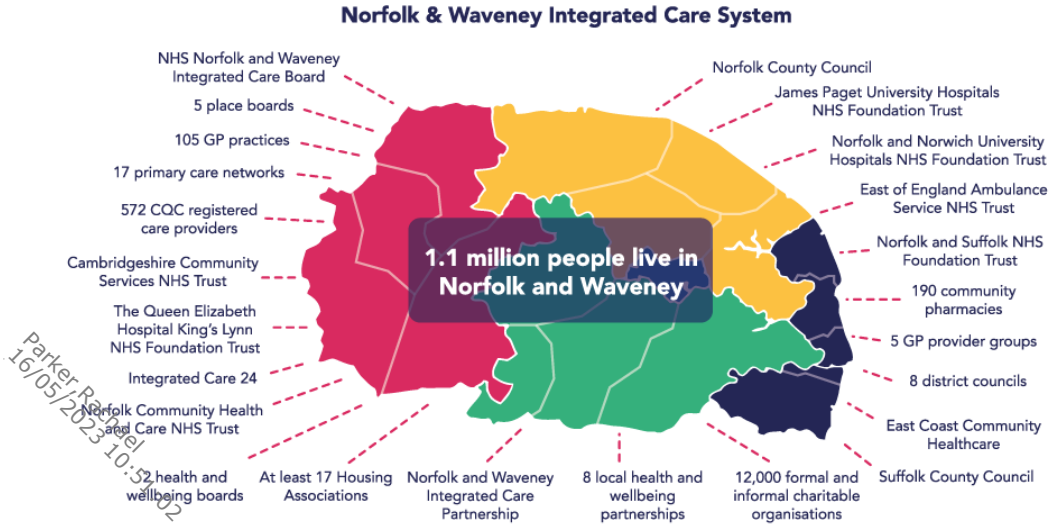
1.0 Scope of the Joint Forward Plan (JFP)

1.1 Introducing the JFP

The Joint Forward Plan is a new requirement set out in the Health and Care Act 2022, for Integrated Care Boards (ICB's) and partner NHS Trusts to describe how they will arrange or provide NHS services for the local population of Norfolk & Waveney. National NHS Guidance (JFP Guidance) confirms what we must include in the plan but first and foremost this document is intended to be a practical plan that the system will deliver, and against which the local population can hold the NHS to account. The needs of our local population are at the heart of this plan, which is ambitious and sets out a number of objectives to improve the quality of our services, as well as ensuring where and how services are provided is informed by local people and our communities.

The JFP describes how we will deliver national NHS commitments such as recovering core services after Covid and improving productivity, as well as transforming care across our eight areas of ambition. The JFP also describes how we will meet our key legal duties, and these are set out in Part 2 of the JFP. A number of these are also referred to within the JFP in relevant sections because they are enablers and will support our improvement and delivery of our eight ambitions which we set out in this plan.

This plan is predominantly about improvements in NHS services but has been developed in collaboration with our ICS partners where services are provided together. This is our first JFP (published in June 2023), and we will update it each year as we set out on a journey of improvement. Progress against the plan will be publicly visible in each NHS partner's annual report, and in the annual report of the ICB.



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We will work together in partnership across the Norfolk & Waveney Integrated Care System (ICS).

Our ICS partners are shown in the stakeholder map.

Within Part 2 of our JFP we have also briefly described the health services that are provided within the ICS footprint.

1.2 Links to our transitional Integrated Care Strategy and local Joint Health and Wellbeing Strategies

It is important that our plan is consistent with local Joint Health and Wellbeing Strategies, and we have two of these which cover our ICS – one for Norfolk and one for Suffolk. Helpfully, the Norfolk Health and Wellbeing Strategy is also the Transitional Integrated Care Strategy for Norfolk and Waveney, so we have one strategy that fulfils both those functions. It was designed in this way to bring everything together, looking across both Norfolk and Suffolk and specifically focusing on themes which are not in the remit of a single part of the system but require a collaborative approach to improvement. The JFP builds on that approach, focusing on improvements that will be achieved by working together differently. Within part 2 of our JFP there is a section on **Implementing any local joint health and well-being strategy** which includes a link to both the strategies, and a summary of their priority themes.

1.3 Link to the core purposes of an ICS

The JFP also addresses the four core (national) purposes of an ICS which are:

- Improving outcomes in population health and care
- Tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Helping the NHS to support broader social and economic development

These core purposes have very good alignment with the Norfolk and Suffolk strategies referred to above. The JFP addresses these through the development of eight areas of ambition, enabled by working differently together and through some key strategic infrastructure which is explained on our strategy map in Section 6.3. Our eight ambitions are:

1. Transforming Mental Health services
2. Improving Urgent and Emergency Care
3. Elective Recovery and Improvement
4. Primary Care Resilience and Transformation
5. Improving Productivity and Efficiency
6. Population Health Management, Reducing Inequalities and Supporting Prevention
7. Improving services for Babies, Children and Young People and developing our Local Maternity and Neonatal System (LMNS)
8. Transforming care in later life

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These eight ambitions are described in this plan with underpinning objectives, trajectories, and milestones where these are confirmed at the drafting stage. We want our local population to be able to see what we plan to do, by when, and what difference it will make to them in their lives.

The ambitions are at the centre of our JFP and are set out within Section 4.2.

2.0 Framework for change

2.1 Five-point approach to developing our JFP

We have adopted a logical approach to developing our JFP, with each step drawing together all the major components of our plan into a coherent vision for improvement over the medium to long term. By doing this, we have carefully considered:

1. **Why** we are doing this – using our ICS Transitional Integrated Care Strategy and the Suffolk Health and Wellbeing Strategy we have set out the needs of our population using evidence, data and public engagement to compile an overall *case for change* to improve the health and outcomes for the people of Norfolk and Waveney. This is section 3.0.
2. **What** our ambitions for improvement are – these are our eight ambitions, with initial objectives identified. This is section 4.0.
3. **When** we expect to deliver – we have created a summary roadmap that illustrates when there will be activity happening on each ambition. This is in section 5.0. Within each objective there are detailed trajectories and milestones for implementation.
4. **How** we are going to work together differently to deliver this – these are the seven ways of working that we have agreed and are set out in section 6.0. This is a really important journey for us to go on as a system, these are our enablers and we have some key areas to focus on – these are equally as vital as the ambitions and objectives themselves.
5. **Commitment** to achievable, measurable and impactful improvements **–** this is how we will know we are achieving our objectives, in our first JFP. Our objectives have been aligned to the NHS Medium-Term Financial Plan to ensure they are affordable, recognising capacity constraints and competing priorities. Working together as system partners is key to our achievement. This is section 7.0.

Each of these five points are set out in more detail in the sections that follow.

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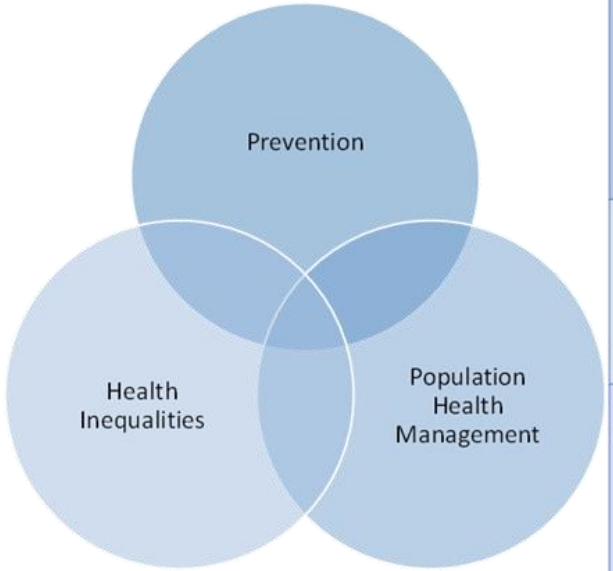
3.0 Why we are doing this – the case for change

In this section we talk about Population Health Management (PHM), Health Inequalities (HI) and Prevention so we have explained what we mean by these terms in the picture below. They are interlinked and help us to give us information about what we can do differently, and what will make the most difference to people.



Prevention – 3 levels 1. Primary prevention - taking action to reduce the occurrence of disease and health problems before they arise 2. Secondary prevention - detecting the early stages of disease and intervening before full symptoms develop 3. Tertiary prevention – softening the impact of an ongoing illness. For more information - Prevention | Local Government Association

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them. NHS England » What are healthcare inequalities?

Population Health Management is a way of working, using joined-up local data and information to better understand the health and care needs of our local people and proactively put in place new models of care to deliver improvements in health and wellbeing. For more information - NHS England » Population Health and the Population Health Management Programme

3.1 Summary of health need for Norfolk and Waveney population

In this section we present a summary of our local population and our associated health needs using a population health management and health intelligence approach, which has been led by our public health team. It makes a compelling case for focussing on the ambitions we have chosen, and particularly what we can do now on prevention, to improve our health and well-being for the future. Let's look at some of the key facts about Norfolk and Waveney[1]:

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[1] Numbers are rounded

- In 2021 there were 8,750 births and 12,860 deaths[2]
- In June 2022 there were 1,081,700 people registered with a General Practice in Norfolk and Waveney.
- During 2022, patients attended 6,280,000 appointments with General Practice [3] (this means that on average, each person across Norfolk and Waveney attended about 6 appointments), and 75.6% of people have a positive experience of their GP practice
- In June 2022 75,000 children had visited an NHS dentist in the previous 12 months and 309,000 adults visited an NHS dentist in the previous two years[4]
- During 2021/2022
    - 57,000 people in Norfolk and Waveney were in contact with Mental Health, Learning Difficulties or Autism services and 16,000 of these were under 18[5]. This is over 5% of the total population and over 8% of the population under 18
    - A&E and emergency departments saw 298,500 attendances[6] with 101,105 Norfolk and Waveney patients admitted as an emergency[7].
    - There were 1,285,000 hospital outpatient appointments and 165,700 hospital operations – of which 111,650 were operations for people on the waiting list[7]
- 165,000 people in Norfolk and Waveney live in the 20% most deprived communities in England (known as the core20 population)[8]
- As of January 2023, 126,700 people in Norfolk and Waveney have 4 or more diagnosed long term health conditions (LTC's) (physical health and/or mental health conditions)
- In terms of physical health, in 2021/2022 the number of people diagnosed with LTC's include 176,900 with high blood pressure, 70,400 with diabetes, 39,600 with heart disease, 30,200 with atrial fibrillation or a common abnormal heart rhythm, 24,400 with COPD which is a lung condition that causes breathing difficulties and 78,900 with asthma[9].
- In terms of mental health, 9,800 people are diagnosed with dementia, 10,400 people are diagnosed with a serious mental illness and 111,500 are diagnosed with depression[9]
- In 2020 across Norfolk and Waveney there were 6,580 cancers diagnosed[10]
- We know there are opportunities for longer term prevention. For example, there are estimated to be
    - more than 120,000 smokers, more than 500,000 people overweight or obese and more than 180,000 who do not exercise[9]
    - more than 89,000 people with high blood pressure that has not yet been diagnosed and managed[11]

[2] https://www.nomisweb.co.uk/
[3] https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice (during 2022)
[4] https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/general-practice-data-hub/dentistry (to June 2022)
[5] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/2021-22-annual-report
[6] https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2021-22
[7] https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2021-22
[8] https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice
[9] https://fingertips.phe.org.uk/ (applying Norfolk prevalence to estimates to Norfolk and Waveney population 19+)
[10] https://digital.nhs.uk/data-and-information/publications/statistical/case-mix-adjusted-percentage-of-cancers-diagnosed-at-stages-1-and-2-in-england/2020
[11] https://www.norfolkinsight.org.uk/wp-content/uploads/2022/08/State-of-Norfolk-and-Waveney-health-report-2022_correctedByPAVE.pdf

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Item 6 Appendix 1

These facts and figures give us some of the context about the health of our population and the scale of the activity that goes on, week in week out. The longer term prevention opportunities and the number of people who have LTC's highlight where we can focus to make a difference.

3.2 The growing population – our older population

We now want to spend some time looking at some facts and figures about our older population in this section, and why we have an ambition of transforming care in later life. Norfolk and Waveney generally has an older population and this is projected to increase at a greater rate than the England average. This creates a key challenge for our health and care system. From 2020 to 2040 there will be an estimated:

- 36% increase in people aged over 65, mostly in those aged 75+
- 3% increase in people of working age
- 1% decrease in children and young people under the age of 16

The greater increase in those in later life compared to those of working age by 2040 means that there will be fewer people of working age for every person under 16 or of retirement age, which has implications for our workforce.

Over the next five years the population is expected to grow by more than 25,000 people, and about 20,000 will be those aged 65+. We anticipate this to continue, and by 2040 the population is likely to have increased by about 110,000 people, this is about the same as the current population of North Norfolk.

As a result of this we can expect to see an increasing demand for appointments at doctors, dentists and hospitals, emergency admissions, and an increase in the numbers of people with LTC's and increased need for care. For example, if nothing changes and current rates apply to the increasing population then over the next five years:

- the demand for appointments with a doctor is likely to have increased by more than a 1,000 per day
- the number of people with 4 or more LTC's which need ongoing management is likely to have increase by about 1,800 per year
- the number of people going to A&E is likely to have increased by about 900 per month
- the number of people who have to stay in hospital having arrived as an emergency is likely to have increased by about 500 per month

For the 126,700 people with 4 or more LTC's the average cost for hospital care for is more than £4,300 per year[12]. The expected increase in the number of people with 4 or more LTC's is likely to add an additional £7.75 million pounds per year to hospital care costs. There are also additional prescribing costs for medication, and GPs will spend time managing these patients.

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This is just the tip of the iceberg and is why it is so important that we prioritise transforming care in later life as one of our ambitions.

[12] Weighted average of costs from Population and Person Insights Dashboard https://tabanalytics.data.england.nhs.uk/#/site/viewpoint/views/Segmentation/SegmentSummary

3.3 We can make a change

What is encouraging to note is that the risks for many LTC's can be reduced through changes in health behaviours and addressing unwarranted variation in clinical care. We have set out a clear ambition in relation to PHM, health inequalities and prevention to start the work on this.

Preventing LTC's 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 time frame by improving other aspects of the health and care system like urgent and emergency care, mental health services, services for families and babies, children and young people and people in later life which are all ambitions in our JFP.

However, there are some poor outcomes for some people at different stages along their life course (Figure 1) and we want to tackle those. For example, for children and young people a higher proportion of pregnant females smoke, and young children are more likely to be admitted to hospital as an emergency. When developing our ambitions and objectives we have carefully considered what this outcomes life course is telling us and focussed on where we need to make improvements based on the evidence.

In addition to smoking, being overweight is one of the biggest causes of illness that can be prevented – it can lead to diabetes, problems with bones, joints and muscles ('musculoskeletal') and heart disease (cardiovascular).

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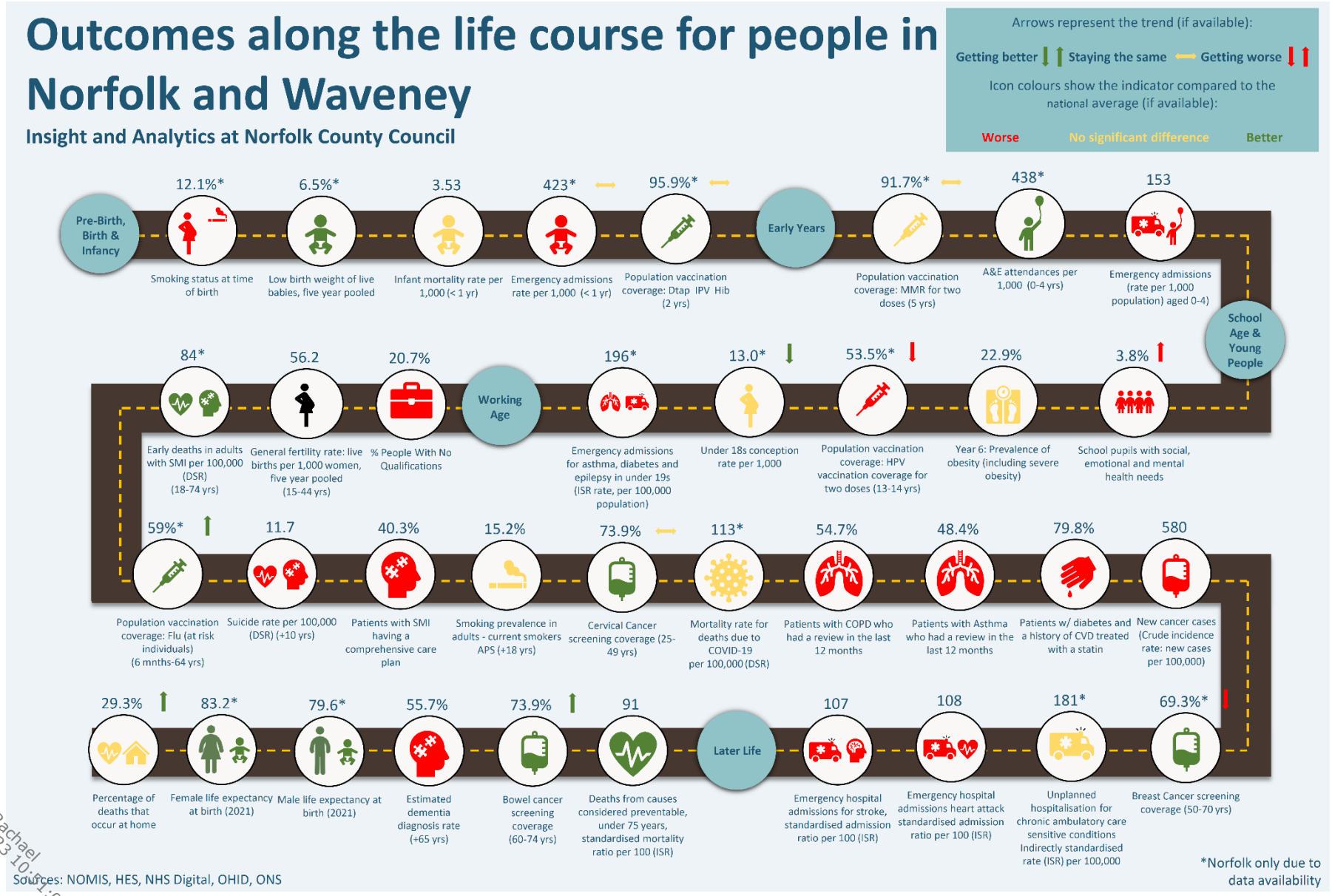

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Figure 1 – Outcomes along the life course for people in Norfolk and Waveney

3.4 Health Inequalities

Aside from the conditions that people die from, the amount of disability or illness that people have varies according to where you live – that is a fact. In Norfolk and Waveney many health outcomes for people are as good or better than in England overall as a comparison, and males and females generally live longer lives in Norfolk and Waveney than the England average. However, there are stark inequalities in outcomes for people in the 20% most deprived communities (known as "core 20"), that then accumulate over the life course. These result in poorer health outcomes and ultimately a shorter life expectancy.

The State of Norfolk and Waveney report 2022[13] shows that the 165,000 people of Norfolk and Waveney that live in some of the 20% most deprived communities in England[14] are more likely to:

- have harmful health behaviours, such as smoking and being less active
- have multiple, limiting, long-term conditions
- attend A&E and be admitted to hospital for an emergency
- be in poor health before reaching retirement age
- and to die early

(Core20 and Core20PLUS5 are explained in more detail in the **legal duty to reduce health inequalities**, Part 2 of the JFP)

The core 20 populations in Norfolk and Waveney are shown on the map in Figure 2 and we know that the health outcomes for the populations in our most deprived communities could be improved further.

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[13] https://www.norfolkinsight.org.uk/wp-content/uploads/2022/08/State-of-Norfolk-and-Waveney-health-report-2022_correctedByPAVE.pdf
[14] https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice

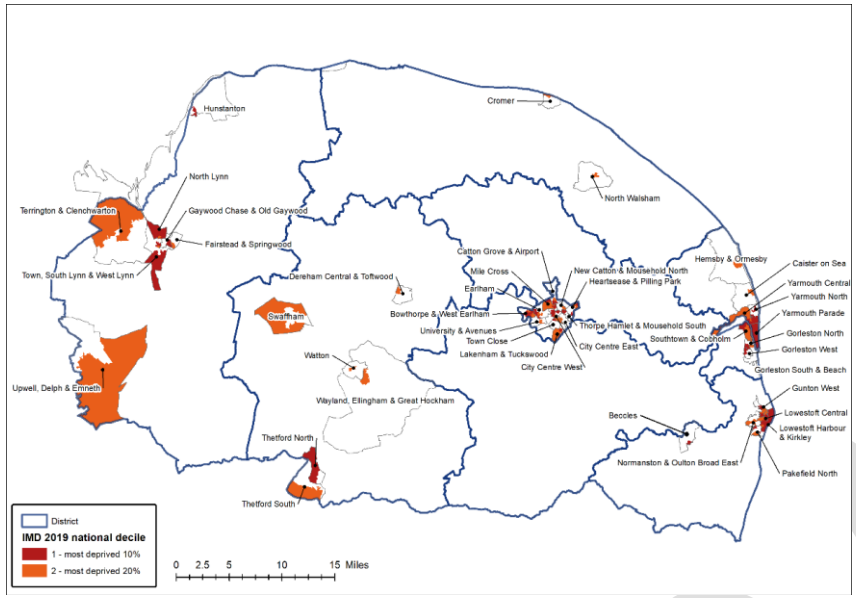

Figure 2 – "Core20" communities across Norfolk and Waveney where some or all of the residents live in the 20% most deprived areas in England according to IMD2019

For example, Figure 3 compares the least deprived communities with the most deprived "core20" communities:

- babies in the most deprived areas are 50% more likely to be of low birth weight and 30% more likely to die before they are one year of age.
- young children are 50% more likely to be admitted as an emergency
- year 6 children are 40% more likely to be obese
- teenage girls are 5 x more likely to have children
- people are 3 x more likely to take their own life
- and people are more than 3 x more likely to die from preventable causes

Other population groups in addition to those that live in the most deprived communities are also more likely to have poor health outcomes and to die early. For example, children and young people with learning difficulties or autism and those that are looked after are more likely to experience mental health issues.

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As people move into adulthood those with learning difficulties are 4 times more likely to die early than others with similar characteristics and those with severe mental illness are 3.7 times more likely to die early[15]. Many of these deaths are preventable.

[15] https://www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness

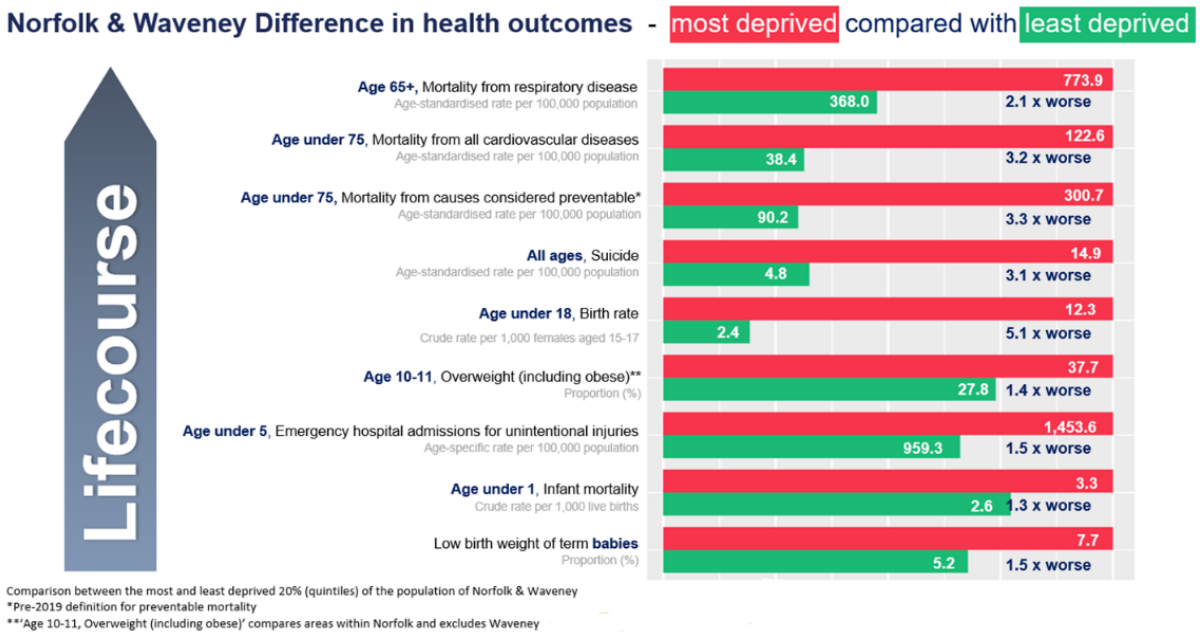

Figure 3 Inequalities in health outcomes between the least deprived and the most deprived core20 communities in Norfolk and Waveney

The accumulation of inequalities over the life course for those in the more deprived core20 communities has an impact on the number of years a person is likely to live.

Across Norfolk and Waveney in 2020-2021 the gap in life expectancy between the most deprived core20 communities and the least deprived communities was 6 years and 9 months for males and 5 years and 4 months for females.

This gap is due to more deaths in the core20 communities from heart attacks, strokes, cancer, respiratory disease and COVID19[16] (Figure 4).

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[16] https://analytics.phe.gov.uk/apps/segment-tool/

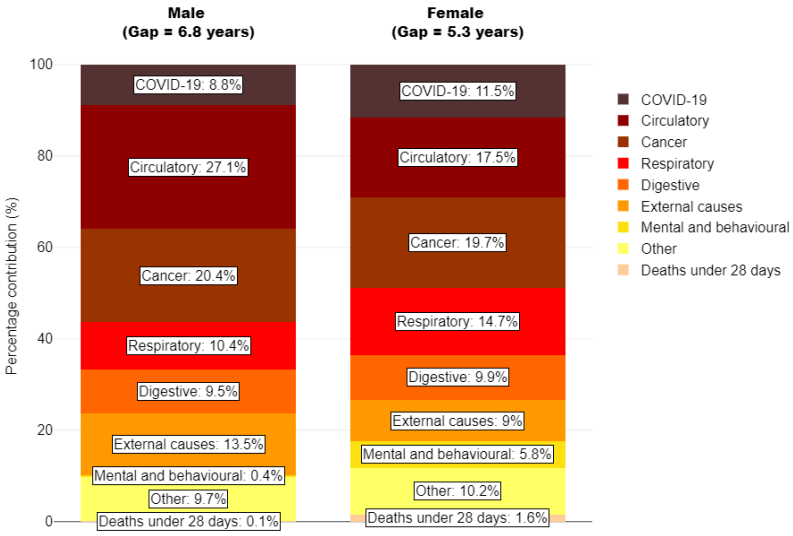

Figure 4 Breakdown of the life expectancy gap between the most and least deprived quintiles of NHS Norfolk and Waveney by cause of death, 2020 to 2021 (https://analytics.phe.gov.uk/apps/segment-tool/)

3.5 Opportunities to improve outcomes

This is all very concerning but some of this gap in life expectancy is preventable by changing health behaviour and addressing unwarranted variation in clinical care. For example, about 20% of the life expectancy gap is due to Cancer. 38% of cancers are preventable, 15% of all cancer is caused by smoking and 6% by obesity[17].

Across Norfolk and Waveney just over half of all cancers are diagnosed early[18] and while overall screening uptake is good (and this helps with earlier diagnosis), people from the core20 most deprived communities are less likely to be screened for cancer. For example, there are 46 GP practices in Norfolk and Waveney where the proportion of people screened for bowel cancer is less than the Norfolk and Waveney average. If all these practices screened at least the Norfolk and Waveney average then an additional 3,500 people would be screened for cancer. For the core20 most deprived GP practices this is an additional 1,300 people, which is more than a 1/3 of the total.

Changing health behaviour will reduce the number of preventable cancers and increasing the numbers of people with cancer diagnosed early, through screening and smoother progress through care pathways, means that chances of survival are better and outcomes improved.

There are also opportunities to improve in outcomes for people with respiratory and circulatory conditions through changing health behaviours and reducing unwarranted variation in clinical care. For example, Norfolk and Waveney has a higher prevalence of COPD than England (2.3% vs. 1.9%)

[17] https://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/preventable-cancers
[18] https://www.cancerdata.nhs.uk/stage_at_diagnosis

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but has a lower proportion of COPD patients that receive a 12-month review (55% vs 60%). And there is variation across Norfolk and Waveney from practices with 10% of patients with a 12-month review to practices with over 90% of patients with a review. For circulatory conditions the Cardiovascular Disease (CVD) prevent work shows that if we were to detect and optimally manage 17,000 the hidden cases of high blood pressure then we would save more than 100 heart attacks and more than 150 strokes over the next three years[19]

Due to inequality in health behaviours, the opportunities for improving outcomes are likely to be greater in the core20 most deprived communities. As deprivation increases the proportion of people with risky health behaviour also increases. Over the long term if we are to reduce inequality in life expectancy due to cancer, circulatory and respiratory conditions, then we will have to address health behaviours such as smoking, physical activity, obesity and diet.

Opportunities to improve outcomes are not only limited to physical health conditions but there are also opportunities to improve outcomes for those with severe mental illness. For example, of the people with severe mental illness only 40% have a comprehensive care plan compared to the England average of 50%. Across the Norfolk and Waveney GP practices this ranges from under 5% of patients to 100% of patients. By at least matching the England average across Norfolk and Waveney, 900 extra people would have a comprehensive care plan with potential risk of self-harm reduced.

By improving health behaviours and reducing unwarranted variation in services and care across Norfolk and Waveney and along the life course, it is an opportunity to improve outcomes for those from the most deprived communities AND reduce the demand on hospitals and GP practices.

This evidence makes for compelling reading and our focus on reducing health inequalities and prevention is key to improving the health and well-being of our local population.

The JFP includes a range of ambitions that address both some of the current issues in relation to those in later life and younger people, those experiencing poor mental health and those with existing LTC's. We also want to update our model for Urgent and Emergency Care and reduce the waiting times for planned operations as these are all affecting our population. Critically though the JFP signals an intent to get ahead of the curve, and the opportunity we have to reverse some of the most concerning trends and variations.

There are opportunities through:

- primary prevention, intervening before health effects occur. For example, by changing health behaviours and vaccination
- secondary prevention, intervening to reduce the impact of disease that has already occurred. For example, regular patient reviews and by managing conditions appropriately
- tertiary prevention, intervening through surgery or similar. For example, coronary artery bypass grafting, to prolong life in some people with stable congenital heart defects that have been present from birth

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[19] https://www.cvdprevent.nhs.uk/home

3.6 Public engagement on the JFP so far

In addition to the data and evidence base that we have turned into a life course, we have also started our public engagement to understand what matters most to the people of Norfolk and Waveney. At the time of the engagement in December 2022 to January 2023, we had started with the five ambitions listed below. We asked if local people thought they were still correct.

1. Transforming Mental Health services
2. Improving Urgent and Emergency Care
3. Improving Elective Care
4. Developing a resilient and integrated model of Primary Care
5. Improving Productivity and Efficiency

We were told that some things were missing, so we added three more:

6. Population Health Management, Reducing Inequalities and Supporting Prevention
7. Improving services for Babies, Children and Young People and developing our Local Maternity and Neonatal System (LMNS)
8. Transforming care in later life

Our online survey received **700** responses in total.

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505 people out of **585** who responded (just over 86%) strongly agree or agree that we have chosen the right priorities. **249** people also left free text comments, for example:

- The absence of **social care** as a priority was highlighted by some
- Perception that **GP access** needs improving
- More **NHS dentistry** needed
- Issues highlighted around **older and other vulnerable people being in hospital beds** due to lack of flow through the system, or disconnected services
- Concerns raised about **finances** – how staying within budget will impact services, and how all the priorities are to be afforded
- Emphasis on **community care,** including **end of life and palliative,** as well as primary care
- Someone who disagreed said that **early help and prevention was missing**
- Concerns about **out of county mental health provision**, and lack of **early and preventative mental health** provision, especially for **children and young people** and people with **Autism**
- Issues raised about **recruitment and retention of staff**, including social care
- Some comments that the priorities do not reflect the future aspirations of an ICS and are '**stuck in the past**'

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- Access to services for **people with extra needs,** e.g. Learning Disabilities and Autism, deaf/hearing impaired
- Improved **digital connectivity** between services, alongside the recognition that some people are **digitally excluded**

537 people out of 592 who completed surveys (just over 90%) responded to **What matters most to you?**
Many of the points listed above were made again, but other issues raised include:

- Knowing an ambulance will come if I need it
- Getting help with caring responsibilities
- Palliative and end of life care, and bereavement services
- Working with VCFSE and community organisations
- Simple ways of getting help – a single front door
- Joined up services, better collaboration and integration, services under one roof, continuity of care
- More help for people to help themselves
- Support for vulnerable people – homeless, CYP, families and older people
- Getting an appointment, especially with a GP – some like face to face, some online
- Shorter waiting times
- Some comments about better communications, and campaigns about using services and self help
- Health and care services aimed at men, and delivered by male staff
- Increase funding for prevention services, including physical and talking therapies, and public education and awareness raising
- The role Oral Health has to play in promoting and protecting general health and wellbeing
- Developing and supporting our workforce to help retention
- Several comments about the Walk-in Centre in Norwich and the need for a new hospital in King's Lynn

You can read the full report, including examples of the comments people made, on our dedicated webpage: JFP page. (Please note JFP microsite will be active to coincide with launch of the final plan).

This is not the end of the conversation. The projects that will form part of the ambitions and their underpinning objectives will need engagement, involvement and co-production with local people, those who use our services and our workforce. We will build an ongoing programme of participation that includes a range of participation methods. Working with our people and communities will be vital if we are to create services that meet the needs of the different people and groups that live in Norfolk and Waveney. Within part 2 of our JFP you can also read more about our legal duty **to involve the public** where there are some useful web-links to further material.

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4.0 Our ambitions for improvement

4.1 2023/2024 immediate priorities

We have two timescales, the immediate priorities that Norfolk and Waveney ICS confirmed to NHS England to meet national NHS planning requirements, and the longer-term improvements captured in our eight ambitions.

We have summarised the immediate priorities below as they are important and form some of the first year elements of our JFP.

Each year the NHS is asked to produce an operational plan detailing the activity levels, performance standards, workforce numbers and financial plans for the next 12 months. Each of these elements are triangulated to ensure consistency, such as an increase in activity is supported by an increase in staffing, which in turn is included in the financial projections. These plans are developed together as a system, working in partnership to achieve the required aims and ambitions as set out in the NHS Priorities and Operational Planning Guidance. The latest 2023/2024 NHS guidance can be found here: Operational Planning Guidance

The operational plan contains many different metrics to enable the NHS to monitor its delivery during the year and there are many links through to the ambitions in the JFP such as:

- Improving the flow of **urgent and emergency care** patients in to and out of our services. We have said we would improve our discharge pathways through increasing the number of virtual ward services for example. This in turn will reduce the length of stay in hospital, bed occupancy, and enable the emergency department to see more patients within 4 hours; allowing ambulances to be released to respond to category 2 calls in the community.
- **Continue to reduce the number of people waiting** for diagnostics and elective care. During the year the plan is to reduce the number of people waiting over 65 weeks for elective care by over 8,000. This and future reductions in waiting times will be achieved by working more closely together, reducing waiting times for diagnostics, faster earlier cancer diagnosis and using technology.
- Increased capacity for people of all ages to **access mental health services earlier**, such as Psychological Therapies and specialist community perinatal services. To manage care closer to home by reducing out of area placements.
- Continue to **address health inequalities and improve prevention services**. For adults this is maternity continuity of care, severe mental health checks, respiratory conditions, early cancer diagnosis and case finding and treating high blood pressure. For children and young people, the focus will be on asthma, diabetes, epilepsy, oral health and mental health.

Through the work undertaken to develop our local plans, we have built upon the system integration and joint working to produce a cohesive and challenging set of targets to deliver on, for the benefit of our population. These are consistent with a number of the ambitions and objectives in the JFP.

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4.2 Our eight longer-term ambitions for improvement

The 2023/2024 immediate priorities are not quick fixes and so feed into the longer-term ambitions. Our eight ambitions are evidence based and consistent with what we heard from our public engagement, with a clear focus on planning ahead to make improvements and to get ahead of the curve with prevention. We have also looked at our local population across the course of an entire lifetime, from conception to end of life, to examine outcomes to inform where improvements could be made.

Our eight ambitions are described in more detail in this section, but this is not the only work we are doing. This JFP does not describe 'business as usual must-do's', such as existing and on-going work that is already underway to support the delivery of the NHS Long Term Plan. If we were to do this, our JFP would simply be too large and complex to be useful as a delivery plan.

As system partners we all want to use this plan because it identifies common ambitions, and we can all lean in to support and drive forward improvements together.

This is why we have purposely selected and made a commitment to a number of achievable, measurable and impactful improvements, presented in this section as Objectives, linked to each of the eight ambitions.

These objectives have been developed in response to what our data tells us, and they require a collaborative system-wide approach to successfully deliver them.

Some of the objectives commit to doing more work to develop key strategies, such as for Population Health Management (PHM), Health Inequalities and for people in later life. Others are much more specific projects with defined and measurable outcomes.

We will refresh this JFP at least annually, with the next version ready for April 2024, and ensure our objectives remain current and focused on what we need to deliver.

A summary of the eight ambitions and 21 underpinning objectives is set out in Figure 5.

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	Joint Forward Plan eight Ambitions and underpinning objectives
	Ambition Objectives
1	**Transforming Mental Health Services**
1a	Build system resources for early intervention and prevention for people of all ages, including those who experience mental health inequalities. This work will include enhancing and expanding skills and knowledge of mental health across our populations; providing a framework of tools and capacity to support mental wellbeing; and delivering a refreshed suicide prevention strategy.
1b	Mobilise mental health system collaboratives to facilitate partnership working and deliver better health outcomes for our residents. The focus of the adult collaborative in year one is to improve support for older people living with dementia, delirium and depression which also has alignment with the Ambition Transforming Care in Later Life.
1c	Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'integrated front door' so all requests for advice, guidance and help are accepted, and support provided to navigate the system and meet the presenting level of need. This will be developed in line with the Thrive principles, with children and young people at the centre of delivery with resources wrapped around them, enabling them to Flourish.
1d	See the whole person for who they are, beyond their complex behaviour. Develop pathways that support and promote recovery for people living with multiple and complex needs – with a focus on dual diagnosis and complex emotional needs (CEN)
2	**Improving UEC**
2a	Improve emergency ambulance response times
2b	Expand virtual ward services
2c	Delivery of the Improving Lives Together programme to reduce length of stay (LoS) in hospitals
3	**Elective Recovery & Improvement**
3a	Effectively utilise capacity across all Health System Partners
3b	Implement digital technology to enable elective recovery
4	**Primary Care Resilience & Transformation**
4a	Developing our vision to provide a wider range of services closer to home, improving patient outcomes and experience
4b	Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.
5	**Improving Productivity & Efficiency**
5a	Improve the services we provide by enhancing productivity and value for money, embracing digital innovation and delivering services together where it makes sense to do so.
6	**PHM, Reducing Inequalities & Supporting Prevention**
6a	Development and delivery of two strategies to support prevention: A Population Health Management Strategy, and a Norfolk and Waveney Health Inequalities Strategy to deliver the "Core20plus5" approach
6b	Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people
6c	Early Cancer Diagnosis - Targeted Lung Health check Programme
6d	Cardiovascular disease Prevention
7	**Improving Services for Babies, Children, Young People & Maternity**
7a	Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach
7b	Continued development of our Local Maternity and Neonatal System (LMNS), including the Three Year Maternity Delivery Plan
7c	Reducing health inequalities including an initial focus on asthma, epilepsy and mental health
7d	Develop an improved and appropriate offer across Norfolk and Suffolk for Children's Occupational Therapy, to meet their needs
8	**Transforming Care in later life**
8a	To develop a shared vision and strategy with older people that will help us to transform our services to be easy to access and designed and wrapped around the needs of older people.

Figure 5 – summary of the eight ambitions and 21 underpinning objectives

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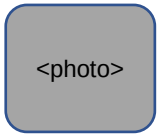
Ambition 1 Transforming Mental Health Services



Dr Ardyn Ross, Clinical Mental Health Lead, N&W ICB, May 2023

"*Our aim is to ensure that people of all ages can access timely and responsive support for all their mental health needs. Working together with partners across health, care, VCFSE and our experts with lived experience, we will offer person centred care at an earlier stage, and provide services that are compassionate, holistic, and responsive guiding people towards better mental health".*
Dr Ardyn Ross, Clinical Mental Health Lead, N&W ICB, May 2023

We hope the JFP will lead to the personalised, joined-up, holistic, timely and ongoing care and support for the people of Norfolk and Waveney that is needed. This includes addressing mental health inequalities, particularly neurodivergence and Autism.

We hope more effective partnership working will mean people are more connected to wellbeing support as well as the right care for them. We hope a joined-up culture will mean more sharing and support for people who support and care for people too, both unpaid carers and staff.

We look forward to continuing to be involved as equal partners in the implementation of the JFP, ensuring effective influence based on lived experience insight from the people and communities of Norfolk & Waveney.

Expert by Experience Reference Group, May 2023 – to be updated
(Please Note, the statement above is strictly draft and subject to final agreement with Experts by Experience).

Our objectives

a) Build system resources for early intervention and prevention for people of all ages, including those who experience inequalities or challenges to their mental health and well-being due to vulnerabilities or reduced protective factors. This work will include enhancing and expanding skills and knowledge of mental health across our populations; providing a framework of tools and capacity to support mental wellbeing; and delivering a refreshed suicide prevention strategy.

b) Mobilise mental health system collaboratives to facilitate partnership working and deliver better health outcomes for our residents. The focus of the adult collaborative in year one is to improve support for older people living with dementia, delirium and depression, which also has alignment with the Ambition Transforming Care in Later Life.

c) Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'integrated front door' so all requests for advice, guidance and help are accepted, and support provided to navigate the system and meet the presenting level of need. This will be developed in line with the Thrive principles, with children and young people at the centre of delivery with resources wrapped around them, enabling them to Flourish.

d) See the whole person for who they are, beyond their complex and co-occurring needs. Develop pathways that support and promote recovery for people living with multiple and complex needs – with a focus on dual diagnosis and complex emotional needs (CEN).

What would you like to see in our five-year plan for health and care services? What matters most to you?

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Children and young people have told us by developing a Mental Health Charter that what matters to them is: -

- Services will care
- Staff will support and be well supported themselves
- Right help, right time, right way
- Treatment will be personalised to meet individual needs
- Communication will be effective
- Young people will have a voice

People with experience of mental health services and others who responded to recent a further mental consultation have also stated *'We must put more focus on prevention and invest in this area, including de-stigmatising mental health – we must see looking after our mental health the same as eating 5 fruit and veg a day'.* They also told us:

- they wanted to be 'empowered to access intervention and holistic wrap-around-care, which supports long-term recovery and on-going they want to 'experience person-centred care, and be treated as an individual, rather than as a diagnosis'. They want choice in how care is delivered and a focus on "what matters to me", instead of "what's the matter with me".
- their diagnosis is only one part of their health journey. Their other physical or mental health conditions, as well as life events, might (or might not) be impacting on my current state. These also need to be considered and addressed.

Why we chose these objectives

Mental health conditions can have **a substantial effect on all areas of life, such** as **school or work performance, relationships with family and friends** and **ability to participate in the community. P**eople with mental health conditions often experience severe human rights violations, discrimination, and stigma

As we can see from the Life Course Infogram in section 3.3, there are increasing numbers of school age pupils with social, emotional and mental health needs, suicide rates are increasing within working age people, and the number of people diagnosed with dementia in later life is up by 55%.

Key vulnerable groups who may be affected by poor MH include children, young people and families, people who experience long term conditions and men experiencing financial and economic constraints and/or relationship breakdown. Improving the offer of proactive and preventive support is a priority outcome for this ambition, where we aim to intervene quickly and broaden the range of specialist support offers to enhance recovery. People with lived experience tell us that the interconnection between mental, social, and physical health is not always recognised, meaning service users, especially those with complex and neurodivergent needs, who do not feel these are met. We will continue to build on our joint working, considering inequalities and additional needs across our population and support personalised approaches to care.

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Who we are going to be working with to deliver this	This Mental Health Ambition is aligned with existing strategies and plans across the ICS in Norfolk and Waveney. It is aligned with our partners in these areas:
• Norfolk and Suffolk County Councils – Adult and Children Social Care, Public Health • Norfolk & Suffolk Foundation Trust • Cambridge and Peterborough Foundation Trust • Hertfordshire Partnerships Foundation Trust • East Coast Community Healthcare • Norfolk Community Health & Care • Change Grow Live Norfolk Alcohol & Drug Behavioural Change Service • University of East Anglia • Cambridgeshire Community Services • VCFSE • Primary Care • Place Boards and HWP's • NHS England • Norfolk and Norwich hospital • James Paget Hospital • Queen Elizabeth Hospital • Our approach will be guided by the considerations outlined in the N&W I-Statements and will be coproduced with experts by experience, service users and carers, children and young people and families	Building system resources for early intervention and prevention including those who experience MH inequalities links to Better Together for Norfolk, Norfolk County Council's high level strategic priority of *Healthy, fulfilling, independent lives* with a focus on prevention and early help, working collaboratively to deliver outcomes. Early Intervention, Prevention and developing pathways that support and promote recovery for people aligns with the **Promoting Independence strategy** and **Connecting Communities programme** core ambitions of Adult Social Services and **Ready to Act, Ready to Change** Public Health Strategy, based on the recognition that early intervention allows people to live healthier, more fulfilling lives. By continuing to embed the Thrive model and ensure resources work around the child, with the child at the centre, enabling them to Flourish Flourishing in Norfolk: A Children and Young People Partnership Strategy – Norfolk County Council. NCC is also currently developing an **Adult Mental Health strategy** that align to these objectives. **Norfolk County Council Public Health:** • Public Health Audit: Suicide in Norfolk 2022 (norfolkinsight.org.uk) • Norfolk Suicide Audit Summary (norfolkinsight.org.uk) • PowerPoint Presentation (norfolkinsight.org.uk) • PMH_NW_Analysis_Final.pdf (norfolkinsight.org.uk) • Infographic_Mental_Health_and_Wellbeing_FINAL.pptx (live.com) This ambition links to *Our Ambitions for Suffolk*, Suffolk County Council's objectives as set out in its Corporate Strategy 2022-26. As part of its objective for promoting and supporting health and wellbeing, the Council will work with the NHS, district and borough councils, and other partners to prioritise the mental and physical health of all people in Suffolk. Actions will also look to create communities and

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	environments that promote and enable healthier, active lives and tackle issues such as isolation, loneliness and obesity. Through its objective of strengthening the local economy, the *Corporate Strategy 2022-26* also recognises the significant impact that economic wellbeing can have on mental and physical health and wellbeing. Suffolk's transitional Joint Health and Wellbeing Strategy 2022-23, Preparing for the Future, includes priorities for: • Public mental health • Good work and health • The wellbeing of children and young people • Listening and engaging with local voices Actions across these priorities aim to: • Strengthen the protective public factors and lessen the impact of social and contextual factors that adversely impact mental health, such as unemployment, loneliness, social isolation, crime, migration, unsafe environments, and poor housing. • Work to promote healthy workplaces and strengthen the factors that can protect against poor mental health in work setting. • Work with partners, including Integrated Care Systems, to strengthen children's and young people's mental and emotional wellbeing. • Listen to the voices coming from employers, have conversations that support mental health and wellbeing, and hear the priorities of children and young people Our Trust Strategy | Norfolk and Suffolk NHS (nsft.nhs.uk)

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Objective 1a Build system resources for early intervention and prevention for people of all ages, including those who experience mental health inequalities. This work will include enhancing and expanding skills and knowledge of mental health across our populations; providing a framework of tools and capacity to support mental wellbeing; and delivering a refreshed suicide prevention strategy.

Mental Health Transformation
Improving Urgent & Emergency Care
Elective Recovery & Improvement
Primary Care Resilience & Transformation
Improving Productivity & Efficiency
PHM reducing inequalities & Supporting Prevention
Improving Services for Babies, Children, Young People & Maternity
Transforming Care in later life

What are we going to do?

1. Develop an ICS structure for mental health literacy, which builds a framework of offers
2. Co-produce, implement and promote a system wide resilience framework
3. Co-develop a refreshed N&W Suicide Prevention Strategy & action plan

How are we going to do it?

Building on the targeted grant programme for vulnerable groups and the health promotion campaign 'Take 5' we will develop 2 complementary programmes which will empower communities and individuals to increase their wellbeing:

1. Mental Health Literacy will enhance and expand the skills and knowledge on mental health. To achieve this a community mental health literacy programme will be developed, to inform the workforce and general population about wellbeing and the mental health continuum and promote activities to keep people well and enable pathways into services if needed. Training and resources will be aimed at:
   - increasing skills to recognise and address wellbeing concerns
   - enable individuals to effectively manage their own wellbeing.
   - Building capacity across the wider system including in the voluntary and community sector to manage wellbeing in the community

What are the key dates for delivery?

There are three clear new priority activities with the following **milestones**

Year 1 April 2023 – Sep 2023
Develop the recommendations to the system regards introduction of a mental health literacy framework and explore options for resourcing.
Year 1 Oct 2023 – Mar 2024
Publish a co-developed refreshed **suicide prevention strategy**, with agreed monitoring.
Agree on a system approach to delivery of the **mental health literacy framework**.
Year 2 April 2024 – Sep 2024
Begin implementation of the targeted workstreams in the action plan of the refreshed suicide prevention strategy. Ensure monitoring is established.
Year 2 Oct 2024 – Mar 2025
Coproduce and promote a system wide **resilience framework** for and with communities.
Launch implementation of the **mental health literacy framework**
Year 3 April 2025 – Mar 2026
Year 3 and 4 – Implement the **resilience framework** and deliver initiatives i.e., impact of sleep and tools to improve sleep quality
Year 4 April 2026 – Mar 2027
Year 5 April 2027 – Mar 2028
Review the suicide prevention strategy.

How will we know we are achieving our objective?

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This will build on two emerging system projects focussed on children and young people – the Talk Centre, and the Health Education England Mental Health learning programme. 2. The Resilience Framework will provide tools and capacity to support mental wellbeing. This will provide a structured framework which provides individuals and communities with the tools to increase and maintain wellbeing will be coproduced, to ensure a consistent standardised approach in the Norfolk and Waveney area. This framework will include a focus on wellbeing initiatives such as a targeted sleep campaign, so that there is a common language and practical solutions to manage mental health and wellbeing. These commitments complement existing prevention initiatives such as digital wellbeing tools, support for schools & families, Community Wellbeing Hubs, and NHS Talking Therapies. We continue to work with experts by experience and learn from others "what good looks like'. 3. the Suicide Prevention Partnership will coproduce a refreshed five-year Suicide Prevention strategy, with anticipated key themes for action around Self Harm, Bereavement, and Primary Care pathways for people with depression – as informed by audits. While this work is underway, we continue to raise awareness, operate campaigns to reduce stigma, provide accessible training, and invest in community assets tailored to specific at-risk groups. There is commitment to continue monitoring outcomes through Suicide Prevention Audits, and real time surveillance on self-harm and suspected suicides **How are we going to afford to do this?**	**Measures** Office for Health Improvement and Disparities, Public Mental Health Dashboard • Self-reporting mental wellbeing – the number of people reporting high anxiety, low happiness and low worthwhile scores Suicide Prevention • Rates of suicide and self-harm

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	The initiatives described will be funded from existing provision in the first instance. We will seek to identify what can be achieved through improved partnership working, at no/low cost and scope where additional resource would improve delivery. We have a good track record of developing successful funding proposals when additional national funding has become available. However, going forward the key resources that would need to be prioritised in the system for this work to succeed are a greater investment and emphasis in frontline prevention roles and activities over time, which enable communities rather than navigating to services. Work is currently underway to scope additional resources to deliver the best possible approaches, however, this is likely to include: • Programme management x 2 • Resources development x 2 • Broader system workforce training on mental health literacy, mental health first aid and suicide prevention first aid. • Voluntary and community sector capacity • Continuing to commission delivery of services	

Objective 1b Mobilise mental health system collaboratives to facilitate partnership working and deliver better health outcomes for our residents. The focus of the adult collaborative in year one is to improve support for older people living with dementia, delirium and depression which also has alignment with the Ambition Transforming Care in Later Life.		
Mental Health Transformation Improving Urgent & Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency	**What are we going to do?** Establish an adult Mental Health (MH) system collaborative and a Children and Young People (CYP) System Collaborative. **Adult Mental Health System Collaborative:** Identify opportunities to work collaboratively, using available data, intelligence, and insights, which focus on improving mental health and wellbeing of adults and older people.	**What are the key dates for delivery?** **Year 1 April 2023 – Sep 2023** ○ Adult MH System Collaborative and CYP System Collaborative Core Executive groups and associated delivery groups launched. ○ Rolling programme of engagement/co-production established (to inform the specific work of the collaboratives as they seek to redesign clinical pathways). ○ Establish delivery groups drawn from the wider membership to develop and implement the redesign agreed by the core executive; considering available data, information, and insights

PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	Consistently using a system-wide perspective when considering how to deliver more integrated, high-quality cost-effective care. **Children and Young People System Collaborative:** Implementation of the Thrive model. In particular, making structural, operational, and cultural changes required to deliver community based multi-disciplinary team working across organisations, to ensure collective support to meet the emotional wellbeing, mental and physical health needs of the Child or Young Person and their family. **How are we going to do it?** Embedding a new approach that: ○ focuses on early intervention and prevention – moving the resource and support further upstream over time and reducing the reliance on specialist and acute support ○ focuses on 'place' and the development of support within local communities – with less reliance on specialist settings, clinics, or institutions ○ moves away from a focus on a clinical model to one which builds understanding and resilience of community-led early support, and which develops the skills and resources of people, families, and communities to help themselves. **How are we going to afford to do this?** Through the development of the Mental Health System Collaboratives, we will work with providers to ensure our collective resource is efficiently and effectively used across the system, embracing opportunities to improve quality, efficiency, and effectiveness. We intend to make use of existing resources in a different way. For example, existing community-based	to understand enablers i.e. workforce, and identify and agree resource. ○ Monthly meetings of the Adult MH System Collaborative and CYP System Collaborative Core Executives will provide oversight and accountability for delivery of expected outcomes. **Year 1 Oct 2023 – Mar 2024** ○ Continued coalition building; gaining commitment of individual organisations to work together to achieve the new ways of working ○ Achieving tangible action; setting an action plan and agreeing local metrics to measure impact ○ Review arrangements **Year 2 April 24 onwards** ○ Building and strengthening on the Year 1 foundation activity; expanding goals as the programme progresses, recognising success and reflecting on lessons learned. ○ Continued checking back with older people living with dementia, delirium and depression and children, young people and families with emotional wellbeing, mental and physical health needs that the transformed services are meeting their needs. **How will we know we are achieving our objective?** Access to support is streamlined, responsive and coordinated for: - Older people living with dementia, delirium and depression - Children or Young Person with emotional wellbeing, mental and physical health needs. The impact will be measured by actively seeking people, families, and professional's feedback before and after any change that is implemented.

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	teams would be upskilled to support people and families with early dementia, which will free up capacity within the specialist teams to support people with more complex needs and reducing the existing specialist waiting lists. This process will be repeated for other conditions and for children and young people too.	

Objective 1c Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'integrated front door' so all requests for advice, guidance and help are accepted, and support provided to navigate the system and meet the presenting level of need. This will be developed in line with the Thrive principles, with children and young people at the centre of delivery with resources wrapped around them, enabling them to Flourish.

Mental Health Transformation
Improving Urgent & Emergency Care
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Transforming Care in later life

What are we going to do?

Norfolk and Waveney health and care partners are launching an integrated front door (IFD) to support Children and Young People (CYP) aged 0-25 with an emotional wellbeing or mental health need to access the right support at the right time. By developing a 'needs led' single integrated access point for all emotional wellbeing and mental health enquiries and requests for support, the aim is that Children and Young People across Norfolk and Waveney will have timely support to allow them to flourish.

How are we going to do it?

The ICB and CYP system partners work collaboratively within a strategic alliance, ensuring that services are committed to working together to provide the best possible care and support for CYP and their families. The IFD will build on this approach to working in an integrated and collaborative way through developing a single place to request advice, guidance and/or support based on an understanding of children and young people's needs. This will provide:

What are the key dates for delivery?

Year 1 April 2023 – Sep 2023

- Launch Interim Arrangement for mild-moderate emotional wellbeing and mental health requests for support
- Coproduce and launch a health and wellbeing website specifically aimed at young people

Year 1 Oct 2023 – Mar 2024

Launch the Integrated Front Door to include all emotional wellbeing and mental health pathways (0-25 years) of support (except crisis, which will continue to be accessed through 111 mental health option)

Year 2 April 2024 – Sep 2024

Launch the Professional Therapeutic Pathway through the IFD

- Refine data and reporting processes (including real-time reporting on system waits and coding) to ensure an improved experience for service users and professionals

Year 2 Oct 2024 – Mar 2025

Develop and embed Artificial Intelligence (AI) and machine learning solutions to improve efficiencies across the IFD

Year 3 April 2025 – Mar 2026

Work with system partners to scope additional CYP and family support services that could be accessed via the IFD and plan for implementation

Year 4 April 2026 – Mar 2027

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	- **Self-Care** support, through validated digital resources and tools, including guided self-help, with a 'request for support' process that automatically leads to suitable resources - **Advice and Guidance –** Improved access to advice and guidance through a single telephone number, and offering timely, single session interventions where clinically appropriate - **Request for Support –** One trusted pathway for children, families and professionals to ask for emotional wellbeing and mental health support. The IFD clinical team will triage and assess every request for support and allocate to the most appropriate service offer to meet the needs of children and young people. **How are we going to afford to do this?** The IFD programme is fully resourced through identified mental health service development funding (SDF) and is factored into medium term financial plans. Any efficiencies gained through implementation of the IFD will be re-invested into enhancing the range of emotional wellbeing and mental health service offers and capacity available.	**Year 5 April 2027 – Mar 2028** **How will we know we are achieving our objective?** 1) Increased proportion of CYP and families directly accessing support for their MH through self-referral 2) More CYP and families will access emotional wellbeing and MH support interventions 3) Reduced waiting lists for CYP to access specialist therapeutic interventions due to optimising capacity and patient flow by integrating system offers 4) An increased number of CYP accessing support for their MH need through advice and guidance, single session and low-intensity interventions across the system 5) Reduced referrals into 'getting more help' and 'getting risk support' based interventions 6) Increased numbers of CYP achieving positive wellbeing outcomes due to the intervention received supporting the presenting need

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Objective 1d See the whole person for who they are, beyond their complex needs. Develop pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on Dual Diagnosis and Complex Emotional Needs (CEN).		
Mental Health Transformation Improving Urgent & Emergency Care	**What are we going to do?** **Complex Emotional Needs:**	**What are the key dates for delivery?** **Year 1 (first half) April 2023 – Sep 2023** **Complex Emotional Needs:**

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Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	1. Further implementation of the Personality Disorder/Complex Emotional Needs strategy, including the development of a collaborative system-wide pathway. 2. Increasing access to psychological therapy for people with complex emotional needs, wherever they present in the system. **Dual Diagnosis:** 3. Develop a recognised system-wide dual diagnosis pathway – with consideration to other issues, social or physical that are commonly associated with this cohort **How are we going to do it?** We will work together, as providers and stakeholders, engaging those with lived experience, at all stages from design to delivery to improve access and care for people with dual diagnosis (defined as those with Mental Illness and substance misuse issues), and complex emotional needs', inclusive of this with Neuro Developmental Disorders (NDD). Accessibility and inclusion are enabled and a "no wrong door" approach will be developed across system partners aiming to meet individuals' needs. Our goal is to make these pathways as inclusive, accessible and as flexible as possible to our population to promote recovery and independence. System provision will be collaborative and should seamlessly cover unmet needs. We will continue to develop the PCN mental health provision, embed the Complex Emotional Needs Strategy and pathway, and join system partners to collaboratively support people with dual diagnosis.	• Provide system wide pathway workshops to map pathways, develop, and integrate the PD/CEN pathway • Integrate new mental health roles within Primary Care Networks • Continuing to develop the evidence-based therapy offer within place based communities and secondary care. • Widen the availability of the Knowledge and Understanding Framework multi-agency training to wider system partners **Dual Diagnosis:** • Establish multiagency pathway leadership and group • Establish mechanism for engaging lived experience. • Increased joint working for mental health and substance misuse teams • Mapping and gap analysis of existing provision, considering and exploring digital health initiatives (Virtual consultations) • Carry out training audit **Year 1 (second half) Oct 2023 – Mar 2024** **Complex Emotional Needs:** • Establish regular pathway integration meetings • Provide a tiered offer of therapeutic interventions for PD/CEN within the Primary care network. • Widen the availability of formulation and supported psycho-education workbook training to wider system partners. • Integration of senior clinical roles into the MHICI, providing consultation to the whole system • Planning the provision of therapeutic interventions of PD/CEN within the primary care network and VCFSE partners based on analysis of unmet needs **Dual Diagnosis:** • Establish protocol for local data collection • Draft of Norfolk & Suffolk Foundation Trust and Change Grow Live pathway with formal agreement **Year 2 (first half) April 2024 – Sep 2024** **Complex Emotional Needs:**

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	How are we going to afford to do this? The initiatives described will be funded from existing provision in the first instance. We will seek to identify what can be achieved through improved partnership working, at no/low cost and scope where additional resource would improve delivery. We have a good track record of developing successful funding proposals when additional national funding has become available. Where initiatives are not funded partners will work collaboratively to explore where the impact of existing resources can be maximised. The Mental Health Integrated Community Interface (MHICI) will consist of system partners joining together to provide this function to improve the experience of people with complex needs.	• Delivery of a tiered offer of therapeutic interventions for PD/CEN within the Primary care network. • Identify therapy providers and upskill existing staff to meet the therapy gaps • Pilot the use of new roles such as the Clinical Associate Psychologists to meet therapy needs in primary care **Dual Diagnosis:** • Implementation within financial constraints and/or develop funding proposals should additional national funding become available **Year 2 (second half) Oct 2024 – Mar 2025** **Complex Emotional Needs:** • Starting to deliver some therapy provision within the primary care networks developed to meet identified system gaps • Complete implementation of CEN Strategy & integrate our pathways across provider collaboratives • Launching our psychological therapies at place level **Dual Diagnosis:** • Consider further pathway work on wider elements of provision **How will we know we are achieving our objective?** Complex Emotional Needs: • 300 additional staff trained per year in KUF, DBT or psychologically informed approaches system-wide • Increase in numbers of service users able to access a psychologically informed intervention outside of the NHS talking therapies and secondary care offer Dual Diagnosis • Referrals into services being accepted via the dual diagnosis pathway • A reduction in presentations to Emergency departments for service users with mental health needs and drug or alcohol problems

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Ambition 2 Improving Urgent and Emergency Care

Dr Lindy-Lee Folscher, ICB clinical lead for UEC (NNUH)

"The aim is to ensure that the population we serve receive the right care, in the right place, at the right time. Everyone should receive the best care that meets their needs whether they access that care through their GP, 111, 999 or by walking into an Emergency Department (ED)"

Our objectives

a) Improve emergency ambulance response times
b) Expand virtual ward services
c) Delivery of the Improving Lives Together programme to reduce length of stay (LoS) in hospitals

What would you like to see in our five-year plan for health and care services? What matters most to you?

Recent JFP consultation feedback: "Involve other services such as the ambulance service when making your 5-year plan as when all the other services fail it's always the ambulance service picking up the pieces". "Next best thing is more rehab beds for step down patients who do not require an acute bed but are simply not well enough to be at home independently. "Really investing in digital health is crucial to ensure joined up, continuity of care". "Easier access to Primary Care services closer to home services in the community to prevent hospital admission or facilitate early discharge home from hospital."

Why we chose these objectives

We want our population to be confident that when an emergency happens the local NHS is there to rapidly respond. This means we must continuously improve our emergency and urgent care services and adapt to our population's changing needs, take advantage of new technologies and develop trusted relationships across all health and care organisations in Norfolk and Waveney.

We know our population wants to receive care at home and avoid stays in hospital where it is safe to do so and the evidence tells us this is best for people too, avoiding deterioration in mobility through bed-based care or hospital acquired infections. Two of our priorities focus on keeping more people at home through enhancing joint working and collaboration between community teams and ambulance services as well as expanding our virtual ward that has technology at the heart of it. Our third priority is making sure that where hospital is the best place for people to be cared for, there are quick, integrated processes to get people home with the support they need to recover.

The COVID pandemic response enabled lots of our teams to integrate and work closer together however, we still have more to do. The Life Course Infographic in section 3.3 illustrates that for our older people who have a heart attack or stroke and our younger children, further work is required to improve admission to hospital where this is clinically necessary.

In 2018 Boston Consulting Group worked with the Norfolk and Waveney system to analyse demand and capacity across the entire health and care system. The report identified mismatches in demand and capacity across the system, which if not addressed would result in a bed

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deficit position by 2023. The recommendations highlighted that these challenges could not be overcome by a single provider but only by the entire health and care system working collectively behind a single vision for urgent and emergency care services and going further with integration. Our three priorities for urgent and emergency care take the next step in collaborative working across organisations to respond to patients when a need arises.

Who we are going to be working with to deliver this	**The UEC Ambition is aligned with existing strategies and plans across the ICS in Norfolk and Waveney. In particular it is aligned with our Partners in these areas:**
The East of England Ambulance Service (EEAST) including volunteer Community First Responders and other supporting organisations Primary Care Place Boards and Health & Well-Being Partnerships Norfolk Community Health & Care East Coast Community Healthcare CiC Norfolk & Norwich Hospital James Paget Hospital Queen Elizabeth Hospital King's Lynn Norfolk & Suffolk Mental Health Foundation Trust Digital partners such as Feebris for Virtual Wards Care Homes Norfolk County Council and Suffolk County Council Social Care – both adults and children The place-based approach will be critical to the successful delivery of this change. Places will identify which teams will be involved in the urgent community response, how they will work together, what pathways should be led by which teams and who will coordinate the response. This will also mean identifying efficiencies and streamlining the triage process, adopting Trusted Assessor models and operationalising rotational ways of working on a day-to-day basis. All partners play a vital role in our urgent and emergency care response. We will ensure a joined up approach and will be clear about what is best to be delivered once across the system and what is more effectively done at place or neighbourhood level tailored to the needs of local communities.	EEAST's strategy recognises the need to evolve the way care is provided and make the best use of clinical skills and resources available to respond to patients with a care need. This may mean EEAST providing care to a patient at home or it could mean working with community teams to coordinate a rapid home visit from a community matron or therapist who can provide equipment, conduct routine observations and assessments and follow up the next day. This is consistent with the hospitals' shared objective of 'care closer to home'. Receiving the right care, in the right place, at the right time, ambulance response times and reducing Length of Stay links to **Better Together for Norfolk,** Norfolk County Council's high level strategic priority of ***Healthy, fulfilling and independent lives and better local services*** as well as the **Promoting Independence Strategy**, **Connecting Communities Programme**, and **Home Care Support strategy** core ambitions of Adult Social Services and the **Flourish** Priorities for Children and Young People. This JFP ambition links to Our Ambitions for Suffolk, Suffolk County Council's objectives as set out in its Corporate Strategy 2022-26. This priority links to the Council's objective of promoting and supporting the health and wellbeing of all people in Suffolk, through which the Council will: • Work with the NHS, district and borough councils, and other partners to prioritise the physical and mental health of all people in Suffolk.

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	It also links to Suffolk's transitional *Joint Health and Wellbeing Strategy 2022-23*, Preparing for the Future. This recognises the importance of greater collaboration and system-working as a cross-cutting issue. Its guiding principles also cite the importance of collaborative leadership, of ceding power and resources to make a difference, and of aligning planning and developing shared priorities and outcomes. This ambition aligns to the Queen Elizabeth Hospital's 2023/24 Corporate Strategy where there is a clear priority to 'ensure equity of access and consistently timely care for our patients.' This is underpinned by a commitment to 'further improve the timeliness and quality of care for our emergency, cancer, and elective patients in line with operational planning guidance'. Within the Clinical Strategy we have clinical priorities to 'provide safe alternatives to emergency admissions and to focus admissions on patients who need them most' and to 'optimise length of stay for all patients (elective and emergency)'.

Objective 2a Improve emergency ambulance response times

Mental Health Transformation
Improving Urgent & Emergency Care
Elective Recovery & Improvement
Primary Care Resilience & Transformation
Improving Productivity & Efficiency
PHM reducing inequalities & Supporting Prevention
Improving Services for

What are we going to do?

When you call 999 for an ambulance your call is categorised into an urgent or an emergency call.

We will work with the ambulance service and community teams to improve how quickly emergency ambulances can respond to our most unwell patients. To do this, we will support community teams to respond to **urgent** care needs thereby allowing the ambulance service to better respond to **emergencies**.

This will result in more 999 calls being safely and appropriately transferred to community services, where the community is best resourced to respond. You will still receive a visit from a member of your local NHS team. This could be from a community nurse or therapist as part of the 2 hour urgent community response team (UCRT), virtual ward or pharmacy. Community teams will work with

What are the key dates for delivery?

Year 1 April 2023 – Sep 2023

- Existing programme of improvement.

Year 1 Oct 2023 – Mar 2024

- Deliver Category 2 30-minute mean response time by the end of March 2024.
- Maintain consistent 70% 2 hour UCR performance throughout 2023/24.
- Identify appropriate urgent calls for transfer to community response.
- Establish the unplanned care hubs and access routes
- Consolidate community urgent care service access points under the unplanned care hub.

Year 2 April 2024 – Sep 2024

Year 2 Oct 2024 – Mar 2025

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Babies, Children, Young People & Maternity Transforming Care in later life	senior medical specialists who will advise on treatments and can access rapid-access clinics and same day appointments at hospital. For patients with an urgent same day care need this will mean an increasing number of patients able to safely stay at home, supported by local health and social care teams to remain safe. **How are we going to do it?** We will work collaboratively with clinicians in the ambulance service, the community, primary care and others to develop the framework and digital capability to identify and transfer patients from emergency services to urgent community services. Our vision for community response teams an integrated team, working across organisations to share skills and make a greater impact by jointly responding and coordinating care and sharing resources. Leaders from partner organisations will determine how this will be modelled and delivered to meet the needs of the local population. This may mean local variation in how services are set up across Norfolk and Waveney but the outcome will be the same – a rapid response from a clinician suitably skilled to assess and treat the patient. Appropriate urgent 999 calls will be digitally transferred to community unscheduled care hubs which will bring together existing community services into a single point of access. For health and care professionals working in urgent and emergency care services this will result in consistent and standardised access points, a single access route for alternatives to emergency care and easier referral mechanisms to transfer patients between services, which will further support workforce satisfaction and retention. **How are we going to afford to do this?**	• Further review and expansion of the type of urgent calls suitable for transfer from 999. • Review how community capacity can be expanded through continued integration at place level. **Year 3 April 2025 –Year 5 Mar 2028** • Continued integration of urgent and emergency care provision, further collaboration across system partners, including Voluntary, Community, Faith and Social Enterprise (VCFSE) to increase the support available. **How will we know we are achieving our objective?** • Confirm a Category 2 30-minute mean response time by the end of March 2024 National description of C2: ***C2** - Emergency. These calls will be responded to in an average (mean) time of 18 minutes, and within 40 minutes at least nine out of 10 times (90th percentile)*

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	We are working together as a system with all our partners, to make sure our resources are used to support transformation and deliver the care our patients need in the right place at the right time.	

Objective 2b Expand virtual ward services		
Mental Health Transformation Improving Urgent & Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	**What are we going to do?** Virtual Wards allow patients to get the care they need at home safely and conveniently, rather than being in a hospital setting. In a virtual ward, patients are cared for in their home. Support can include remote monitoring using digital technology, wearable medical devices such as pulse oximeters and face to face care provided by multi disciplinary teams in the community. Where patients can leave hospital earlier with remote monitoring support we refer to this as Step Down. All three of our hospitals have a Step Down Virtual Ward in place. We will expand these acute based virtual ward services by increasing the specialties that are supported by virtual ward and by developing a new community-based service to offer an alternative to hospital admission for patients who are unwell in the community – a step up service. We will do this by: • Building a new ICS collaborative partnership to promote joint working, innovation and new ways of working, instead of more traditional commissioning and contracting approaches • Ensuring strong clinical leadership is in place to support collaboration. This will move towards an integrated model of care that uses resources across the system rather than in individual organisations. • Developing a common digital solution with one dashboard for clinical teams to access. • Expanding the conditions that a virtual ward can support to include respiratory, frailty and heart failure provision, as well as pioneering new, locally driven models of care.	**What are the key dates for delivery?** **Year 1 April 2023 – Sep 2023** • Current virtual ward provision. **Year 1 Oct 2023 – Mar 2024** • Put in place a single platform across the ICS to ensure consistent ways of working, reporting and viewing capacity are available. • Launch of the community step up virtual wards across Norfolk and Waveney • Establish consistent tracking against targets to inform the Partnership and aid decision making and risk mitigation • Evaluate virtual wards and use the findings to be at the heart of service transformation. An interim report on the early implementation will be available from October 2023 and will be used in collaboration with all partner organisations to co-design outcome measures for step up and step-down wards. The full report will be available from March 2024. **Year 2 April 2024 – Sep 2024** • Use findings from the evaluation to refine and improve the service. • Agree an ICS wide approach to medicine administration and point of care testing, based on two trials currently under consideration. • Continue to expand the specialties Virtual Ward can support. **Year 3 April 2025 – Mar 2026**

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- Develop a system wide step up model which will play a key role in managing urgent care demand and building capability in the community to safely support people at home outside of a hospital setting.
- We will work with the whole provider community -Primary, Community and Acute care, 999 and 111 (CAS) all need to be part of developing, supporting and using the additional capability that the virtual ward creates, to deliver better outcomes for patients
- Integrate and embed virtual ward in the care system. As well as pioneering new ways of working, there is a huge opportunity to link all pre-hospital initiatives into one overall integrated urgent care 'pre-hospital' model with enhanced clinical oversight that allows the community teams to do more to safely support patients outside of hospital.

How are we going to do it?
Virtual Ward will work across the whole health and care system. We will identify referral routes in and out of virtual ward for equal service provision across Norfolk and Waveney. We will make sure there are automated, digital referral routes and the ability to transfer patient details electronically so patients only have to tell their story once.

Local teams will design the new models of care and supporting processes that will form the Virtual Ward face to face response. These need to be joined up with existing services and offer staff opportunities to work across different organisations to enable better integration and use of skills.

How are we going to afford to do this?
Virtual Ward has an allocation of national funding that is to be used to maintain and expand services. In the longer term it is expected that local areas will need to fund virtual ward services.

As virtual ward expands we anticipate there will be corresponding changes in where urgent care activity is managed – increasingly outside of hospital settings.

- Use outcomes from the evaluation report to further develop virtual wards.
- Continue integration of virtual wards with urgent and emergency care services
- Extend Virtual Ward service to enhance multiple long term condition management to reduce inpatient demand and improve outcomes.

Year 4 April 2026 – Mar 2027

- Continuous cycle of learning and evaluation to respond to patient feedback and improve the service.

Year 5 April 2027 – Mar 2028

How will we know we are achieving our objective?

Trajectories

- By April 2024 we will have 368 virtual ward beds

We will know whether virtual wards are having the impact we want them to have if:

- We are able to increase the patients who are discharged earlier from hospital to a virtual ward (reduced length of stay in the acute hospitals).
- We are able to offer virtual ward as an alternative to admission to hospital (reduction in admissions, number of referrals from Emergency Departments into Virtual Wards).
- We receive good patient feedback and use this to further develop services.
- We can see an increase in virtual ward utilisation across the whole urgent and emergency care system.

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Objective 2c: Delivery of the Improving Lives Together Programme to reduce length of stay (LOS) in hospitals		
Mental Health Transformation Improving Urgent & Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	**What are we going to do?** We want to improve discharge planning and processes, so that you can take the next step in your recovery and rehabilitation after a period of illness, quickly and safely, in a place where you can be as active and independent as possible and stay connected with the people and activities that matter most to you. The 'home first' principle is important to us when we start your discharge planning. We want to make sure that you can return to your home, if this is the right place for you, and meets your needs. If things have changed while you have been in hospital, and home is no longer the right place for you to live, then we can work together to plan what that will look like. The date and time for your discharge home will be agreed with you in advance, to allow you to make plans with carers, loved ones and/or family members and we will make sure you have a supply of medication and a discharge letter to share with your GP so that they know what help and support you may need once you arrive home. Better discharge planning helps to reduce your length of stay in hospital, and reduces deconditioning and the need for readmission, which also helps us to bring people into hospital more quickly when they need emergency or planned care because we have more space and resources. It's about getting you to the right place, for the right care and support, at the right time. **How are we going to do it?** The Improving Lives Together Programme will bring system partners together to lead and deliver improved discharge planning and reduced hospital length of stay, across Norfolk & Waveney. There are two timelines for the delivery of discharge improvement, which will happen alongside each other. We will focus on **process-based improvement** to be delivered in the first 6 months and a programme of wider **transformational improvement** with a longer term 18-month timescale. The **immediate** priorities over the next 3 months	**What are the key dates for delivery?** **First 6 Months: April 2023 to September 2023** • Beginning of Optica phased rollout and real-time tracking of patients through discharge, reducing then eliminating manual Transfer of Care form. Early sight of patient by hubs to start planning complex discharge needs. • Embed SAFER flow bundle and 'red to green' management system. • Focus on early discharge planning for P0 patients and increase P0 discharges through criteria lead discharge and weekend discharge activity. Voluntary sector integration and utilisation by Wards and Discharge Teams. • Agree ITOC system principles, aligning goals and purpose with Place-based delivery. Relationship building & seamless communication. Increase Trusted assessor model. • Increase community bed capacity. • Improve multidisciplinary working to support complex discharge planning for service users awaiting discharge from mental health settings. • Review the ICS Discharge Board and system-level governance. Set and monitor metrics, agreeing principles and

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will be:

1. Mobilise a digital solution (Optica) for managing patients through their discharge pathway more efficiently. It is expected that this will quickly reduce the discharge timeline by up to 14 days in most cases.
2. Focus on early discharge planning, embed the SAFER flow care bundle, and increase the number of Pathway 0 discharges and weekend discharges for people who do not need additional care and support to go home.
3. Build an Integrated Transfer of Care (ITOC) Team at each Place, which will bring together hospital, community, voluntary, therapy, transport and pharmacy resources around the patient and deliver more seamless support.
4. Continue to develop collaborative leadership, with a clear and consistent governance structure to support delivery. Include the needs of people who are being discharged from Mental Health settings into the improvement journey.

The ICS Discharge Board has agreed these priorities and will oversee improvement and delivery of metrics. Principles and outcomes agreed at system level will help ensure consistency while delivery will be driven at Place-level with support from NHSE improvement. In the longer term, the system will create a stable and sustainable model of care for discharge support across the board, but particularly for discharge Pathways 1 to 3, which are pathways for patients who require support following a hospital stay.

Data & Digital

Data is a significant issue and risk for all partners due to the digital immaturity of the Norfolk and Waveney system, however, this highlights the importance of a digital solution to help us monitor, track and report on the discharge position and impact of our interventions and improvements. New national guidance will be issued in 2023 and NHSE will report more discharge data publicly; this will be addressed with current workarounds until Optica is fully operational.

How are we going to afford to do this?

Reducing length of stay for patients improves quality outcomes and offers opportunity for savings to be realised or re-invested. Maintaining people's

outcomes at a system level to ensure consistency.
- Reduction of deconditioning so that patients can leave on the most appropriate pathway.

October 2023 to March 2024

- Continue to map and amend pathways and services to support discharge across the system. Develop and establish the ITOC process at each Place.
- Fully onboard Mental Health into the improvement journey with digital and collaborative leadership.
- Robust oversight of discharge plans to ensure that they are meeting patient needs.
- Reduction in the requirement for intermediate beds and complex long term care packages.

April 2024 to March 2025

- Fully embed Optica digital tool.
- Create comprehensive evidence-based Place-level Discharge Demand and Capacity Plans. NHSE Regional and National Teams to determine the allocation of funding for beds over and above the core offer.
- Evaluation of the programme's effectiveness; review the evidence base and celebrate and share successes.
- Review and reset goals and metrics to measure effectiveness and to evidence continuous improvement.

April 2025 to March 2027

- Deliver a stable and sustainable model of care for discharge. Focus on discharge Pathways 1 to 3, for patients who require

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	independence will enable funding to be diverted toward reablement and care at home, reducing costs associated with long term complex care packages and residential care. Reduced length of stay will reduce the risk of patients deconditioning and needing a higher level of care and support, in the longer term. As part of this ambition, we need to develop a sustainable financing model. To do this we will need systemwide partner financial and operational negotiations, to determine how we can resource changes in activity across organisations and develop workforce models that allow organisations to create the right capacity to meet demand, while also ensuring all providers across our system are able to achieve a breakeven position. **How will we know we are making a difference?** • Reduction in length of stay is the key outcome metric of this programme. • We can see a reduction in the average length of stay in acute and community beds and an overall reduction in use of intermediate care beds. • See improved outcomes for patients following discharge, and better experiences for their carers. Deconditioning and readmission rates will fall. • We can see an increase in our daily numbers of patients discharged. • Can stop using surge and escalation beds to manage day to day pressures. • We achieve or exceed the national target to reduced hospital occupancy to 92% or less.	additional support following a hospital stay; ensuring there is better patient choice and communication with carers so that decisions can be made together. **April 2027 to March 2028** • Digital maturity fully embedded. • A model of care that meets demand.

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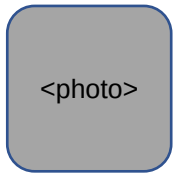
Ambition 3 Elective Recovery & Improvement



Joanne Segasby
CEO of James Paget and Senior Responsible Officer of Elective Recovery across Norfolk and Waveney

"The aim is to work together to improve access and quality of elective care for the people of Norfolk and Waveney with a focus on addressing inequalities"

Our objectives

a) Effectively utilise capacity across all Health System partners
b) Implement digital technology to enable elective recovery

What would you like to see in our five-year plan for health and care services? What matters to you most?
Recent JFP consultation feedback: "Reduced waiting times for urgent surgery for things that are not necessarily life threatening, but which have a massively detrimental effect on our ability to hold down a job, function at a basic level, and live independently without the need to constantly rely on people for support"

Why we chose these objectives
Our patients and communities identified this as their main concern whilst we carried out engagement on the Norfolk and Waveney ICS Clinical strategy - reducing long waiting times and improving access through elective recovery was very important to them. To improve patient safety, outcomes, experience and improve the welfare of our population it is imperative that across Norfolk and Waveney we reduce long waits for elective (planned) care, cancer backlogs, and reduce our waiting times for those needing diagnostic tests. This is likely to also reduce demand on our Urgent and Emergency Care system. These are also national ambitions. **We recognise that fully recovering elective activity is a longer-term piece of work.**

There are increasing numbers of new cancer cases being diagnosed and we know that early diagnosis is key to saving lives so it is essential that we continue to ensure patients can be offered alternative locations for their care and are seen in the right place, at the right time, by the right person. This will mean that complex health care is seen and treated at an acute hospital whilst less complex but potentially 'life limiting' health concerns may be treated elsewhere. This links to and aligns with the work we are doing around the way people are referred for diagnostic testing and/or treatment in the community or via the local GP.

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Who we are going to be working with to deliver this	This elective recovery and improvement ambition is aligned with existing strategies and plans across the ICS in Norfolk and Waveney. In particular it is aligned with our partners in these areas:
Norfolk and Norwich Hospital James Paget Hospital Queen Elizabeth Hospital Norfolk Community Health and Care East Coast Community Healthcare NHS England East of England Cancer Alliance Our local population Our staff Primary Care Leads for Community Diagnostic Centres Independent Sector Our future intention is to increasingly work with: Norfolk and Suffolk County Council Public Health and Social Care teams Voluntary & Community organisations across Norfolk and Waveney	All three hospitals are working together on the development of a joint electronic patient record and development of three diagnostic assessment centres (DAC's), one at each hospital, which will significantly improve access to diagnostic services and reduce waiting times for treatment, especially for a cancer diagnosis. They are also working together to provide community diagnostic hubs in several locations. Two of the three acute hospitals have been successful in securing national Transformation Improvement Funding (TIF) which will see elective hubs built at James Paget hospital and the Norfolk and Norwich hospital. Elective hubs will provide extra theatre capacity. They also benefit from separation from busy A&E departments so that planned care is not interrupted. The Queen Elizabeth hospital in Kings Lynn successfully secured TIF funding to procure a robot which will also help with some procedures. Digital transformation is key for Norfolk and Waveney and is a collective aim. The electronic patient record programme is one of the biggest pieces of digital transformation work we have ever undertaken, moving from paper-based records to electronic ones. By bringing all IT and patient record systems together, we can provide better joined up care wherever patients are treated. Improving performance and providing high quality safe care through service development and transformation is another priority seen throughout the three hospital strategies. An example of this is the combined aim to have a single waiting list across our three acute hospital trusts which helps to achieve and sustain improved waiting times for patients. This is linked to Objective two of this Ambition. The hospitals are working with Primary Care Networks (PCNs) in Norfolk and Waveney. The PCNs are speaking to individuals on waiting lists for planned care and checking they still want to be seen and, if so, would they wish to travel to another place of care if it meant being seen sooner.

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	This partnership working will reduce waiting lists and give increased levels of patient choice. This ambition links to *Our Ambitions for Suffolk*, Suffolk County Council's objectives as set out in its Corporate Strategy 2022-26. Through these, the Council will: • Work with the NHS, district and borough councils, and other partners to prioritise the physical and mental health of all people in Suffolk. • Expand the council's integrated health and care technology offer, including greater take-up through NHS organisations in Suffolk, Children and Young People's Services, and the private sector, to help more people to live safe and independent lives. • Play a major role in building one linked health and care dataset for adults across Suffolk; and will also provide new analytics, with health colleagues, to help design and deliver new, targeted health and wellbeing interventions The ambition also links to Suffolk's transitional *Joint Health and Wellbeing Strategy 2022-23*, Preparing for the Future. This recognises the importance of greater collaboration and system-working as a cross-cutting issue. Its guiding principles also cite the importance of collaborative leadership, of ceding power and resources to make a difference, and of aligning planning and developing shared priorities and outcomes. This ambition aligns to the Queen Elizabeth Hospital's 2023/24 Corporate Strategy where there is a clear priority 'to ensure equity of access and consistently timely care for our patients.' This is underpinned by a commitment to 'further improve the timeliness and quality of care for our emergency, cancer, and elective patients in line with operational planning guidance'. Within the Trust's Clinical Strategy, we have a clinical priority to 'optimise length of stay for all patients (elective and emergency)' and to 'transform outpatient services using technology to become a more responsive, patient focused service'.

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Objective 3a Effectively utilise capacity across all Health Partners

Mental Health Transformation
Improving Urgent & Emergency Care
Elective Recovery & Improvement
Primary Care Resilience & Transformation
Improving Productivity & Efficiency
PHM reducing inequalities & Supporting Prevention
Improving Services for Babies, Children, Young People & Maternity
Transforming Care in later life

What are we going to do?

We will identify and utilise all available capacity to ensure residents access the right service, at the right time in the most convenient and suitable location. Through working in partnership, we will identify whole system transformational opportunities. This will reduce waiting times, deliver care in more convenient locations and provide a more patient centric service.

We will continue to narrow health inequalities in access, outcomes, and experience for our population and ensure this is supported by a strong workforce, digital capabilities and is co-produced with all partners including the residents and patients.

We will

- Deliver more diagnostic care.
- Deliver more elective care.
- Increase day case elective procedures.
- Reduce cancer backlogs.
- Reduce unnecessary outpatient follow up appointments.

How are we going to do it?

We will deliver more diagnostic care.

Norfolk and Waveney have been asked to develop plans and business cases for multiple Community Diagnostic Centres (CDCs) and are waiting for confirmation of national investment to proceed.

- Our plan is to invest in state-of-the-art diagnostic equipment across our geography, new diagnostic centres at acute hospital sites and in the community setting to increase capacity to offer a suite of multiple diagnostic tests in 'one stop' closer to where you live.
- Streamlined access for Primary Care colleagues to enable direct access to diagnostic tests and clinical guidance across the health services to meet the needs of the individual.
- Tackle health inequalities by creating better access to diagnostic testing in our deprived areas.

What are the key dates for delivery?

Year 1 April 2023 – Mar 2024

- Mutual Aid rolled out across specific specialties and patient groups.
- PIFU rolled out across specific specialties.
- Norfolk and Norwich Orthopaedic Centre opened
- James Paget Hospital Elective Surgery Hub opened
- There will be additional diagnostic capacity across Norfolk and Waveney (national funding dependent)
- The system will work collaboratively to optimise direct access for primary care across health services.
- Continue to support Primary Care in the delivery of the Earlier Cancer Diagnosis PCN DES
- Continue to support the hospitals to implement the Best Practice Timed Pathways for Cancer
- Implementation of a clinical decision support tool for cancer in primary care
- Share the learning from improving access to cancer services for people living with learning difficulties project

Year 2 April 2024 - Mar 2025

- Mutual Aid rolled out across all specialties and all patient groups.
- Patient Initiated Follow Ups rolled out across all specialties.

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- We will optimise what we do and share best practice to standardise procedures, processes and pathways to increase productivity, efficiencies and clinical quality.

We will deliver more elective care.

- Mutual Aid' (whereby patients are asked if they would be happy to be treated at any of the three acute hospital trusts in Norfolk and Waveney if their treatment can be completed sooner) will be further rolled out.
- Increasingly use data to help understand key areas to improve.
- We will build additional theatre capacity at our acute hospital sites. (i.e. Elective hubs)
- We will more readily share best practice between the acute trusts thereby appropriately increasing standardisation of procedures, pathways and support functions.
- Together these approaches will increase theatre productivity where patients need to be treated in a theatre, but it will also contribute to increased planned care treatments in Hospital Outpatient clinical areas, GP practices and Community care settings.

Increasing rates of 'day case' elective procedures

- We will use national best practice initiatives such as High Volume Low Complexity (HVLC) and Get it Right First Time (GIRFT) to ensure that where appropriate Norfolk and Waveney residents are able to fully benefit from 'Day Case Care' for planned care procedures.
- This will ensure patients have reduced length of stay and risk of complications.
- This will also help release beds and prevent cancellations of planned care procedures which need overnight stay(s) in hospital.

Reducing cancer backlogs

- We will use evidence and audit to co-produce pathways with primary and secondary care, standardising pathways and ensuring appropriate safety netting where possible.
- Continue to embed system-wide nationally defined Best Practice Timed Pathways (BPTP) for cancer, and vague symptoms pathways to improve efficiency, diagnosis, and patient experience

- Norfolk and Norwich hospital Elective Hub opened
- A further increase in diagnostic capacity across Norfolk and Waveney (national funding dependent)
- Develop an approach to fixed term posts funded through cancer transformation funding to improve sustainability
- Develop career pathways for cancer nursing and therapeutic radiography to support recruitment and retention

Year 3 April 2025 – Mar 2026

Expand collaborative working with Public Health, social care and VCFSE partners.

Years 4 and 5 Apr 2026 – Mar 2028

Throughout the phases of this objective, we will review the benefits and explore further opportunities to enhance Elective Recovery & improvement including our digital technology which will inform our strategic direction for years 4 and 5.

Additional Clinical Equipment at Queen Elizabeth Hospital Kings Lynn: Funding utilised on Cancer Diagnostic Equipment (£1.6m), Theatre Equipment of £2.0m & General Clinical Equipment of £3.0m.

How will we know we are achieving our objective?

Waiting time will reduce for patients:

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- We will build on our current projects using PHM approaches to identify people who are at a higher risk of cancer, and those with inequitable access to cancer services, so we can apply these methodologies to cancer backlogs in the future. This will form part of the development of our ICS PHM strategy.
- Provide additional workforce capacity to support clearance of the waiting list
- Ongoing work to raise awareness of cancer guidance within primary care to reduce the variation in quality of referrals

Reducing unnecessary outpatient follow up appointments.

- One of key approaches is called PIFU (Patient Initiated Follow Ups) to prevent clinically unnecessary appointments and to ensure that any appointment is booked by the patient at a date, time and location which is convenient to them.
- Clinicians will discuss with patients *what* and *when* is expected post intervention and, unless recovery is different from the discussed recovery pathway, the patient will not attend an Outpatient Follow Up appointment.
- We will ensure there are opportunities for the patient to request (or initiate) a Follow Up appointment if they are unhappy or worried in anyway and details how to do this will be given to patients.
- Patients will notice they have more involvement and/or choice of whether to have Follow Up appointments. This will save patients time and transport costs, whilst at the same time releasing clinician time to other priority areas.

How are we going to afford to do this?

National capital funding (TIF) has been requested through the development of local plans and business cases to support Elective Hubs, Community Diagnostic Centres and Diagnostic Access Centres. We await final funding decisions before we can move forward with these initiatives.

Elective

- Patients will not wait any longer than 65 weeks for their planned care treatment by March 2024 and 52 weeks by March 2025.

Diagnostics

- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%

Cancer

- Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.
- Continue to reduce the number of patients waiting over 62 days.
- Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028.

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Objective 3b Implement digital technology to enable elective recovery

- Mental Health Transformation
- Improving Urgent & Emergency Care
- Elective Recovery & Improvement
- Primary Care Resilience & Transformation
- Improving Productivity & Efficiency
- PHM reducing inequalities & Supporting Prevention
- Improving Services for Babies, Children, Young People & Maternity
- Transforming Care in later life

What are we going to do?

We will implement digital technology and initiatives to support our ambition for elective recovery and improvement.

Digital is a key enabler for improvements in health and care in Norfolk and Waveney and our ICS Digital Strategy sets out clear priorities for improvement. A single waiting list for all three hospitals is stated within our Digital Transformation Strategic Plan and Roadmap as a priority.

- **Peri-operative care** - Digital initiatives will be rolled out in peri-operative care which will allow patients to complete important personal health and lifestyle questionnaires online to streamline the process.
- This will help ensure patients are 'fit and ready' for their planned care/treatment which will reduce cancellations, reduce length of stay and improve recovery.
- We will support patients to "wait well" and identify and prioritise patients at risk of potential harm while waiting.
- We will ensure non-digital options will also be available for those who do not have access to, or cannot use, IT and those who prefer not to.

- **Single Waiting List** - We will have one waiting list across our three hospitals to ensure patients waiting for treatment at any of our hospitals will receive the same levels of access to care (i.e. waiting times for treatment) and we will proactively offer patients an alternative location to receive their treatment if they could be seen more quickly.
- We want to ensure everyone on the waiting list has 'equity of access' This is important as we have pledged to work to actively reduce health inequalities in Norfolk and Waveney.

How are we going to do it?

- Online Peri-operative care is being tested in Trauma and Orthopaedics first as this is a speciality which has large numbers of patients waiting for treatment.

What are the key dates for delivery?

Year 1 Apr 2023 – Mar 2024

- Online Peri-Operative Care testing complete and rolled out in two of the three hospital trusts.
- Single waiting list testing phase for Trauma and Orthopaedic, Cancer, Ophthalmology, Vascular and Endoscopy complete.
- Single waiting list in operation at all three hospitals by March 2024 for selected specialities

Year 2 Apr 2024 – Mar 2025

- Online Peri-Operative Care implemented in all hospitals.
- All hospitals using the single waiting list across all services.
- All patients at the point of referral to have the choice of the waiting list management to be predicated on the *place* of care or the *timeliness* of their care.

Year 3 Apr 2025 – Mar 2026
Increased levels of data quality assurance routinely seen across all three hospitals waiting lists.

Year 4 and 5 Apr 2026 – Mar 2028

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	• The next phase of testing with be specialities such as Ear, Nose and Throat and Gynaecology as these also have large waiting lists. • The intention is roll out across all specialities in two of the three hospitals by March 2024. The final hospital intends to roll out online Peri-operative across its specialities by March 2025. • This will also help prevent cancellations of planned care procedures which need overnight stay(s) in hospital. • To implement the single waiting list, a new piece of IT Software has been purchased and is currently being implemented in specific areas of care such as Trauma and Orthopaedic and Cancer to test that it is working properly. It is anticipated the testing stage should be completed before the summer of 2023. • Next, we will expand the testing to other areas of care such as Ophthalmology, Vascular and Endoscopy, it is anticipated this will be completed by the autumn of 2023. • Our intention is for all three hospital trusts to be using the single waiting list by March 2024 • This will enable us to actively manage our single patient waiting list to support patients to 'wait well' and identify and manage those at greater risk of harm. • The following years will see increased confidence levels in staff using the new IT software, the process to be really embedded and for all patients to have the choice of the waiting list management to be predicated on the *place* of care or the *timeliness* of the of their care at the point of referral. **How are we going to afford to do this?** We have purchased the software and hardware necessary for both the Peri-Operative Care and single waiting list initiatives. The Peri-Operative Care business case has identified future costs which have been agreed as per the signing off of the business case. With regards to the single waiting list there will be some costs associated with training although the 'Train the Trainer' model should keep costs to a minimum.	Throughout the phases of this objective, we will review the benefits and explore further opportunities to enhance our digital technology will inform our strategic direction for years 4 and 5. **How will we know we are achieving our objective?** By measuring how many patients have been offered mutual aid once our single waiting list is in place. We will also measure how many patients took the opportunity to choose a different place against those who chose to wait at their preferred treatment location.

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Ambition 4 Primary Care Resilience & Transformation

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"The aim is to integrate primary care services to deliver improved access to a wider range of services from a multi-disciplinary team. This will deliver more proactive care, preventing illness and improving outcomes, for local communities closer to home."

Our objectives

1. Developing our vision for providing a wider range of services closer to home, improving patient outcomes and experience.
2. Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.

What would you like to see in our five-year plan for health and care services? What matters most to you?
Recent JFP consultation feedback: "Primary care needs to be top of the list. People are attending A&E because they cannot see a GP, that needs transforming first. It's been the same for years". "Preventing and managing ill health starts in primary care." "NHS dentistry should be a priority within the primary care focus". "For me personally, primary care and specifically the GP surgery is the key priority. I believe that all the other priorities are heavily dependent on the performance of GP surgeries."

Why we chose these objectives
Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care is an umbrella term which includes general practice, community pharmacy, dentistry, and optometry (eye health) services.

Nationally, all primary care services are facing greater challenges than ever due to workforce shortages, alongside an increasingly complex workload. Norfolk and Waveney have an ageing workforce within general practice with approximately 30% of staff being over the age of 55. In the last 10 years, the number of dentists has declined in our area compared to the East of England region and the whole of England. This decline has a greater impact in Norfolk and Waveney due to higher levels of need, areas of deprivation and a higher number of residents in later life. Poor oral health is widely considered to be an important aspect of our general health and wellbeing and is largely preventable and can have a significant impact on quality of life, such as eating, speaking, discomfort and cause an increase in days lost from work and school.

Our ambition aligns with The next steps for integrating primary care: Fuller stocktake report which outlines the new vision for integrating primary care services to improve access, experience and outcomes for our patients and communities.
NHS England has recently published the Delivery plan for recovering access to primary care which focuses on the need to streamline access to care and advice, reducing the number of people struggling to contact their practice and so that patients know how their request will be managed, on the day they contact their practice. The plan also outlines the ambition for expanding community pharmacy services to make them the first port of call for minor common conditions, supporting better integration in line with the vision set out in the Fuller stocktake report.

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We will

- empower people to understand and manage their health and wellbeing through coordinated care and support networks and, as far as possible, people will be able to manage their health and wellbeing where they live, in their homes and communities.
- make care more personalised; providing individuals with support tailored to their needs, rather than a one-size-fits-all approach which can lead to inequalities in access and health outcomes.

Who we are going to be working with to deliver this	**This primary care ambition is aligned with existing strategies and plans across the ICS in Norfolk and Waveney. In particular it is aligned with our partners in these areas:**
Primary Care Networks (PCNs) General Practices Dentists Community Pharmacists Optometrists Local Medical Committee Local Dental Committee Local Dental Network Local Pharmaceutical Committees Local Optical Committee Our local population Norfolk & Norwich Hospital James Paget Hospital Queen Elizabeth Hospital Norfolk Community Health & Care East Coast Community Healthcare CiC VCFSE sector District Councils County Councils Care Homes Place Boards and HWP's NHS England	PCNs have identified the top three priorities as: • increasing the workforce and building resilience, • improved interface between primary and secondary care and supporting care closer to home, • Better managing complex need and frailty at home. To support this PCNs are • Ensuring the right staff are in the right place to meet health and care needs, • Addressing organisational barriers so we make decisions and implement at pace, • Empowering our people to test opportunities through collaboration and working differently together. Developing integrated neighbourhood teams, services closer to home, improving patient outcomes and experience and stabilising dental services by building a local resilient multi-skilled professional workforce links to **Better Together for Norfolk**, Norfolk County Council's high level strategic priority of ***Healthy, fulfilling, independent lives -levelling up health, living well and better local services*****.** Developing integrated neighbourhood teams to provide a wider range of services closer to home, improving patient outcomes and experience aligns with the **Promoting Independence strategy, Connecting Communities Programme,** and **Home Care Support strategy** core ambitions of Adult Social Services and **Ready to Act, Ready to Change** Public Health Strategy, based on

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	improving accessibility to services allows people to live healthier, more fulfilling, independent lives. Increasing joint working in communities so more families are able to get the support they need in the places and spaces that they already visit, or in their homes is part of **Flourish** Children and Young Peoples Strategy. This ambition links to *Our Ambitions for Suffolk*, Suffolk County Council's objectives as set out in its Corporate Strategy 2022-26. In particular, this priority links to the Council's objective of promoting and supporting the health and wellbeing of all people in Suffolk, through which the Council will: • Work with the NHS, district and borough councils, and other partners to prioritise the physical and mental health of all people in Suffolk. • Enable residents to lead healthier, active lives and address health inequalities, including working to combat isolation and loneliness and tackling obesity. • Continue, through its services, to prioritise vulnerable older people and adults, as well as young people and children needing extra support. This JFP ambition also links to Suffolk's transitional *Joint Health and Wellbeing Strategy 2022-23*, Preparing for the Future. This recognises the importance of greater collaboration and system-working as a cross-cutting issue. Its guiding principles also cite the importance of collaborative leadership, of ceding power and resources to make a difference, and of aligning planning and developing shared priorities and outcomes.

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Objective 4a Developing our vision for providing a wider range of services closer to home, improving patient outcomes and experience.

- Mental Health Transformation
- Improving Urgent & Emergency Care
- Elective Recovery & Improvement
- Primary Care Resilience & Transformation
- Improving Productivity & Efficiency
- PHM reducing inequalities & Supporting Prevention
- Improving Services for Babies, Children, Young People & Maternity
- Transforming Care in later life

What are we going to do?

First, we will develop some overarching principles and our strategic vision for future primary care delivery supporting our ambition to deliver cohesive primary and community care services across Norfolk and Waveney.

We will build on this to develop a detailed general practice and dental strategy which we will begin to implement across the second year of this plan.

We will develop our local delivery plan for the existing East of England Partnership Strategy for Community Pharmacy, recognising that this strongly supports the Fuller Stocktake vision for integrating primary care.

We will also develop our strategy for Optometry services alongside the on-going system Eye Health transformation.

Currently, our PCNs work as groups of general practices to deliver care to their population. Our next step is to provide our Community Pharmacy teams with the support, training and mentorship to enable Community Pharmacy PCN Leads to develop the skills they need to integrate local community pharmacies into Primary Care Network planning and activities.

Going further, our vision is to create Integrated Neighbourhood Teams that will deliver joined up primary and community care in a model that is closer to patients' homes.

The specific delivery model will be designed locally by our Place teams where they will decide which services are needed and how this will improve patient outcomes and experiences. We will deliver services at scale where possible and at PCN level where more targeted local services are required.

How are we going to do it?

What are the key dates for delivery?

Year 1 April 2023 – Sep 2023

- Develop an outline for key milestones for strategy development including which stakeholders we will engage with and by when.
- Review population health data to identify key priorities and need within each Place.
- Develop local definition of an Integrated Neighbourhood Team.

Year 1 Oct 2023 – Mar 2024

- Overarching Primary care strategy vision and principles developed.
- Engagement with our local population and system partners.
- General Practice Strategy developed.
- Dental strategy developed.

Year 2 April 2024 – Mar 2025

- Implement the first stage of the General Practice and Dental strategy.
- Develop the delivery model for Integrated Neighbourhood Teams at Place and PCN level.
- Local delivery plan for the East of England Community Pharmacy Partnership strategy developed.
- Develop strategy for Primary Optometry services alongside the system ICS Eye Health Transformation programme.

Year 3 to 5 April 2025 – Mar 2028

- Continue to implement the new strategy with frequent monitoring of outcomes.

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	We will support our Community Pharmacy PCN Lead roles to engage with the Integrating Community Pharmacy into Primary Care Networks programme. We will agree a local definition of an Integrated Neighbourhood Team and how we will approach new ways of working. We will use population health data to identify the priorities for developing new models to meet local population health and care needs. We will work collaboratively and in partnership with our partners in secondary care, community services, VCFSE and wider groups to support a blended model of care that not only focusses on a patient's health needs, but also their socio-economic needs providing more holistic and joined up care, including management of clinical risk. **How are we going to afford to do this?** We will work with our partners to agree how new pathways of care will be resourced and funded from within the current funding allocations across the system.	**We will begin to see our approach is working because we will begin to be able to measure** We will have published the first stage of our overarching vision and our strategy for general practice and dentistry by March 2024, informed by strong public engagement and using data to meet the needs of our population.

Objective 4b Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years		
Mental Health Transformation Improving Urgent & Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency	**What are we going to do?** Develop a near term plan to identify and prioritise populations in the greatest need of access to NHS dental services using data from the renewed Oral Health Needs Assessment (OHNA) and Public Health data for Norfolk and Waveney. This will ensure we can deliver short term interventions and begin to improve access to NHS dental services by Autumn 2023. Next, we will develop a Norfolk and Waveney strategy to improve the oral health of our population and explain our approach to build resilience across all our NHS dental services including our local workforce plan. This five year strategy will be ready for implementation from April 2024.	**What are the key dates for delivery?** **Year 1 April 2023 – Sep 2023** • Updates to the OHNA published in Spring 2023 and updated in Summer 2023. • Develop plan for short term interventions based on updated to the Oral Health Needs Assessment targeting the areas requiring the greatest interventions.

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PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	Working with key stakeholders and system partners to develop solutions for securing access to NHS dental care for the whole population. **How are we going to do this?** We will develop a plan for the near term to address immediate needs: • We will use all available data to understand and prioritise the immediate dental need. This may be a clinical need or a geographical need. • We will seek interest from current dental providers to increase the number appointments they are able to offer on a short term basis. • We will monitor the impact these actions have to improve access to dentistry and build this information into our next part of the objective – to develop a dental strategy for Norfolk and Waveney. Next, we will develop a five year dental strategy for Norfolk and Waveney: • Establish a 'Dental Taskforce' to hear to the challenges faced by the profession and work collaboratively to find solutions to improve access to dental care. • To listen to our patients and hear their lived experiences, and to ensure our local population has access to oral health prevention advice, working with local authorities and the voluntary sector in Norfolk and Suffolk. • Use our population health data, OHNA we will ensure our strategy is evidence based, balanced to meet the needs of residents, and reduces health inequalities. • Identify steps to retain, grow and develop our local dental workforce to meet our patients' needs. We will build multi-skilled dental teams, including roles such as Dentists, Dental Nurses, Dental Hygienists and Dental Therapists. • We will implement this strategy by April 2024. **How are we going to afford to do this?** We will utilise our existing dental funding allocation to commission services with flexibility to meet the needs from the Oral Health Needs Assessment published in Spring 2023.	**Year 1 Oct 2023 – Mar 2024** • Develop a Dental Strategy to outline our commissioning intentions for the next three to five years, our strategic approach to commissioning and how we plan to build resilience across all our NHS dental services alongside the development of our local workforce plan for Norfolk and Waveney. **Year 2 April 2024 – Mar 2025** • Implement the first stage of the dental strategy. **Year 3 to 5 April 2025 – Mar 2028** • Continue to implement the new strategy with frequent monitoring of outcomes. **How will we know we are achieving our objective?** <KPIs to be confirmed in final plan>

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Ambition 5 Improving Productivity & Efficiency

Andrew Palmer, Director of Performance, Transformation and Strategy, Norfolk & Waveney ICB

"Our ambition is to change how we work with partners across the Norfolk and Waveney ICS to look at ways we can work together more effectively and become more efficient, whilst driving forward service improvements to meet the needs of our local population. It is not simply about saving money but also about delivering better services and outcomes for our patients and local communities."

Our objectives

a) Improve the services we provide by enhancing productivity and value for money, embracing digital innovation and delivering services together where it makes sense to do so.

What would you like to see in our five-year plan for health and care services? What matters to you most?

The focus of this ambition is to systematically review data about our services and compare how we perform with other systems nationally, seeking out opportunities to work more effectively and efficiently for the benefit of our population. We will work together in partnership to ensure we achieve value for money, ensuring we use our resources as wisely as possible for the benefit of our population.

Why we chose these objectives

Deciding where to look to improve productivity and efficiency has been driven by the data and in discussion with our staff. All partners are looking at their own internal efficiencies as a constant process. We have access to the Model Health System https://www.england.nhs.uk/applications/model-hospital/ which allows NHS organisations to compare themselves with each other and look for variances. Opportunities to improve productivity and outcomes identified though Getting it Right First Time (GIRFT) https://gettingitrightfirsttime.co.uk/ benchmarking are also being reviewed. We look at examples of good practice across the local system, regionally and nationally, and use our Health Intelligence data to determine where to focus next. Across all the NHS partners we are also looking at opportunities to achieve economies of scale through procurement, sharing estates resources and collaborating when purchasing the medicines we prescribe and dispense.

For Procurement the core programme of work is to modernise the function and work collaboratively across the system to gain value for money by using the purchasing power of the combined Norfolk and Waveney NHS. This programme is live, with a workplan that constantly reviews the opportunities to save money by purchasing suitable supplies at a lower cost.

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The Estates programme, similarly to the Procurement work, will maximise the opportunities for more effective ways of working and how we use the Norfolk and Waveney estates assets across all system partners. The goal is to ensure the best value for money, including for example, securing capital receipts for the disposal of old and, where appropriate, surplus estate.

The Medicines Management programme is utilising pharmacy expertise to target drug and medicines savings. One significant opportunity arises when licenses change and certain 'branded' drugs can in future be made by other companies, usually at more competitive prices. Clinicians, pharmacists and procurement experts are working together across the system to ensure best value in this area.

Who we are going to be working with to deliver this	**This Productivity and Efficiency Ambition is aligned with existing strategies and plans across the ICS in Norfolk and Waveney. In particular it is aligned with our Partners in these areas:**
Norfolk & Norwich Hospital James Paget Hospital Queen Elizabeth Hospital Norfolk Community Health & Care East Coast Community Healthcare CiC Norfolk & Suffolk Foundation Trust Norfolk & Waveney ICB NHS England, Primary Care and other specialist redesign and transformation organisations	*The thread of productivity and efficiency runs through every organisation and every service development, meaning it is an integral part of every strategy across Norfolk and Waveney*. Increasing productivity and efficiency in key areas links to Better Together for Norfolk, Norfolk County Council's high level strategic priority of *Healthy, fulfilling, independent lives -levelling up health, living well and better local services*. Workforce efficiency, procurement and estates aligns with the **Promoting Independence strategy**, **Connecting Communities Programme, Home Care Support strategy** and **Flourish Strategy** ensuring that working in partnership, our services are sustainable and can meet the needs of the local population which are core ambitions of Adults and Childrens Services. This ambition links to *Our Ambitions for Suffolk*, Suffolk County Council's objectives as set out in its Corporate Strategy 2022-26. Improving productivity and efficiency links to the Council's objective of providing value for money for the Suffolk taxpayer, as driving productivity, efficiency and innovation will help sustain high-quality services and drive future improvement. The Council aims to meet this objective by: • Redesigning services and processes to drive productivity and value for money. • Maintaining its strong track record of sound financial management and governance. • Investing in technology and using the internet and innovation to improve communication, access to services, service delivery and efficiency. The Council's New Ways of Working programme aims to increase the ability of its workforce to deliver these objectives, and to rationalise its office estate, including creating opportunities to share spaces with public sector partners and support effective partnership working. Programmes such as People First and Independent Lives will develop new models of care that will ensure services remain sustainable while enabling people to lead lives that are as independent as possible. The Council will also work with partners to develop a

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	Prevention Action Plan and to implement the service and data improvements needed to embed CORE20PLUS5, to improve population health outcomes, reduce health inequalities, and prevent future ill-health in Suffolk. Suffolk's transitional *Joint Health and Wellbeing Strategy 2022-23*, Preparing for the Future, recognises the importance of greater collaboration and new ways of working in achieving greater efficiency and making better use of collective resources. It is also a guiding principle of the strategy that evidence and data will be used to set the right priorities based on population needs. This ambition aligns to the Queen Elizabeth Hospital's 2023/24 Corporate Strategy where there is a clear priority to 'deliver transformation through our major programmes of work including the New Hospital, Electronic Patient Record, Acute Clinical Strategy and Provider Collaboration.' This is underpinned by our commitment to 'deliver our financial plan and savings plan for the year, in turn contributing to delivery of the wider system's financial requirements.'

Objective 5a Improve the services we provide by enhancing productivity and value for money, embracing digital innovation and delivering services together where it makes sense to do so.

Mental Health Transformation
Improving Urgent & Emergency Care
Elective Recovery & Improvement
Primary Care Resilience & Transformation
Improving Productivity & Efficiency
PHM reducing inequalities & Supporting Prevention
Improving Services for Babies, Children,

What are we going to do?

Our organisations have established improvement programmes examining a range of areas in which to increase productivity and value for money. We have already brought together some administrative functions to improve value for money. Existing improvement programmes include a focus on Procurement, Estates and Medicines Management opportunities.

Our two areas of focus for year one and two are:

a) Organisations will continue to improve their operational efficiency across a range of areas of spend including procurement, estates, workforce and prescribing.

What are the key dates for delivery?

Year 1

- By May 2023 our Improving Lives Together programme will develop cases for change for improvements in Digital and Workforce services. These proposals will then be considered by partners in our ICS, and individual projects will be set up to deliver the agreed changes beginning, where possible, in the second half of 2023/24.

Year 2

- 2024/25 will see the full roll out and effect of any changes to Digital and Workforce services, and our Improving Lives Together programme will continue to assess further service areas for wider opportunities to improve.

Years 3 - 5

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Young People & Maternity Transforming Care in later life	b) Work together to enhance outcomes, productivity and value for money through our new Improving Lives Together Programme. **How are we going to do it?** We have established our Improving Lives Together programme, an ambitious improvement programme, drawing together partners from across our system to work together to improve the services that we provide. We will assess opportunities based on evidence and benchmarking of data through sources including the Model Health System. The initial focus of this work is on Digital and Workforce services, and we have already undertaken a detailed assessment of how we currently deliver these services to see how we can make improvements. Options are being developed that will help us to reduce duplication, improve outcomes and make best use of every pound we spend as an ICS. **How are we going to afford to do this?** This programme of work will deliver enhanced productivity and value for money and is not anticipated to increase overall costs in our system. Options will be carefully assessed as part of approving the cases for change for individual service areas.	• Our Improving Lives Together programme will continue to support review and improvements in services as part of our continuous service improvement approach. **How will we know we are achieving our objective?** • We will undertake post implementation reviews for changes led through our Improving Lives Together programme to formally assess that we have successfully delivered the operational and financial improvements. • We will use national benchmarking data drawn from the Model Health System to measure our improvement relative to national benchmarks and other ICSs.

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Ambition 6 Population Health Management (PHM), Reducing Inequalities and Supporting Prevention

Tracy Williams
ICB Clinical Lead for Health Inequalities & Inclusion Health
N&W ICB
Norwich locality Adviser

Suzanne Meredith
Deputy Director of Public Health Norfolk County Council

Associate Director PHM

"The aim is to enable all people to stay healthy by predicting and planning for health and care needs before they happen, and ideally preventing them if we can. By working together with partners across the NHS and other public services in Norfolk and Waveney we can make an even bigger difference to many of the factors that affect our health and improve the health outcomes for our population"

Our objectives

a)Development and delivery of two strategies:

- A **Population Health Management** Strategy, and
- A Norfolk and Waveney **Health Inequalities** Strategy to deliver the "Core20plus5" approach

The delivery of three specific **Prevention** work programmes designed to tackle:

- b) Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people
- c) Early Cancer Diagnosis – Targeted Lung Health Check Programme
- d) Cardiovascular disease (CVD) Prevention

What would you like to see in our five-year plan for health and care services? What matters most to you?

Recent JFP consultation feedback: "There should be more emphasis on prevention rather than cure." "Preventative Screening needs to be prioritised too". "Focusing on early intervention and prevention by broadening opportunities for roles such as social prescribing, community connectors, champions and health workers - providing holistic support to divert demand and in doing so, building capacity in our communities". "Preventative proactive healthcare in the community through Making Every Contact Count. Education in relation to self-care and responsibility for health"

Why we chose these objectives

We have identified initial Population Health Management priorities at a system level to address health inequalities and meet the Core 20 plus 5 priorities, which will have the greatest impact and where we know there are opportunities to improve. These are smoking, especially smoking in Pregnancy, Serious Mental Illness, Chronic conditions – Cancer (including earlier diagnosis), Cardiovascular and Respiratory. We will be aspiring to a reduction in the differences in outcomes we currently experience in terms of accessing services and improvements in the health care processes for the Core20 PLUS populations. We will also be seeking to prioritise prevention activities, particularly relating to smoking, alcohol, diet and physical activity and uptake of cancer screening and immunisations. Prevention is part of our Business as Usual agenda but we have identified three priority areas that we will lead on, and these are reflected in the three specific Prevention Work Programmes that we have chosen, underpinned by the evidence base as set out here.

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In 2020, nationally 8.9% of women smoked at time of delivery. In Norfolk and Waveney, the smoking at time delivery rate (SATOD) is significantly higher at 13.6% and remains an outlier for the East of England. Within Norfolk the highest rates of smoking in pregnancy are in West Norfolk and Great Yarmouth.

At present over 70% of Lung cancers are diagnosed at stage 3 or 4 where treatment is often difficult, or patients are palliative. The early cancer diagnosis programme aims to shift this stage at diagnosis to Stage 1 or 2 when it is at an early stage when treatment with a curative intent is more possible.

People with common conditions such as high blood pressure and high cholesterol are more at risk of developing cardiovascular disease, but they can be given treatment to help stop this happening. It is often the case that people remain undiagnosed and untreated because they have no symptoms. By doing this work, we will be helping to identify and offer treatment to people most at risk and ultimately preventing strokes and heart attacks in people living in Norfolk and Waveney over the next ten years.

Who we are going to be working with to deliver this

Primary Care Networks
Place Boards
Norfolk County Council – public health, adults and children's social care teams
Suffolk County Council – public health, adults and children's social care teams
HWP's
Norfolk & Norwich Hospital
James Paget Hospital
Queen Elizabeth Hospital
Norfolk Community Health & Care
Cambridgeshire Community Services
Hertfordshire Community Trust
East Coast Community Health
Norfolk & Suffolk Foundation Trust
VCFSE sector
ICS Clinical and Care Assembly
Cancer Alliance

The PHM, Reducing Inequalities and Supporting Prevention Ambition is aligned with existing strategies and plans across the ICS in Norfolk and Waveney. In particular it is aligned with our Partners in these areas:

The strategies and three work programmes with a focus on predicting and planning for health needs as well as prevention, link to **Better Together for Norfolk**, Norfolk County Council's high level strategic priority of ***Healthy, fulfilling, independent lives - Levelling up Health, Living Well and Better Local Services*** - *where everyone can start life well, live well and age well, and where no one is left behind.* Smoking during pregnancy workstream aligns to the **FLOURISH** strategy and promoting healthier lifestyles in pregnant women. Reducing inequalities and supporting prevention aligns with the Adult Social Care **Promoting Independence strategy** vision of supporting people to be independent, resilient, and well. Prevention and predicting and planning for health and care needs before they happen aligns with the **Ready to Act, Ready to Change** Public Health Strategy, based on the recognition that early intervention allows people to live healthier, more fulfilling lives.

This ambition links to *Our Ambitions for Suffolk*, Suffolk County Council's objectives as set out in its Corporate Strategy 2022-26. Through these, the Council will:

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	• Work with the NHS, district and borough councils, and other partners to prioritise the physical and mental health of all people in Suffolk. • Strengthen the consideration of equalities and inequalities in decision making. • Work with partners to create communities and environments that promote and enable healthier, and more active lives. • Promote economic growth that reduces inequalities. Key actions include: • Working with the NHS and wider partners to develop a Prevention Action Plan and to implement the service and data improvements needed to embed CORE20PLUS5, to improve population health outcomes, reduce health inequalities, and prevent future ill-health in Suffolk. • Strengthening digital services, so physical resources can be focussed on the most vulnerable and those at risk of the greatest inequalities. The JFP ambitions also link to Suffolk's transitional *Joint Health and Wellbeing Strategy 2022-23*, Preparing for the Future. This recognises reducing inequalities as a cross-cutting theme, with actions aiming to reduce inequalities through improving people's access to good jobs, raising incomes, and tackling the effects of poverty on families and children. The strategy also includes as guiding principles: • Focusing on prevention and early intervention. • Listening to evidence and data, to set priorities based on population needs, and focusing on what makes people well rather than just repairing damage. • Aligning planning across partners and developing shared priorities, encouraging Health in All policy approaches, and ensuring decisions are based on improving population health. This ambition aligns to the Queen Elizabeth Hospital's Clinical Strategy where we have a clinical priority to 'improve access and

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	reduce inequalities of access for patients on waiting lists, improve cancer outcomes and addressing the pandemic related backlog.'

Objective 6a Development and delivery of two strategies to support prevention: A Population Health Management (PHM) Strategy, and a Norfolk and Waveney Health Inequalities (HI) Strategy to deliver the "Core20plus5" approach

Mental Health Transformation
Improving Urgent & Emergency Care
Elective Recovery & Improvement
Primary Care Resilience & Transformation
Improving Productivity & Efficiency
PHM reducing inequalities & Supporting Prevention
Improving Services for Babies, Children, Young People & Maternity
Transforming Care in later life

What are we going to do?

We are going to develop two strategies. The strategies will ensure we are clear on our priorities for targeting resources and that we are working on agreed priorities for PHM and HI together. There is good work happening in pockets across the system, which needs to be co-ordinated so we set out a clear plan of what we are going to tackle first, how we will do it and why.

Develop a Population Health Management strategy, to proactively use joined up data and to put in place targeted support to deliver improvements in health and wellbeing. The strategy will include our plans for how we will be using data, how we will be developing our ICS-wide intelligence function and a single analytical platform to carry out relevant analysis to support our local decision making and planning and how we will evaluate our programme.

This proactive approach will be focussed on prevention, reducing inequalities and improving the quality of care. It will also be driven by our knowledge of local communities, and by partners working together to identify new things that can really help to improve health.

Develop a strategy for reducing health inequalities, aiming to deliver "equitable access, excellent experience and optimal outcomes" for all people and communities living in Norfolk and Waveney. This strategy will include how we plan to implement the "Core20plus5" national health inequality improvement framework which identifies population groups and clinical areas which require accelerated improvement.

We will also be seeking to increase uptake of vaccinations and cancer screening where there is low uptake in patient groups and communities. We will be seeking to minimise the health inequalities as a result of the impact of Covid-19. We will also include the wider factors that impact on health and well-being such as housing and the environment we live in.

What are the key dates for delivery?

Year 1 April 2023 – Sep 2023
Start the mapping of existing work, gap analysis, and development of strategic priorities that are evidence based

Year 1 Oct 2023 – Mar 2024
Two strategies published by March 2024

Year 2 April 2024 – Sep 2024
Action plan developed for each strategy with SMART objectives, milestones and trajectories

Year 2 Oct 2024 – Mar 2025
Delivery of the action plan, reflection and review, reporting and re-set for Year 3 based on year 2 outcomes.

Year 3 April 2025 – Mar 2026
Strategy refresh/update if required, and continued delivery

Year 4 April 2026 – Mar 2027
Continued focus on extending our PHM approach and reducing HI based on the data, re-set of SMART objectives, milestones and trajectories

Year 5 April 2027 – Mar 2028
Reflection and continued focus on using PHM to drive improvement across the system and inform where we focus our effort, and a continued targeted focus on reducing HI

How will we know we are achieving our objective?

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	How are we going to do it? By using joined up data to proactively identify prevention opportunities and groups of people who would benefit most from targeted health and care interventions. We will need to have a data hub in place to allow access to joined up data and facilitated interpretation of the data and insight to support local teams to identify their own priorities. This approach will be driven by the needs of local communities, and interventions designed to support them. This may also involve working across the ICS to plan new services or models of care in an integrated way across the ICS. Therefore, we need to have participation in the development process by the range of partners and stakeholders. **How are we going to afford to do this?** No additional funding is required to develop the strategies, but further resources may be needed to support ongoing projects, on an invest to save basis – each project to be considered on its own merits and evaluated. Some national funding is allocated to the ICS to support the delivery of the Core 20 plus 5 priorities.	Publication of a system wide Population Health Management strategy, and a Health Inequalities Strategy setting out our ambitions to reduce health inequalities over the next 5 years and the improvement we expect to see. Develop a programme of evaluation based on the best available data and insight to measure progress.

Objective 6b Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people.		
Mental Health Transformation Improving Urgent & Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation	**What are we going to do?** Stopping smoking is a preventative approach to improving health for all, especially in pregnancy. We will develop and provide specialist support that gives all pregnant women across Norfolk and Waveney the best help and advice to stop smoking at a time when they are likely to be	**What are the key dates for delivery?** **Year 1 Apr 23 – Sep 23** • Gather learning from existing services and agree a new plan. • Equality and equity plan published. • Deliver a Population Health Management pilot project, addressing smoking during pregnancy working with midwives at Queen Elizabeth Hospital (QEH).

Improving Productivity & Efficiency PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	motivated to quit, in line with the NHS Long Term Plan commitments. Our vision reflects the nationally recommended model for stop smoking services for pregnant women and this will be provided through the development of a new midwifery led NHS-based service. Each hospital trust will have stop smoking advisers who will offer support based on what research tells us works best. **How are we going to do it?** • The NHS will work together with local authorities, Maternity and Neonatal Voice Partnership and others through our Tobacco Dependency Clinical Programme Board, Tobacco Control Alliances and the Health Improvement Transformation Group to plan how we can best make use of our shared resources and how support should be rolled out. • We will focus on health inequalities ensuring that we understand access by population subgroups (such as age, ethnicity and deprivation) to ensure equity of access. • We will work with the VCFSE around wider issues like income, cost of living and mental wellbeing that could be linked to smoking choices. **How are we going to afford to do this?** National NHS funding has been provided to help us roll out NHS tobacco support in Norfolk and Waveney. In 2023/24 a total of £555k will be received, of which it is suggested £203k should be used for maternity. We are expecting this	• Pilot a Smoking in Pregnancy incentive scheme with Norfolk Public Health. **Year 1 Oct 23- Mar 24** • Recruit more maternity tobacco advisors and roll out support at QEH and Norfolk and Norwich University Hospital in line with the new plan. **Year 2 Apr 24 – Sep 24** • Roll out longer term plan, in line with the evaluation of year one. **Year 2 Oct 24 – Mar 25** • Roll out smoking in pregnancy incentive scheme in line with learning from any previous pilots and in alignment of further announcements from the Department of Health and Social Care. **Year 3 Apr 25 – Mar 26** • Review support provision for partners of pregnant women to support smokefree homes. • Review the current service with MNVP. **Year 4 Apr 2026 – Mar 2027** • Review longer-term support available in the community after the baby is born. • Review engagement with local authority and VCFSE to ensure good access to wider community support e.g., social prescribers and peer support groups. • Explore opportunities to enhance joined up working e.g., between tobacco advisers, antenatal team and mental health for women with perinatal mental health conditions. **Year 5 Apr 2027 – Mar 2028** • Use the Maternity and Neonatal Safety Improvement Programme to ensure we continue to improve on smoking reduction in pregnancy. • Explore opportunities for the use of technology to improve the support to pregnant smokers and their wider families.

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	funding to be made available every year, though this is yet to be formally confirmed by NHS England. The Tobacco Dependency Clinical Programme Board will lead on agreeing how tobacco support (including maternity) should be rolled out over the next five years and the estimated cost, based on learning from areas where support has already gone live. If it is identified that the national funding will not be enough, a formal request will be made for additional investment from NHS and local authority partners.	**We will begin to see our approach is working because we will begin to be able to measure a reduction in the percentage of women in Norfolk and Waveney who are smoking at time of delivery.** Data for Norfolk and Waveney from December 2022 shows that 12% of mothers were smoking at time of delivery. We would aim to see this reduce over the next three years, by March 2026, towards the regional and national average of 9% and to reduce further to 6% by the end of year 5, March 2028. Ultimately, the national ambition, which we share for Norfolk and Waveney, is to become 'smoke-free' by 2030 – achieved when adult smoking prevalence falls to 5% or less.

Objective 6c Early Cancer Diagnosis – Targeted Lung Health check programme		
Mental Health Transformation Improving Urgent & Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children,	Targeted Lung Health Checks are a preventative approach to improve the health of those who may be at risk. **What are we going to do?** Deliver a Targeted Lung Health Check (TLHC) Programme designed to assess a patient's risk of Lung Cancer and to identify any signs of cancer at an early stage when it is much more treatable – ultimately saving lives. We will prioritise patients in our most deprived, Core 20 populations. The programme will also incorporate smoking cessation support to encourage current smokers to quit as there is strong evidence that individuals who live in areas of high deprivation, with higher smoking rates are likely to have particularly poor Lung Cancer outcomes.	**What are the key dates for delivery?** **<u>Year 1 to March 2024</u>** • Continue to deliver TLHC to the Great Yarmouth population reaching full run rate by the start of Q1. This will result in approximately 350 LHCs per month and estimated 200 scans in line with trajectory. • Expansion to the Lowestoft area by end of July 23. This delivery will be increased to full run rate of 350 LHC per month during Q3 in line with trajectory. **<u>Year 2 April 2024 – March 2025</u>** • Mar 2025 Continue to deliver TLHC to the Great Yarmouth and Lowestoft populations. Commence roll out to Central Norfolk and West Norfolk with a target of expanding to cover the whole eligible population of approximately 125,000 individuals by 2028/29. The initial target will be our Core 20 areas of highest deprivation. • Confirmation of system model July 2024

Young People & Maternity

Transforming Care in later life

The programme is being offered to people between the ages of 55 to 74 who are current or former smokers and at greater risk of lung cancer.

Those eligible will be contacted by the NHS to invite them for a Lung Health Check appointment. At the Lung Heath Check a risk assessment will be undertaken which will identify if the patient is at a higher risk of Lung cancer. If the participant is considered to be at high risk of lung cancer, they are then referred for a Low Dose CT scan, as close as possible to home. If the scan results come back with signs of anything of concern, the participant is contacted with further information and referred for further tests and treatment. Most of the time no issue is found, but if a cancer or an issue with a participant's breathing or lungs is found early, treatment could be simpler and more successful.

How are we going to do it?

Places:

- As the programme is rolled out across the Norfolk and Waveney system, the place-based approach will be supporting promotion of the TLHC programme.
- The programme is currently being delivered in Great Yarmouth, with plans to extend to Lowestoft in July 2023. This will mean that we double the number of eligible patients in the target cohort to approximately 27,500 (20% of the NHSE N&W target eligible population). Of these it is expected that 12,000 will be invited to a LHC across the two areas (approximately 9% of the N&W eligible population).
- Finalise modelling/planning for the system model to incorporate the populations in West and Central Norfolk ensuring capacity and affordability in line with the new funding process.

Year 3 April 2025 – March 2026

- Complete the Lung Health Checks for the initial eligible population in Great Yarmouth and Waveney and commence 24-month follow-up scanning.
- Invite patients who have reached the age threshold to join the programme. Continue roll out to the remaining ever smoker cohort across Norfolk and Waveney focusing initially on areas of higher deprivation.

Year 4 April 2026 – Mar 2027 and Year 5 April 2027 – Mar 2028

- Continue expansion to the remaining 'ever smoked' populations in Norfolk and Waveney, including invitation of patients who age into the programme and 24 month follow up scanning.

How will we know we are achieving our objective?

Trajectory for 23/24:

Success measures	Planned performance against success measures:				
	Baseline Position Against Metric:	Q1	Q2	Q3	Q4
Number of first invitations sent to eligible participants	712	1600	3000	3600	3600
Number of Lung Health Checks completed	95	1000	1800	2100	2100
Uptake (%) of Lung Health Checks	25% (to date but only just started therefore this is	40%	40%	50%	50%

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- This programme links to the work of the Diagnostic Assessment Centres, to build diagnostic capacity in Norfolk and Waveney.

How are we going to afford to do this?

- The Targeted Lung Health Checks programme is currently funded by the National Cancer Action Team, pending the decision from the National Cancer Screening Committee to incorporate it into the National cancer screening programme.

	not representative)				
Number of CT scans completed (baseline and follow-up combined)	28	650	980	980	1200

Objective 6d: Cardiovascular disease (CVD) Prevention – develop a programme of population health management interventions targeting High Blood Pressure and Cholesterol

Mental Health Transformation

Improving Urgent & Emergency Care

Elective Recovery & Improvement

Primary Care Resilience & Transformation

Improving Productivity & Efficiency

PHM reducing inequalities & Supporting Prevention

Early detection of cardiovascular disease forms a preventative approach to improving health of those at risk of developing the disease.

What are we going to do?

We will provide Primary Care Networks (PCNs) with real time data on their specific patients:

- a diagnosis of CVD
- one of six high-risk conditions associated with CVD
- and not being reviewed or treated in line with national guidance.

In addition, we will be implementing a Population Health Management pilot as part of our system wide "Priority Patient Review initiative", by case finding specific patients who will benefit from low intensity statins or who have untreated hypertension.

How are we going to do it?

What are the key dates for delivery?

Year 1 April 2023 – Sep 2023

- We will scope a reliable source of robust data which will be needed by our PCNs.

Year 1 Oct 2023 – Mar 2024

- We will commence production of local data reporting to align with the metrics that are already produced nationally via CVD PREVENT and share with PCNs.

Year 2 April 2024 – Sep 2024

- Delivery to commence through monitoring of identified patients with a diagnosis of CVD or at higher risk.

Year 2 Oct 2024 – Mar 2025

- Year one evaluation to be undertaken.

Year 3 April 2025 – Mar 2026

- Metrics in CVD PREVENT domains should see a notable improvement in Norfolk and Waveney.

Year 4 April 2026 – Mar 2027

- Second evaluation

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Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	Place engagement will be a key component of the CVD Prevention ambitions. Each place has a different demographic, set of challenges, and an array of VCFSE partners. Their engagement will be key in supporting PCNs to achieve our targets. We will be use “CVD PREVENT”, a national primary care audit tool, to prevent and reduce the negative outcomes of unmanaged CVD, highlighting gaps, inequalities and opportunities for improvement. We will evaluate our finding using the CVD Prevent audit tool and as part of our Population Health management programme evaluation. As CVD PREVENT is updated on a Quarterly basis, our attainment and progress can be monitored very closely. Provider Collaboratives – We will scope how Primary and Community Care services could work together to enhance our ability to prevent CVD. Given that this ambition focuses on the desire to prevent CVD *before* community services input is required, the greater scope will be for Primary care working with other ICS VCFSE partners. **How are we going to afford to do this?** Funding is identified to support the delivery of the Priority Patient Review initiative. There are links with Primary Care funding and Quality Outcomes Framework funding.	**Year 5 April 2027 – Mar 2028** • Further evaluation. **How will we know we are achieving our objective?** In the short term we expect to see more patients with high blood pressure identified and treated and those who would benefit treated on low intensity statins. In the longer term we would expect to see reduction in inequalities in terms of early mortality, reduction in admissions related to CVD related events, as well as supporting people to live a longer and happier, healthy life.

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Ambition 7 Improving Services for Babies, Children, Young People and Maternity (BCYPM)

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"Our collective Ambition is that all babies, children and young people (BCYP) will have the best start in life, achieved through person and family centred, high quality support to enable them to 'Flourish'. We will focus on collaborative working with system partners to promote the importance of a strong start in life for children and young people.

We will prioritise the voices, needs and ambitions of children and young people so they can live their happiest, most rewarding lives and meet their potential."

Our objectives

a) Successful implementation of Norfolk's Start for Life and Family Hubs approach
b) Continued development of our LMNS, including the Three Year *Maternity Delivery Plan*
c) Reducing health inequalities including an initial focus on asthma, epilepsy and mental health
d) Develop a combined and improved offer across Norfolk and Suffolk for Children's Occupational Therapy

What would you like to see in our five-year plan for health and care services? What matters most to you?
Parents and children have told us that they want access to better information and support for their physical and mental health needs, waiting times to assessment and treatment are too long, services supporting children, young people and families should work better together and maternity care should be personalised.

Why we chose these objectives
The first 1001 days of a child's life are critical, and the NHS plays a crucial role in improving the health of babies, children and young people: from pregnancy, birth, and the early weeks of life; through supporting essential physical and cognitive development before starting school through to help in navigating the demanding transition to adulthood. We know the health of children and young people is determined by far more than healthcare. A stable and loving family life, healthy environment, education, safe housing, and income all significantly influence young people's health and life chances.
The outcomes we seek to achieve for children will be consistent across Norfolk and Waveney so that regardless of postcode, families can expect to have access to appropriate services. We aim to provide holistic care through design and implementation of care models that are age appropriate, closer to home and bring together physical and mental health services to support development. We can improve outcomes and make a difference through working in partnership with other organisations.

In Norfolk and Waveney:

- Babies in the most deprived areas are 50% more likely to be of low birth weight and 30% more likely to die before they are one year of age.
- Smoking status at time of delivery is 12% leading to low birth weight, premature births, and increased risk of perinatal deaths
- Poorly coordinated care for Diabetes, Epilepsy and Asthma leads to emergency admissions to hospital and poor health and education outcomes

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- Poor access to support and information leads to increased risk of attendance at hospital for 0–4-year-olds
- Children in Year 6 are 40% more likely to be obese, leading to increased risk of long-term conditions and a negative impact on wellbeing.

Who we are going to be working with to deliver this	**The CYP Ambition is aligned with existing strategies and plans across the ICS in Norfolk and Waveney. In particular it is aligned with our Partners these areas:**
Core Partners: Babies, Children and Young people Parent/Carer Forums Norfolk County Council and Suffolk County Council Public Health Our Place Boards and Health and Well-Being Partnerships Primary Care Networks Community Health Providers Early Years settings, Schools & Colleges Norfolk and Norwich Hospital James Paget Hospital Queen Elizabeth Hospital King's Lynn VCFSE sector & community groups Local Maternity Neonatal System (LMNS) Norfolk & Waveney Maternity & Neonatal Voice Partnership (MNVP) The Children and Young People's Strategic Alliance Board Prevention and Early Help Board Waveney Children and Young People's group	The objectives all link to **Better Together for Norfolk**, Norfolk County Council's Strategy The Start for Life and Family Hubs programme, NHS single maternity delivery plan, Norfolk's Ready to Act, Ready to Change Public Health Strategy Suffolk's Children and Young People's wellbeing plan, Suffolk Family 2020 Strategy, and This ambition links to *Our Ambitions for Suffolk:* Suffolk County Council's objectives as set out in its Corporate Strategy 2022-26. Through the strategy, the Council aims to meet its objective to promote and support the health and wellbeing of all people in Suffolk by: Working with partners, including the NHS and district and borough councils, to prioritise the physical and mental health of everyone Suffolk. • Continuing to prioritise vulnerable children and young people, including delivery of further improvements in services for children and young people with SEND. This ambition also links with Suffolk's transitional *Joint Health and Wellbeing Strategy 2022-23*, Preparing for the Future, which includes priorities for: • Public mental health. • Good work and health. • The wellbeing of children and young people. • Listening and engaging with local voices. Across these priorities, actions aim to ensure that children and young people in Suffolk have the best start in life, enjoy good mental health,

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	are resilient and productive, enjoy positive and happy relationships, and are able to achieve their full potential. The strategy aims to tackle the impacts of child poverty; to ensure equal access to education and other opportunities; and to ensure that children's and young people's interests are recognised in the decisions that affect their lives. This ambition aligns to the Queen Elizabeth Hospital's Clinical Strategy where we have a clinical priority to 'improve maternity care in line with national recommendations. National recommendations to be delivered include the **Better Births Review**, **Saving Babies Lives Care Bundle V2** and **Ockenden Review** as well as supporting Families and Local First Inclusion Programmes

Objective 7a Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach		
Mental Health Transformation Improving Urgent & Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children,	**What are we going to do?** Implement a Start for Life (SfL) and Family Hubs (FH) approach model, using whole family approach to provide a single access point to family support services that is integrated across health (physical and mental health), social care, VCFSE organisations and education settings. Whilst the emphasis will be on support for families in local areas, there will be a designated physical family hub site in each of the seven districts, which includes a site in each of the four largest urban areas of Norwich, King's Lynn, Great Yarmouth/Gorleston, and Thetford, where 37% of Norfolk's overall population reside, and which also contain the most deprived areas in Norfolk. Virtual services will also be available through the family hubs approach.	**What are the key dates for delivery?** Year 1 April 2023 – Sep 2023 June 2023 Co-produced Norfolk Start for Life and Family Hubs approach agreed & goes live Year 1 Oct 2023 – Mar 2024 Year 2 April 2024 – Sep 2024 Year 2 Oct 2024 – Mar 2025 Year 3 April 2025 – Mar 2026 Year 4 April 2026 – Mar 2027 Year 5 April 2027 – Mar 2028 **How will we know we are achieving our objective?** The programme team is currently working with the DfE/DHSC in developing an evaluation process for the national FH and SfL programme. In addition, at a local level a performance

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Young People & Maternity Transforming Care in later life	**How are we going to do it?** Through improved data sharing arrangements and a more joined up approach to capturing 'whole family' needs whatever part of the system families' access. Through FH sites and the FH network we will see co-located teams working alongside each other to provide support. Prioritising prevention and early intervention through providing advice and guidance to families at the earliest opportunity when families engage with FHs. This will also include the signposting to self-care resources, and a strengthened peer support offer. **How are we going to afford to do this?** There is circa £1,9m of DHSC funding, for perinatal mental health and parent-infant relationship support, to be effectively utilised to deliver the programme's minimum expectations by March 2025. The funding required to develop and implement a SfL and FH approach in Norfolk is secured through an overall grant of approximately £6m paid to the host agency, Norfolk County Council. There is an added requirement for Partners (resource expertise) across the system to collaborate to ensure the most effective support is in place to benefit families.	measurement dashboard will be developed to track the identified KPI's across the programme and for each individual work strand. 1. Feedback from families on Start for Life and family hubs offer (inclusive, 90% accessible, co-ordinated approach, greater connection through services, easier to navigate access services, 2. 90% access integrated referral pathways tell story once & 90% of families access the advice, information and guidance they need feedback from parent and carer panel feedback 3. More Practitioners across agencies work in a whole family approach (data single view – data sharing agreements) 4. Recruitment of additional 70 peer support volunteers recording families receiving support and recruitment numbers by 2025/26. 5. Aim 250 of families supported via Every Relationship Matters reduce parental conflict on children 6. Families receiving help to manage financial challenges (measured through DWP advisors embedded in family hubs) 7. Families accessing non funded services 8. Parents accessing Start for Life and family hub services have improved understanding of the contribution to child's wellbeing, achievement & school attendance. Measured increase in number of families receiving support & increase in school attendance. 9. Families with SEND receive early support reducing escalation measured through reduction in EHCP & needing access Alternative provision. 10. Improved health & development outcomes for babies & children with focus on most deprived 20% of Norfolk population (measured by aligned public health outcomes.

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Objective 7b Continued development of our Local Maternity and Neonatal System (LMNS), including the Three Year *Maternity Delivery Plan*		
Mental Health Transformation	**What are we going to do?**	**What are the key dates for delivery?**

Improving Urgent & Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	The LMNS brings together the NHS, local authorities and other local partners with the aim of ensuring women and their families receive seamless care, including when moving between maternity or neonatal services or to other services such as primary care or health visiting. Alongside this, NHS England published a three year delivery plan for maternity and neonatal services in Spring 2023. https://www.england.nhs.uk/long-read/three-year-delivery-plan-for-maternity-and-neonatal-services/ which sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. Our LMNS equity and equality action plan Norfolk and Waveney Maternity Equity and Equality action plan is a five year plan that will be monitored, reviewed and updated to ensure; - equity for mothers and babies from Black, Asian and Mixed Ethnic groups - those living in the most economically deprived areas - race equality for staff - development of co-produced equity and equality action plans to support the Core20PLUS5 approach. **How are we going to do it?** The LMNS will continue to focus on delivering a model of care that is community based with equity and equality as the underlying theme supporting local access to maternity services and family support. The LMNS will align with the wider work to develop Family Hubs (implementation of Family Hubs is in objective 1 of this ambition) to ensure that safe, healthy pregnancy and childbirth is embedded into the Start for Life approach https://www.gov.uk/government/collections/family-hubs-and-start-for-life-programme We will - improve equity and equality in accessibility of services. - offer a 'one stop shop' for care to all pregnant women and people. - improve maternity safety and outcomes. - improve maternal and staff satisfaction. - reduce footfall through the acute trust.	**Year 1 Apr 2023 – Sep 2023** Culture Workshop held. Publication of LMNS Data Dashboard to automatically report KPIs to LMNS board. Review of LMNS governance and reporting **Year 1 Oct 2023 – Mar 2024** MNVP action plan produced and published. Review of MNVP function supported by national and regional guidance by Jan 24 **Year 2 Apr 2024 – Sep 2024** Revised MNVP approved and ready for implementation. LMNS governance and reporting reviewed, refreshed and updated. **Year 2 Oct 2024 – Mar 2025** Pelvic Health Prevention Service is embedded. **Year 3 (Apr 2025) – Year 5 (Mar 2028)** We will continue to embed the learning, upskill the workforce, continue to hear the service user voice and drive continued quality and safety measures as part of our usual business. **How will we know we are achieving our objective?** - We will see the maternity workforce vacancies reduce and retention improve, with clear evidence of future leaders ready to drive forward maternity improvement. - As at May 2023 the vacancy rate is 9% which will be our baseline position to measure improvement against

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We will develop a workforce improvement plan to reduce our vacancies for maternity staff. The plan will include

- implementation of consistent job roles across the system,
- systemwide recruitment of midwifery students,
- deliver systemwide training and learning events,
- support our hospital trusts to have current and robust digital maternity strategies, forming the basis for digital integration in maternity services.

We will make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury.

LMNS will have oversight of quality assurance and transformational programmes to ensure the quality and safety of maternity services. We will share learning and development, informed by the experiences of people using maternity services. This will include access to postnatal physiotherapy and a focus on reducing in smoking during pregnancy.

We will deliver a workshop aimed at improving the culture to share learning and best practice working with learning and development teams.

We will ensure our Maternity and Neonatal Voices Partnerships (MNVPs) are representative of the population and the LMNS can evidence continued co-production with service users of service improvement.

How are we going to afford to do this?
6 March 2023 funding allocation letter received detailing available funding for delivery of the three year delivery plan across the system. There will also be an expectation that existing funding within the system is utilised to continue to deliver the quality, safety and transformation requirements that will be detailed in the three year delivery plan.

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Objective 7c Reducing health inequalities including an initial focus on asthma, epilepsy and mental health		
Mental Health Transformation Improving Urgent & Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	**What are we going to do?** We will establish clinically led professional networks who will work together to implement the recommendations of two bundles of care; Asthma https://www.england.nhs.uk/wp-content/uploads/2021/09/B0606-National-bundle-of-care-for-children-and-young-people-with-asthma-phase-one-September-2021.pdf and Epilepsy (expected June 2023). Over the next two years, we will increase access to psychological support for those affected by asthma and epilepsy, raise awareness of the conditions across universal services and improve support available to children and families. This links to the Core20PLUS5, which is an NHS England approach to reduce health inequalities for children and young people at both national and local level. There are '5' focus clinical areas requiring accelerated improvement which includes Asthma and Epilepsy. **How are we going to do it?** Clinical networks will be rolled out involving stakeholders across Norfolk and Waveney to support consistency in clinical pathways, raise awareness of gaps in provision and identify areas for improvement to ensure the NHS improves the quality of care for children with long-term conditions such as asthma, epilepsy and diabetes. This will be achieved though sharing best clinical practice, supporting the integration of paediatric skills across services and bespoke quality improvement projects. Our public participation group has developed a CYP Mental Health Charter, which details what is important to CYP and their families in the delivery of services, and there is a newly developed governance structure which enables CYP to hold the us to account. Our next step will be to increase the reach into communities of CYP and families who are seldom heard to ensure that the experience of all our communities	**What are the key dates for delivery?** **Year 1 April 2023 – Sep 2023** Establish system wide clinical networks. ICS leads should map the pathway of care for CYP with asthma through primary, secondary, and tertiary care. Development and implementation of plans to deliver the national asthma bundle **Year 1 Oct 2023 – Mar 2024** Work with regional teams to develop and implement plans to deliver improvements in the four areas of focus for epilepsy improvements **Year 2 April 2024 – Sep 2024** Design and implement new model of care with psychological support. Evaluate impact of Asthma deliverables achieved **Year 2 Oct 2024 – Mar 2025** Increase access to training from VCFSE and extend new model of care with psychological support. **Year 3 April 2025 – Mar 2026** To be defined by the local networks **Year 4 April 2026 – Mar 2027** To be defined by the local networks **Year 5 April 2027 – Mar 2028**

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	are captured and help to shape the future support to ensure the best start in life. We will support children with epilepsy and asthma to access activities within their communities and remain well while doing so through delivery of better care across clinical and non-clinical services, including access to condition specific training. We will support improved independence to self-manage conditions and access to skilled advice and support to keep children out of hospital. **How are we going to afford to do this?** Regional funding of £115k per annum is allocated to Norfolk and Waveney to progress plans. Local systems are able to submit expressions of interest for linked innovation schemes	To be defined by the local networks **How will we know we are achieving our objective?** Decreased admissions for asthma for young people aged 10-18 Decreased admissions for epilepsy for children and young people aged 0-19 Link for indicators is here: https://fingertips.phe.org.uk/indicator-list/view/paGkBr8vy0#page/1/gid/1/pat/15/ati/167/are/E38000239/iid/93136/age/288/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

Objective 7d Develop an improved and appropriate offer across Norfolk and Suffolk for Children's Occupational Therapy		
Mental Health Transformation Improving Urgent & Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency PHM reducing inequalities &	**What are we going to do?** Norfolk and Waveney are piloting the impact of integration across children's occupational therapy services. Regardless of where you live, the aim is that access to specialist support should be consistent and of a high quality, able to meet the needs of children and young people. This programme will deliver • Increased and expanded skill mix of the clinical workforce. • Increased access to advice, support, and training for universal services	**What are the key dates for delivery?** **Year 1 Apr 2023 – Sep 2023** Establish a clinical working group. Co-design the resources for the website and handbooks for schools Co-design training packages for professionals. **Year 1 Oct 2023 – Mar 2024** Accelerate co-production with parents and carers. Publish the parent page. Commence recruitment of additional therapists **Year 2 Apr 2024 – Sep 2024** Finalise Joint Commissioning Strategy

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Supporting Prevention Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	• Publication of a joint commissioning strategy involving Norfolk and Suffolk local authorities • Increased levels of investment to expand the workforce in order to meet need. **How are we going to do it?** We will improve independence to self-manage conditions and provide access to skilled high-quality advice and support to reduce the need to specialist interventions. We will explore the viability of shared care records across the footprint through a single point of contact, meaning you will only have to tell your story once. We will ensure that children with sensory needs can access clinical support through an NHS pathway. We will work with parents and carers to ensure those with lived experience play an integral part in the co-production of the improved service. Within a joint commissioning strategy, individual pathway teams will work to a consistent service specification with good partnership working across the Norfolk and Suffolk local authorities. We will reduce the number of children who require exceptional treatment options by providing access to targeted training for school staff and parents and carers to create inclusive school and home environments. This will free up specialist support for those who most need it. Children with complex needs will be supported sooner through the implementation of a graduated model of support.	Commence joint funding arrangements with the local authorities. **Year 2 Oct 2024 – Mar 2025** Evaluate the impact of deliverables achieved Refresh the joint strategy and expanding the blueprint for joint commissioning priorities. **Year 3 Apr 2025 – Mar 2026** Implementation of revised plans **Year 4 Apr 2026 – Mar 2027** Use the evaluation & learning to develop the future service. **Year 5 April 2027 – Mar 2028** **How will we know we are achieving our objective?** Improved patient experience evidenced through feedback with families and a reduction in inappropriate referrals to specialist services. **Outcomes** Improved access to digital resources online and accepted referrals for sensory needs Improved access to specialist advice and therapy through increased interventions Improved access to specialist training by clinical professionals Improved access to universal training non-clinical professionals and parents/carers This programme will be evaluated by Ipsos Mori with outcomes expected by 2024/25

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	Access to a digital offer of support and training will enable universal services to provide better support to children and young people. **How are we going to afford to do this?** External funding for this programme is available until March 2025. Work during 2024/25 will include recommendations to Integrated Care system on how new workforce model can be sustained. Joint Commissioning Strategy will include local authority funded provision assuming a reduction on independently funded packages of care. Engagement with services and families has strengthened and integrated commissioning is an established approach. A four-year occupational therapy transformation programme is underway that will provide a valuable blueprint for the future, across both Norfolk and Suffolk.	

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Ambition 8 Transforming Care in Later Life

Dr Frankie Swords
Executive Medical Director,
NHS Norfolk and Waveney

Ian Hutchison
Chair/ Senior Responsible Officer for Ageing Well Programme Board
Chief Executive Officer of East Coast Community Healthcare

Zena Aldridge
Specialty Advisor for Older People, Frailty and Dementia,
NHS Norfolk and Waveney

"Our aim is to simplify, improve and integrate health and care for people in later life (including at the end of their life) across Norfolk and Waveney. We want to design our services with and for the people of Norfolk and Waveney, to support them to have the best possible quality of life."

Our objective

a) To develop a shared vision and strategy with older people that will help us to transform our services to be easy to access and designed and wrapped around the needs of older people.

What would you like to see in our five-year plan for health and care services? What matters to you most?
Recent JFP consultation feedback: "Support for social care for older people to reduce acute admissions". "Access to the right care pathway and improved social care for dementia and Alzheimer's." "Tackling dementia care". "Older/frail people kept well at home"

Why we chose these objectives
Our population is older than in most systems, but a lot of our services have not been designed with older people in mind. Current services are often confusing or complicated to access meaning that people don't always get the help they need until far too late. So, we want to design our services with our older residents. We want to make it easy for older people to access support as soon as they need it, whether that support is for social, care or health needs. We want to simplify and join up all of our different services, so they are wrapped around our residents, and delivered as close to home and as early as possible. By making it easy to access support and by removing the barriers between the different types of support available, we will work together to support older people to maintain their independence and preserve their quality of life.

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Who we are going to be working with to deliver this	This Transforming Care in Later Life ambition is aligned with existing strategies and plans across the ICS in Norfolk and Waveney. In particular it is aligned with our Partners in these areas:
Partners across the ICS including: People in later life, their families and carers VCFSE sector Community Healthcare providers Adult Mental Health Provider Collaborative The East of England Ambulance Service (EEAST) Integrated Care 24 (IC24) Norfolk County Council Suffolk County Council General Practices Acute Trusts Healthwatch Via existing forums such as the: • Urgent and Emergency Care Programme Board • Place Boards • HWP's	Improving wrap around services, enhancing access to early intervention and prevention for those in Later Life links to Better Together for Norfolk, Norfolk County Council's high level strategic priority of ***Healthy, fulfilling, independent lives levelling up health, living well and better local services.*** Enhancing access to early intervention and developing better integrated care for people also aligns with the aims in the **Promoting Independence strategy**, **Connecting Communities Programme,** and **Home Care Support Strategy** core ambitions of Adult Social Services and **Ready to Act, Ready to Change** Public Health Strategic plan, recognising that early intervention and prevention allows people to live healthier, more fulfilling, and independent lives for as long as possible. This ambition links to *Our Ambitions for Suffolk*, Suffolk County Council's objectives as set out in its Corporate Strategy 2022-26. Through the strategy, the Council aims to meet its objective to promote and support the health and wellbeing of all people in Suffolk by: • Working with partners, including the NHS and district and borough councils, to prioritise the physical and mental health of everyone Suffolk. • Enabling residents to lead healthier and more active lives, tackling issues such as isolation, loneliness and obesity, and working to address health inequalities. • Continuing to prioritise vulnerable older people and adults. Within these, older people will benefit from programmes such as People First and Independent Lives, which both focus on the individual and aim to provide the maximum independence for each person's circumstances. They will also benefit from actions taken against the objective of strengthening the local economy, including older people to switch careers or start a business, and the promotion of economic

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	growth, which encourages people to fulfil their potential and prevents them falling into crisis. Suffolk's transitional Joint Health and Wellbeing Strategy 2022-23, Preparing for the Future, continues to regard a good quality of life for Suffolk's older people as a priority. As such, older people will continue to benefit from actions against the current priorities of: • Public mental health. • Good work and health. • Listening and engaging with local voices. Working with partners, these actions will, amongst other things, tackle loneliness and isolation, promote active participation in daily life, support greater opportunities for volunteering, and support the development of healthy and sustainable communities where people can live their best lives. This ambition aligns to the Queen Elizabeth Hospital's Clinical Strategy where we have a commitment to become a centre of excellence within Frailty and Stroke.

Objective 8a: To develop a shared vision and strategy with older people		
Mental Health Transformation Improving Urgent & Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency	**What are we going to do?** Develop a shared vision and strategy with older people, that will help us to transform our services to be easy to access and designed and wrapped around the needs of older people. We will then work together to deliver that strategy, to improve people's health, wellbeing, clinical outcomes and experiences of using and being supported by our services in their later lives. **How are we going to do it?**	**What are the key dates for delivery?** **April - Sept 23**: • Identify partners from across the ICS; including people in later life, to engage and co-produce the vision. • Map the 'as is' position of existing services and support. Identify gaps, overlaps and opportunities. • Agree a system wide definition and assessment tool for frailty to be used across all providers

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PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	Bring together members of our older population with colleagues from health, local government, the care sector and voluntary and community services to agree what the ideal service would look like for older people. Work backwards from that to identify what needs to be in place to achieve that vision, using population health data and evidence based best practice to identify where and how this should be delivered. Map our current services to identify gaps and overlaps between the current and desired future state. Identify what new services or projects we need, and which current services need to change, expand or stop to best achieve this. Establish an Ageing Well Programme Board to develop and then oversee the delivery of this strategy over the next 3 - 5 years. **How are we going to afford to do this?** Simplifying access and focusing on early and local intervention will reduce long term need and costs e.g.by preventing unnecessary ambulance call outs and hospital admissions. Co-designing services with older people to focus on maintaining independence will divert funding toward reablement and care at home, reducing costs associated with long term complex care packages and residential care. Co-ordinating services using a system-wide perspective to deliver more integrated, high-quality cost-effective care from multiple sectors so reducing waste and duplication so saving cost for our system. We will actively seek new external monies / funds to support people in later life.	• Develop a strategy and 3-year plan to achieve the vision. Test this with a wide range of people in later life, carers, VCFSE and other health and care professionals **Oct 23 – March 24**: • Develop a detailed road map to identify changes to services, commissioning, and communication of the future state. • Continued coalition building; gaining commitment of individual organisations to work together to achieve the new ways of supporting people as they age to live well. • Set up working groups to lead on the workplan, set and monitor metrics to measure impact. **April 24 – March 25**: Maintaining the momentum and effort • Resetting goals and metrics to measure effectiveness of programme, changing the plan to ensure it is delivering as needed • Recognising success and reflecting on lessons learned. • Continued checking back with people in later life and carers that the transformed services are meeting their needs. **How will we know we are achieving our objective?** Publication of an Ageing Well strategy including road map of work required to deliver this over 3-5 years.

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5.0 When we expect to deliver

For each of the Objectives, we have developed a series of key milestones. To show how the overall profile of work looks for our key objectives, we have split Years 1 and 2 into six-monthly timeframes to provide more detail and then we have included our longer-term planning years 3-5. This provides a programme summary, which will be developed in more detail as our JFP evolves and responds to need, and is shown in Figure 6.

Figure 6 – outline programme plan for the JFP objectives

	Joint Forward Plan eight Ambitions and underpinning objectives							
		Timeline for delivery						
	Ambition Objectives	Year 1		Year 2		Year 3	Year 4	Year 5
		1st	2nd	1st	2nd			
1	**Transforming Mental Health Services**							
1a	Build system resources for early intervention and prevention for people of all ages, including those who experience mental health inequalities. This work will include enhancing and expanding skills and knowledge of mental health across our populations; providing a framework of tools and capacity to support mental wellbeing; and delivering a refreshed suicide prevention strategy.							
1b	Mobilise mental health system collaboratives to facilitate partnership working and deliver better health outcomes for our residents. The focus of the adult collaborative in year one is to improve support for older people living with dementia, delirium and depression which also has alignment with the Ambition Transforming Care in Later Life.							
1c	Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'integrated front door' so all requests for advice, guidance and help are accepted, and support provided to navigate the system and meet the presenting level of need. This will be developed in line with the Thrive principles, with children and young people at the centre of delivery with resources wrapped around them, enabling them to Flourish.							
1d	See the whole person for who they are, beyond their complex behaviour. Develop pathways that support and promote recovery for people living with multiple and complex needs – with a focus on dual diagnosis and complex emotional needs (CEN)							
2	**Improving UEC**							
2a	Improve emergency ambulance response times							
2b	Expand virtual ward services							
2c	Delivery of the Improving Lives Together programme to reduce length of stay (LoS) in hospitals							
3	**Elective Recovery & Improvement**							
3a	Effectively utilise capacity across all Health System Partners							
3b	Implement digital technology to enable elective recovery							
4	**Primary Care Resilience & Transformation**							
4a	Developing our vision to provide a wider range of services closer to home, improving patient outcomes and experience							
4b	Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.							
5	**Improving Productivity & Efficiency**							
5a	Improve the services we provide by enhancing productivity and value for money, embracing digital innovation and delivering services together where it makes sense to do so.							
6	**PHM, Reducing Inequalities & Supporting Prevention**							
6a	Development and delivery of two strategies to support prevention: A Population Health Management Strategy, and a Norfolk and Waveney Health Inequalities Strategy to deliver the "Core20plus5" approach							
6b	Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people							
6c	Early Cancer Diagnosis - Targeted Lung Health check Programme							
6d	Cardiovascular disease Prevention							
7	**Improving Services for Babies, Children, Young People & Maternity**							
7a	Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach							
7b	Continued development of our Local Maternity and Neonatal System (LMNS), including the Three Year Maternity Delivery Plan							
7c	Reducing health inequalities including an initial focus on asthma, epilepsy and mental health							
7d	Develop an improved and appropriate offer across Norfolk and Suffolk for Children's Occupational Therapy, to meet their needs							
8	**Transforming Care in later life**							
8a	To develop a shared vision and strategy with older people that will help us to transform our services to be easy to access and designed and wrapped around the needs of older people.							

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6.0 How are we going to work together differently

The seven ways in which we are going to work differently are explained in this section. This 'how' section is crucial to the delivery of the Ambitions and is as critical as the ambitions and objectives themselves because it is working together differently that signals the changes we need to make as an ICS to successfully deliver our plan.

1. **Place based approach** with clearly defined remit, responsibilities and decision making. Be clear about what we do at System level and what would be more effectively determined and delivered more locally in our communities.

2. **Provider Collaboration** – confirming our Acute hospital, Mental Health and integrated Community Collaborative arrangements, so we understand their remit, responsibilities and decision making.

3. **Existing ICS Strategies** – ensure everything we do is aligned with strategic commitments that we have already agreed such as those set out in our transitional Integrated Care Strategy and Joint Health & Well-Being Strategy, Clinical, Digital, Quality, Estates and Net Zero / Green strategies and our People Plan. The existing Strategies and ambitions in our JFP need to work together as one, all pulling in the same direction.

4. **Empowerment** – defining the functions and responsibilities at system level and those more suited for local determination, to unlock the benefits afforded to ICBs and ICSs, creating the conditions for change and moving our system from responding, to innovating.

5. **People and Culture** – continuing to develop inclusive partnerships as we work together as a senior leadership team and to facilitate a climate of improvement for all our teams to work in, as they deliver the ambitions of our JFP.

6. **Engagement and co-production** – listening and facilitating inclusive engagement with our people, patients and their families and carers, so we can deliver responsive and joined up care that is genuinely co-designed and produced with those that use our services.

7. Empowering and working with the Voluntary, Community, Faith and Social Enterprise (**VCFSE)** sector differently and integrating VCFSE provision into our design and delivery models for services.

The 2022 Health and Care Act established the legislative framework to promote better joined-up services. This includes a duty for all health and care organisations to collaborate to rebalance the system away from competition and towards integration.

Working in this way should mean that health and care providers, including voluntary sector organisations and primary care, will organise themselves around the needs of the population rather than planning at an individual organisational level, in delivering more integrated, high-quality, and cost-effective care.

Provider collaboratives and place-based approaches are just two of the ways of working differently together in an ICS to enable the delivery of our core purpose and the transformation ambitions.

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6.1 Our place-based approach

We are committed to the principle of subsidiarity. Described simply, if we can do something better locally, then we should do so, using a place-based approach. We want to build relationships around communities themselves, where local people are involved and take an active part in creating the solutions.

There are five Place Boards and eight Health and Well-Being Partnerships (HWP's) across Norfolk and Waveney ICS and they are shown on the map below in Figure 7.

<placeholder for Figure 7 map>

The key role of our Place Boards is to bring together colleagues from health and care to integrate services, with a focus on effective operational delivery and improving people's care.

The key role of the HWPs is to seek to address the wider determinants of health and wellbeing, through collaboration and in line with evidence-based practice. They are using this planning toolkit to support and develop their work: Toolkit. The HWPs are particularly well placed to deliver against both the Norfolk and the Suffolk Joint Health and Wellbeing Strategy's overall themes of integration, connected, thriving and resilient communities, addressing and reducing inequalities, and prioritising prevention.

The Place Boards and HWP's have complementary roles, which are aligned. They also work with the VCFSE and there is a VCFSE Place based lead aligned to each Place Board.

When we talk about a place-based approach we mean this in the broadest sense of a way of working locally, rather than an entity. The Place Boards and HWP's work with each other and across Norfolk and Waveney. We have agreed that we will establish a coordinating group in central Norfolk to support the three Place Boards to work closely together when needed, for example when working on pathways with the Norfolk and Norwich University Hospital, while also ensuring each Place Board can work on its own local priorities too.

The place-based approach has a proven track record of delivering improvements for local people, especially in prevention, intervening upstream to anticipate issues before they become a problem, providing an integrated community response and connecting communities together.

We do however recognise that the place-based approach needs a framework to work within, and the ICS needs be clear about the overall direction of travel. We have therefore agreed some broad principles. Agreeing 'what is best done where?' is key, so the place-based approach continues to make a difference. Figure 8 below is a helpful way to begin to describe what is decided by the ICS and what is decided locally by Place Boards.

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Figure 8 – responsibility map

The place-based approach also needs resources and we have agreed a way that resources can be allocated to Place Boards.
It is proposed to have a new system committee to ensure that place plans are not held up by lots of 'red tape'. The Place Boards would plan services and then seek approval to release the funding. The committee would approve the Place Boards' plans as long as it met the agreed principles.

The governance is intentionally light touch but it will ensure that our efforts are co-ordinated. The HWPs have some resources allocated to them through some funding from the Covid Recovery Fund, Better Care Fund and also Active NoW. We are also reviewing the staffing resources that are available to support the place-based approach, with support from clinical and care professionals.

In 2023/2024, our Place Boards will be primarily focused on delivering against two of our ambitions: urgent and emergency care, and primary care resilience and transformation, particularly moving care closer to home. Other ambitions have referenced Place Boards and HWP's as key partners too, but it is acknowledged that more needs to happen to confirm details and resourcing. This approach sets out an intent and a signal that if we can deliver locally in our communities then we should do so.

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The HWPs are working on a strategy for each area across a 2-5 year time period. Action plans are in development as part of strategy work for each HWPs, which will identify timelines and milestones for delivery in 2023. Future plans will be determined through place-based Health and Wellbeing strategies for the 2023-25 period and beyond, developed with reference to key strategic priorities from the District they serve and the ICS vision. Current priorities are set out in Figure 9 and all of them can be linked to at least one of the ambitions in the JFP.

Figure 9 – HWP priorities

Partnership	Priorities
Breckland	Overarching Priority - Inequalities • Mental Health (all ages) • Alcohol (targeted – geographies) • CVD (Prevention)
Broadland	• Long Term Conditions: Musculoskeletal (MSK) problems • Lifestyle: Alcohol • Lifestyle and Long-Term Conditions: Diabetes and Cardiovascular disease
Great Yarmouth	• Health & wellbeing – focussing on inequalities: Increasing healthy eating and physical inactivity • Attainment, skills & aspirations: Increasing employment opportunities • Vulnerability & exploitation: Toxic trio: mental health, domestic abuse, substance misuse • Loneliness, isolation & social exclusion: Connecting residents, building community capacity
KLWN	• Mental Health • Weight Management • Alcohol Consumption
Norwich	• Health Inequalities • Mental Health • Domestic Abuse
North Norfolk	• Aging population • Mental health • Inequalities
South Norfolk	• Long Term Conditions: Musculoskeletal (MSK) problems • Older People: Dementia A) Children, Early Years & Young People: Unintentional injuries in children (0-14 years) B) Lifestyle and Long-Term Conditions: Diabetes and Cardiovascular disease

In summary we are clear about the role of the place-based approach in delivering the medium to longer term priorities in both the Joint Health and Wellbeing Strategy's and the eight ambitions in the JFP, but we cannot do everything at once. We are pulling in the same direction and aiming for the same things, whilst ensuring the place-based approach can respond to local needs. After an initial set up phase and a lot of hard work, the focus is on evaluating what has worked well and re-setting for the future.

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6.2 Provider collaboration

This is about partnership arrangements between Trusts who are working together and at scale across multiple places or locations, with a shared purpose. We are on a journey to develop the potential of provider collaboration, which is an important part of successful ICS working.

Acute hospital collaboration

The Norfolk and Waveney Acute Hospital Collaborative (N&WAHC) is a Provider Collaborative formed by the Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust, the Norfolk and Norwich University Hospital NHS Foundation Trust and the James Paget University Hospitals NHS Trust. The aim of the N&WAHC is to improve health outcomes for all through:

- Enhancing clinical effectiveness and patient experience and,
- Reducing known inequities in health outcomes and access to services.

These aims are consistent with the JFP through the ambitions focused on prevention and reducing health inequalities.

The N&WAHC has identified a number of pivotal programmes of work it will be focusing on, which will make a real difference to our local population by doing them together:

The first is **implementation of a single acute Electronic Patient Record (EPR)**
This is a joint digital solution that enables clinical and operational processes to run seamlessly and efficiently on one platform across the three acute trusts bringing tangible benefits around reduced clinical risk, efficient use of clinician time, improved decision-making, patient care and experience. It will also provide a platform to transform integrated acute pathways and services. It is a critical component of the ICS Digital Strategy for good reason because it will make a difference on the ground to our population and our staff and is referenced in nearly all the ambitions as a key enabler.

The second is the **development of a joint Acute Clinical Strategy**
The joint clinical strategy will align directly to the clinical objectives set out in the ICS clinical strategy and it will also support the individual acute hospital trusts' clinical strategies by identifying the specific opportunities where clinical collaboration can improve the way we deliver services for our patients. The objective of the strategy is to ensure right sized and stable inpatient capacity that responds to long-term population health and demand. Underpinning this are design principles of onsite acute care only where true clinical value is added and vertical and horizontal integration of services, teams, and pathways. The development of this strategy is referenced in the place-based approach as we focus on care closer to home as an initial priority, and the ambition that is about primary care resilience and transformation where we talk about the development of neighbourhood teams.

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The third programme is about **Unblocking delayed discharges; creating stronger, consistent support for frail elderly**
With an existing population demographic weighted towards people living longer into later life, which is projected to grow and age faster than most other places in England, the collaborative will prioritise resource and capacity to appropriately configure and integrate services, teams, and pathways to reduce the burden of unnecessarily long inpatient stays and the deconditioning of patients. This collaborative focus from the N&WAHC will be a critical

enabler to the ambition that is about transforming care in later life and improving urgent and emergency care where we have a focus on length of stay in hospitals.

The fourth programme is about **Improving productivity across the acutes and the wider system**
N&WAHC will be working more closely together, identifying areas to align support and corporate functions with a focus on doing things once and at scale. This focus is consistent with the ambition to improve productivity and efficiency, and without this focus this ambition is unlikely to succeed as the three hospitals collectively account for the majority of the NHS Norfolk and Waveney budget.

The fifth programme is about **Major acute capital projects.** For example, N&WAHC is collectively working on plans for three Diagnostic Access Centres (DAC's), one at each hospital, which will significantly improve access to diagnostic services and reduce waiting times for treatment, especially for a cancer diagnosis. These are referenced within the elective recovery and improvement ambition as key enablers to the creation of more capacity so more patients can be treated and waiting lists reduced.

Mental health partner collaboration

In addition to the acute hospitals, collaboration across mental health (MH) in Norfolk and Waveney is relatively well established and has been a focus for several years. In 2019 both the adult, and children and young people's (CYP) MH strategies placed integration and collaboration at the heart of their service models moving forward.

We are proposing to establish an adult mental health system collaborative and a children and young people's (CYP) system collaborative. This is because the current providers and models of delivery in each life stage are different. The responsibility for transition services (18-25 yrs) will be agreed for one of the collaboratives to lead but will converge over time. Whilst both collaboratives are prioritising mental health services, we want to include physical health outcomes and a focus on the wider determinants of health aligned to the ICS Clinical Strategy objective of seeing me as a whole person.

Initially the adult mental health collaborative will focus on:

a. Building the 'case for change' for dementia provision, inclusive of delirium and depression.
b. Identifying national best practice and best definitions.
c. Given the breadth of the pathway, using a. and b. to advise on which element/s of provision are addressed first.

This links directly to the transforming care in later life ambition, acknowledging that dementia can span all-age – albeit in smaller numbers.

Initially the CYP MH collaborative will focus on the development of a system collaborative to develop a model of prevention and intervention with an initial focus on the redesign of community-based services covering mental health services; the Special Educational Needs and Disabilities (SEND) redesign of the operating model and neurodevelopmental pathways.

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Such is the importance of this enabler, that we have included the development of these two MH collaboratives as one of the key objectives within the Transforming MH services ambition.

Community services collaboration

Prior to the formation of NHS Norfolk and Waveney, community services have been historically commissioned by five different Clinical Commissioning Groups, each having their own approach to prioritisation. This led to differences in how services were commissioned across Norfolk and Waveney. We now have an important opportunity to look at the way community services are commissioned and delivered across Norfolk and Waveney, and we can improve how and where care is provided. To do this, we will undertake a review of community services.

This review is an important first step to the transformation of services and provides an opportunity for us to address some of our historic challenges to ensure that people receive timely care and the support they need, in the most appropriate setting, helping them live independent lives for as long as is possible. It also provides an opportunity to deliver on some of the commitments made in the Norfolk and Waveney clinical strategy, in terms of moving health and care pathways into the community and the Fuller Stocktake, recommending integrated community teams supporting general practice.

The review will cover community services provision for people at all stages in their lives, recognising that a high proportion of our population are older. Engagement with organisations, stakeholders, VCFSE sector and wider partners will take place in the summer followed by the production of a report in the autumn to inform the wider transformation of community services across Norfolk and Waveney. At this point, we will engage fully with the people and communities of Norfolk and Waveney, building on their comments and feedback to date and seeking views on initial ideas to improve and strengthen community health and care of the future.

6.3 Enabling Norfolk & Waveney's Strategies

Within each of the eight ambitions we have shown the linkages with the work that is already being done by partners within the system so we can see how we are all working together and how things join up.

We also evidence how the eight ambitions are supported by published ICS strategies. These provide enabling infrastructure to support the transformation. Some of the individual Strategies have explicit and very direct links to the eight ambitions, and we have clearly referenced these as a separate section in Appendix 1 to Part 1 of the JFP. Using and building upon existing local strategies and plans is a key principle of our approach. In addition, a visual depiction of how our ambitions and strategies link is shown in Figure 10.

<placeholder for Figure 10 Strategy Map>

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6.4 Empowerment

We will ensure our system is designed to both preserve accountability, at the right level, and free our leaders to innovate and transform care to deliver the best outcomes for our population. Our work will be underpinned by a quality improvement approach and we will ensure the right data are available to support service improvement and transformation across all levels of our system.

We will define the functions and responsibilities that will be most effective delivered together at a system level and confirm those more suited for local determination to meet local needs. Getting this balance right will unlock the benefits afforded to Integrated Care Boards and Integrated Care Systems, creating the conditions for genuine change and will move our system beyond responding to challenges, into innovating and truly transforming care.

6.5 People and culture

This JFP describes the changes we want to make, and change happens by people working together differently. Our ICS aims to improve performance and effectiveness and Organisational Development (OD), can help to support that change.

The aim of our OD Programme is to shape a thriving Norfolk & Waveney ICS. This can only be achieved by focusing on relationships with and between the people and organisations we work with, the culture and processes, and supporting our leaders to navigate their way through the challenges and complexity. Working across organisations is more challenging as leaders and teams must consolidate their organisations goals with the shared vision and purpose for Integrated Norfolk and Waveney system. The foundation of strong relationships, a deep sense of community, a desire to make the system work for the local population of Norfolk and Waveney and, positive developmental work with key stakeholder groups and Boards across the ICS are the bedrock of our maturing ICS.

Specifically, we are working on a collective system culture of compassion and inclusion and are working on the following:

- With our partner organisations to develop compassionate and inclusive leaders and teams across the ICS;
- With all our Boards and key stakeholder groups to develop mature working relationships and structures to support the goals and ambitions of the ICS;
- We have a Leadership Framework embedded across the ICS to support the people that are leading the changes; and
- We will evaluate and review our actions with the aim of planning and co-creating the next phase of the maturity journey. There are a number of key elements we are focusing on to ensure all our ICS partner organisations work closely together in a very complex health and social care setting to deliver the outcomes set out in the JFP.

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An integral part of the People and Culture enabler is the way that **clinicians and care professionals** (CCPs) are involved in decision-making across the ICS. This ultimately improves the quality outcomes and experience of our local population, and it is also recognised nationally as best practice.

Our CCP vision is to '*put CCP leadership at the heart of our discussions at every level of our system, so that it becomes integral to our culture and how we work together*'. We have confidence that the CCP voice is now included in every decision-making group across the ICS – no decision

regarding the care we provide or commission is made without formal consideration by a CCP. This includes at the Place Boards, VCFSE Assembly and Provider Collaboratives.

Working closely with our partners we have ensured that we have Social Care and VCFSE representation forming part of the CCP Assembly membership. Our governance structures also reflect this requirement and we have established one other consultative forum: The VCFSE Assembly, with a third, The Patients and Citizens Assembly due to be set up during 2023/2024. Work to align the forward plans of all three Assemblies is currently underway and this will be aligned to the JFP.

It became clear that historically the majority of our CCPs were doctors, the vast majority of whom were GPs. In the changing health and care environment of the ICS, we are committed to ensuring that our CCP leaders better reflect the diversity of our workforce.

We are implementing a **Leadership Framework and 10-point CCP manifesto which is on our website** <placeholder for microsite link> to take action on the 5 core principles for effective clinical and care professional leadership.

The CCP Assembly (CCPA) reviews and advises on all ICB decisions affecting health and care. It acts as a consultative forum and diverse critical friend for the ICB and ICP to sense-check ideas, plans and decisions that may affect delivery, development and future clinical and care provision for our local population.

We will also be establishing a smaller Clinical and Care Professional Council. It will lead the coproduction of the CCP framework and strategy, support the ongoing programme of training and development for CCPs and support the empowerment culture we wish to create that is also referred to in this section.

We will be working differently in the future and the CCP Leadership programme is extremely ambitious. We recognise that this is a big cultural change required which takes time. Our plans reflect the 3 – 5 years we envisage it will take to fully embed these new ways of working. One of the first things we are doing is exploring options for the development of a series of health and care focus sessions to look at language, relationships, and commonality. This involves identifying key areas of mutual focus.

New CCPL roles have been aligned to each of the ambitions as outlined in the Joint Forward Plan, as well as focusing on those areas highlighted in the national Core20PLUS5 agenda. This will be further strengthened by leadership development and wider training planned for this group of CCP leaders, as we continue to establish a Norfolk and Waveney pipeline of suitable trained, supported and empowered CCPs.

We are also developing an ICS Quality Faculty, focusing on coordinating our training and support programmes in quality improvement and evaluation across the system. As we create an inclusive and empowering culture of improvement, they will bring this community of CCPs together, acting as a role model for this new culture.

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6.6 Engagement and Co-production

Norfolk and Waveney is committed to listening and facilitating inclusive engagement with our people, patients and their families and carers, so we can deliver responsive and joined up care that is genuinely co-designed and produced with those that use our services. We believe that all feedback has value and should be supported through a spectrum of participation methods (Figure 11):

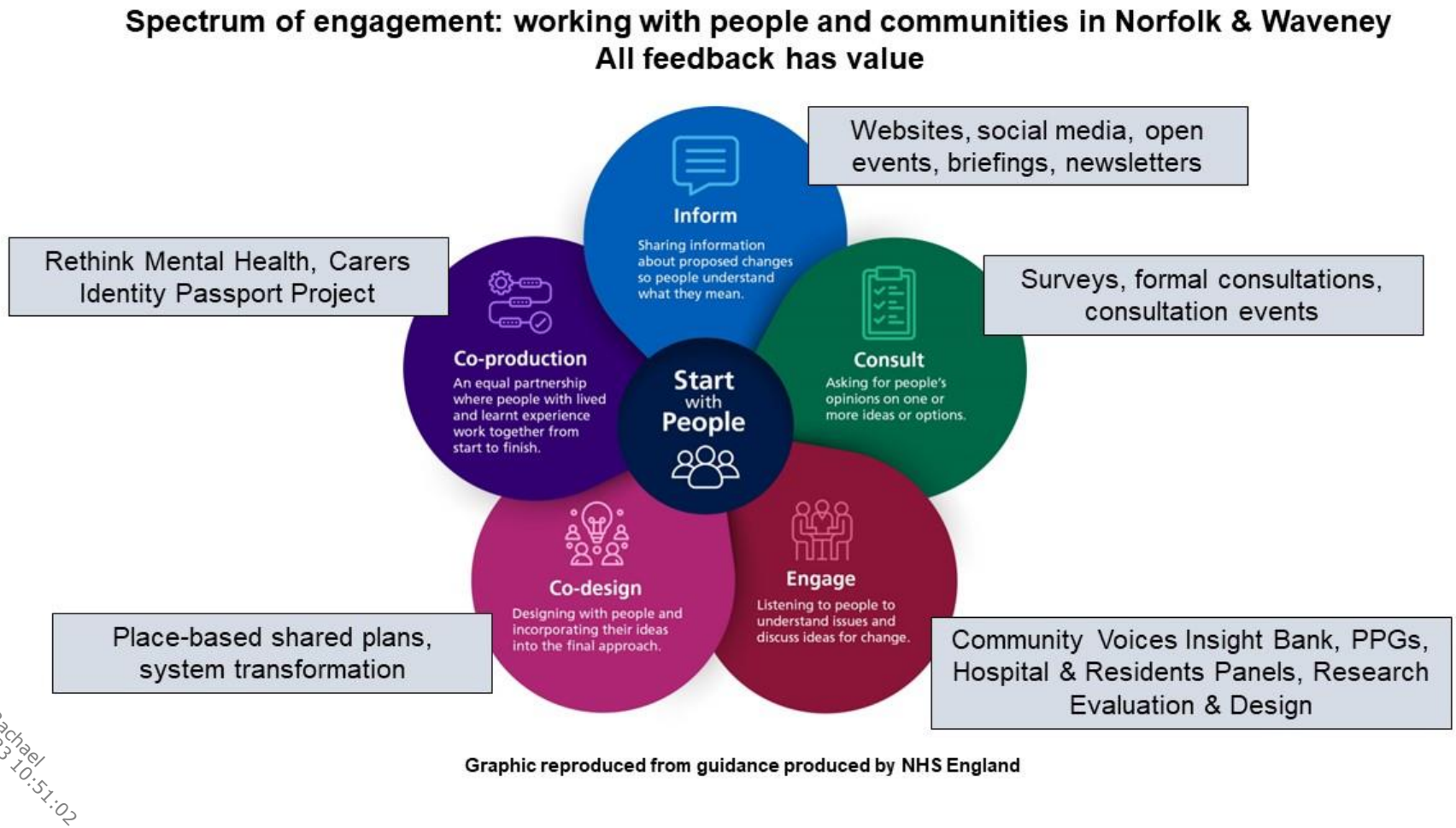

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Figure 11 spectrum of engagement

All the partners in our ICS are talking and listening to people and communities every day. Our vision is that people would tell their story of lived experience once and it's heard by everyone in the ICS. We want to develop on-going relationships with communities to learn what matters to them, and work together to address the key issues for our system. This puts us in a very strong place to work with our people and communities around our JFP.

We are working with system partners to align and develop a broad range of participation methods. Some examples of regular partnership working have been developed:

- A Norfolk and Waveney ICS Communications and Engagement (ICS C&E) group was established in September 2021 to work as a system on a variety of local priorities, such as communications campaigns, participation and co-production and to act as a learning network. Membership includes representatives from Norfolk and Suffolk - 8 NHS provider trusts, 2 county councils, 2 Healthwatch's, 8 district councils, Norfolk Police, 2 Chambers of Commerce, Out of Hours/111 provider, Active Norfolk, Norfolk Older People's Strategic Partnership, 4 VCFSE organisations, representatives from housing associations.
- Each Place Board has a C&E lead to support communications and engagement activity for Place Boards and HWP's. Working with people and communities at 'place' level will support all the different voices of our people and communities to be part of local decision-making, as conversations about 'the place where I live' are often much richer.
- Norfolk and Waveney Patient Experience and Engagement Leads meetings have been taking place weekly for several years and give an opportunity for people working in NHS provider trusts to meet and share practice across the system. They have been a vital opportunity to begin to test and develop the idea of the 'wider team' working with people and communities across the ICS to listen to and involve patient experience feedback in quality and wider commissioning.
- Communications and engagement support is being given to the Norfolk and Waveney VCFSE Assembly

The ICS website hosts the people and communities hub for Norfolk and Waveney, which aims to develop and maintain a shared vision in listening to and working with local people across the ICS. It offers a place for all system partners to share live participation opportunities, as well as signposting to information, describing our approach to working with people and communities and feeding back on what we will do as a result of what you have said.

We learnt during the COVID-19 pandemic that we need to get better at listening to what really matters to our people and communities, especially if we are going to address health inequalities, which is one of our eight ambitions. A really effective way to do that is to use trusted communicators, people who are part of the local community – 'people like me'. We can do this by working with VCFSE organisations, as well as colleagues in, for example, housing associations and district and county councils who already have long standing relationships and networks throughout Norfolk and Waveney

Another key area of support centres around the patient voice in primary care. We asked Healthwatch Norfolk to engage with local practices and Patient Participation Groups (PPG's) to find out what support would be most useful. The ICB is now working to deliver the key recommendations from the report. A PPG webpage features case studies including examples that promote different models of patient engagement. There is also other information and links to resources including a toolkit produced by Healthwatch Norfolk following the period of engagement which aims to give Doctor's Practices and PPGs a step-by-step guide. PPGs are another key source of insight and feedback from our people and communities and will be helpful in the delivery of our primary care ambition.

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Communications and engagement work at a very local level is key to developing on-going relationships with people and communities and we have aligned our staff resources with this. Opening up new networks for engagement will be vital in supporting the work of the Joint Forward Plan.

One particular area of participation that we will be developing further is around the promotion of true co-production. This refers to a process of shared power to effect change. The term co-production is generally used to mean an end-to-end process where people with lived experience work with those who design services and projects in an equal partnership.

Examples of co-production do exist in Norfolk and Waveney and work is underway within the system to align existing work and develop a shared approach:

- Development of a co-production hub as part of our People and Communities hub to share examples from the system, to promote co-production principles and to signpost to support materials
- Development of a Norfolk and Waveney Mental Health Co-production strategy for lived experience to effectively influence ICS mental health transformation, services and support.
- Being a part of the Norfolk Making It Real (MiR) steering group which promotes co-production particularly for people with lived experience of physical and learning disabilities.
- Supporting various NHS England funded initiatives in Norfolk and Waveney such as a series of co-production projects across the ICS around Quality Improvement
- Co-production as an integral part of designing research projects
- Exploring ideas around the development of some system-wide shared principles around co-production for Norfolk and Waveney
- Developing a Volunteer Expenses and Co-production Payments Policy that includes a threshold for when participation becomes co-production, and details how we can offer effective support for our people and communities through the whole spectrum of participation methods.

6.7 Working with the VCFSE differently

Empowering and working with the Voluntary Community Faith and Social Enterprise (VCFSE) sector differently and integrating provision into our design and delivery models for services is one of our ways of working.

Norfolk and Waveney enjoys a broad and diverse VCFSE sector. There are 3645 registered charities, 220 community interest companies and 124 registered societies with their registered offices in Norfolk & Waveney. Many of these organisations have been born of local communities of interest or geography, responding to specialist need to provide not for profit services and support. Many of these organisations will focus on early intervention and preventative services, born of lived experience, which empower their communities to build resilience and maintain control of their own lives.

Underpinned by a memorandum of understanding our VCFSE Assembly was launched in July 2022 with a headline objective to connect this rich and diverse public benefit across the overarching mission for Norfolk & Waveney's ICS. The Assembly provides the sector with a strong voice across the

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decision-making process, having adopted the principles of a Memorandum of Understanding drawn up ahead of its formation. VCFSE representatives sit across our five place boards and eight health and wellbeing partnership boards, providing a vehicle for engagement of local organisations across the eight ambitions and other emerging local priorities.

The VCFSE sector in Norfolk and Waveney is facing a 'perfect storm' of rising running costs and reduced fundraising income as supporters tighten their belts. Set against a backdrop of increasing demand for services more and more sector leaders are currently facing tough decisions as they try to maintain their public benefit mission. With the establishment of our Assembly we do now have an opportunity for ICS partnership and strategic alignment across the early intervention and prevention ambition specifically. Not only could this start to shift demand away from more acute interventions, it will help the people of Norfolk and Waveney to live longer, healthier, and happier lives.

At its heart, the VCFSE Assembly is the vehicle through which our ICS will shape the development of effective strategic and operational partnerships across the diversity of Norfolk & Waveney's VCFSE sector; listening to and seeking to involve any, and every, VCFSE organisation providing health and care support for the benefit of their communities across Norfolk and Waveney. The graphic below (Figure 12) sets out how the listening and involvement work of the Assembly is being augmented; through the support, nurturing and development work of our VCFSE infrastructure organisations and through improved collaboration, co-production and shared governance as an integral part of our ICS.

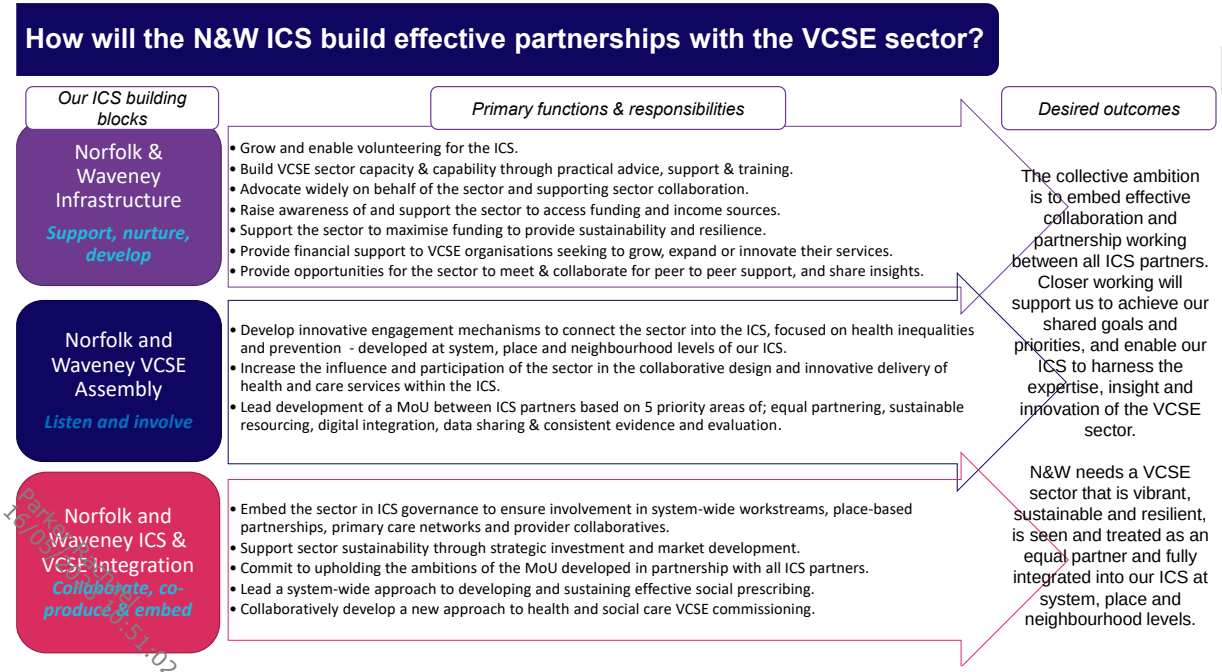

Figure 12 – building effective partnerships with the VCFSE sector

As our place-based approach takes shape the work of the Assembly will focus across the following three priorities over the coming months;

1. **Agree next steps for development of a VCFSE commissioning strategy.** As a system we do already have a number of key commissioning arrangements in place with VCFSE organisations working across our system. The next steps for the development of our commissioning strategy will be to focus on how we can partner across a broader range of organisations, many of whom will work on a smaller scale and at a local level. Our strategy will be informed through relevant stakeholder engagement to help us build shared understanding across three key areas;
   - The impact that preventative and early interventions across our communities can have; what is our shared understanding of value and how can we measure it?
   - The added social value brought through strategic VCFSE sector partnering; financial value, community value, and the value of long term strategic partnering.
   - The importance of building empowering practice into everything that we do, of supporting every individual to understand what behaviour change might mean for the health and wellbeing of themselves and their loved ones.

2. **Support the ICS health inequalities agenda**. Our Place-based Assembly representatives were appointed on the basis of their connectivity to, and insight across, the inequality priorities for each place. These representatives will look to connect relevant VCFSEs into our emerging ambitions and priorities, helping to build the relationships and partnerships that will facilitate the VCFSE sector to engage with places at a strategic and operational level.

3. **Create a 'road map' for VCFSE Assembly development.** The road map will consider all that we have learned through our first fifteen months of operation and make recommendations for the next phase of our VCFSE Assembly in Norfolk and Waveney, considering the following areas in particular but not exclusively;
   - Improving communications and direct engagement opportunities between the Assembly and our VCFSE constituency
   - Reviewing how we best connect relevant VCFSE organisations with the place-based approach and the work happening locally
   - Reviewing Assembly board membership remains relevant to our evolving agenda
   - Ensuring Assembly operations are sustainably resourced and facilitated

7.0 Commitment to achievable, measurable and impactful improvements

The improvements we make will be measured through system Programme Boards, reported in annual plans and key metrics will be included in our Integrated Performance Report (IPR). A summary of key metrics for each objective is shown in Figure 13.

<placeholder for Figure 13 final metric summary>.

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Our **commitment** is to listen to the people who use our services to see if we are successfully improving the health and care for the people and communities of Norfolk and Waveney and delivering our joint forward plan ambitions.

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Appendix 1 ICS Strategies that will support the Ambitions

Ambition 1 Transforming Mental Health Services
Other ICS Strategies that will support the Mental Health Ambition: The joint HWB and Integrated Care Strategy for N&W priorities of **Driving Integration** by mobilising Mental Health collaboratives in the delivery of people-centred care; **Prioritising Prevention** with a MH collaborative and shared resources, supporting people to be resilient throughout life; **Addressing Inequalities** by providing support for those who are most vulnerable using a collaborative approach to develop pathways **and Enabling Resilient Communities** by supporting people with complex needs to remain independent whenever possible, through promotion of early support and recovery. **Clinical Strategy Objectives:** See me as a whole person including parents, families and carers in these conversations. Agreeing a universal bio-psycho-social model of clinical assessment with clinicians and patients. **Digital Strategy & Roadmap:** Digitised patient records, shared information **Estates:** Norfolk & Waveney estate will play a key role in supporting prevention. Mental Health services have already begun to work in a more integrated way with primary care services, positioning services discretely alongside other community based clinical service provision. We will ensure we have the correct infrastructure model in each locality through the five mental health and wellbeing hubs being developed alongside primary and community health and wellbeing hubs. This will allow for creating a more joined up approach to care and better continuity between urgent care and community services. The hubs will support a reduction in referrals to crisis teams and subsequently reduce the number of people attending hospital for emergency care. Significant investment in new hospital sites will enable us to care for our population in modern and well equipped environments, securing better health outcomes. **Our Net Zero Green Plan focus areas:** Sustainable models of care (community hubs), Digital Transformation, Medicines, Nature Connection and Biodiversity. (**Our Green plan provides a point of focus and coordination across 11 key focus areas. Through this plan we bring clinical and operational service teams together to positively impact the journey toward net zero through innovative projects between our Health providers. In our focus area ‘**Sustainable models of care’ (community hubs) we define and implement ‘health & care pathways’ that enable integration with community based NHS services, seeing the patient as a person and supporting the notion of ‘only telling the story once’; Other parts of our Green plan include Digital Transformation – such as our electronic patient record programme – providing safe access to all clinical

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practitioners about a person's health conditions; Optimising medicines to minimise impacts on the environment – such as our inhalers programme changing to inhaler type that exclude harmful propellants; we use our programme for Nature Connection and Biodiversity to coordinate investment in our built environment to provide spaces that promote health and aid wellbeing).

Research: **TBC once published**

People Plan: Work is underway to make MH services more accessible in the community by integrating new MH roles such as MH Practitioners, MH Pharmacists and MH Recovery. Workers into GP practices. We will continue to build psychological therapy skills in our workforce recognising the importance of giving people the resources they need to recover from poor mental health and build the skills and insights to maintain recovery.

Quality Strategy: Focussed on improving care quality and outcomes, using insights around health inequalities and population health to achieve fair outcomes and ensuring services are safe and sustainable for future generations.

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Ambition 2 Improving Urgent and Emergency Care
ICS Strategies that will support the UEC Ambition include: The joint HWB and Integrated Care Strategy for N&W priorities of **Driving Integration** by working together as a system to ensure people receive the right care, in the right place, at the right time and reducing LoS. **Addressing inequalities** by improving accessibility and reducing ambulance wait times and **Enabling Resilient Communities** by supporting people to return back to their communities by reducing LoS and expanding virtual ward services. **Clinical Strategy Objectives**: See me as a whole person to enable patients to only tell their story once and act early to improve health by integrated solutions for effective 111, Urgent Treatment Centres, Same Day Emergency Care, discharge and 999 services. **Digital Strategy & Roadmap**: Digitised patient records, shared information, virtual health and care are all key critical enablers to the UEC ambition **Estates:** Our estate strategy aligns with the UEC ambition by developing and managing estate that allows delivery of the right care in the right place, enables better patient outcomes, and empowers health, social care and third sector staff to provide the best possible care. This is achieved through the strategic objectives of: • Improving Access – ensuring that the right services are delivered in the right place, matching demand and capacity • Improving Quality & Condition – Providing safe, flexible, modern, and fit-for-purpose estate and supporting services for our patients, visitors, and staff • Improving Sustainability – Implementing interventions to decarbonise our estate and reduce carbon emissions arising for our buildings, infrastructure, and services • Improving Efficiency – Providing a right sized estate and supporting services that delivers value for money and long-term financial sustainability • **Our Net Zero Green Plan focus areas:** Sustainable models of care (virtual wards and community hubs), Digital Transformation as referenced in the digital roadmap, Travel and Transport. Our Green plan includes a focus on developing sustainable models of care which aim to embed prevention in the development of all models of care e.g. an expanding virtual ward service enabling patients to recover and be monitored at home. We continue to harness digital technology and systems that support and streamline services, resources, and expand our ability to reduce carbon emissions

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Research: **TBC once published**

People Plan: Expansion of the workforce across health and social care to ensure the support of patient flow throughout the ICS.

Quality Strategy: Focus on improving care quality and outcomes, using insights around health inequalities and population health to achieve fair outcomes & ensuring services are safe and sustainable for future generations

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Ambition 3 Elective Recovery & Improvement
ICS Strategies that will support the Elective Recovery Ambition: The joint HWB and Integrated Care Strategy for N&W priorities of Driving Integration, Prioritising Prevention, Addressing Inequalities and Enabling Resilient Communities **Clinical Strategy Objectives:** Reducing long waiting times by prioritising waiting lists and target those at highest clinical need and developing management and care for those on long waiting lists for example the 'while you wait' information on Improving Lives together ICS website. Developing elective diagnostic hubs which will help with capacity and capability and focus on increasing access to virtual care and services **Digital Transformation Strategic Plan and Roadmap capabilities:** Digitised patient records, Shared Information, Data and Analytics, Citizen and Patient Tools, Virtual Health and Care, Fully Integrated Infrastructure and Connectivity. Digital is a key enabler to this Ambition and a Single Waiting List is specifically noted as a priority within the Shared Information capability in the strategy. **Estates: TBC** **Our Net Zero Green Plan focus areas:** Sustainable models of care (community hubs), Digital Transformation, Medicine, Supply Chain and Procurement, Food and Nutrition **Research: TBC once published** **People Plan:** Ensuring the system has the right capacity to meet demands both in the here and now and in the future. This will include building on the existing substantive workforce to ensure they have the correct capabilities and supporting this through safe temporary staffing measures through the collaborative bank and the reservist programme. Building the workforce to meet future demand will also ensure the system keeps safe and sustainable. **Quality Strategy:** Focussed on improving care quality and outcomes, using insights around health inequalities and population health to achieve fair outcomes and ensuring services are safe and sustainable for future generations.

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Ambition 4 Primary Care Resilience & Transformation

ICS Strategies that will support the Primary Care Ambition:

The joint HWB and Integrated Care Strategy for N&W priorities of Driving Integration by working in partnership priorities of **Driving Integration** by developing MDT neighbourhood teams shifting focus to community support; **Addressing Inequalities** by ensuring our services are easily accessible to all and improving accessibility to our services for those who need more support at a local level and **Enabling Resilient Communities** by building a local resilient multi-skilled professional workforce and with services closer to home, enabling people to live independent healthy lives in their communities for as long as possible.

Clinical Strategy Objectives: See me as a whole person, to bring care closer to home wherever possible to do so.

Digital Strategy & Roadmap: Digitised patient records, shared information, population health management, citizen and patient tools, virtual health and care (e-referrals), fully integrated infrastructure - wi-fi connectivity and cloud telephony in primary care

Estates: To provide integrated 'out-of-hospital care,' with a focus on prevention, self-care and supporting people to live well at home for longer, our community-based providers, NCHC, NSFT, CCS, EEAST and ECCH, are working with PCNs to develop their integrated service models / PCN Estate strategies, influencing the size and type of wider community estate. Where necessary, community providers will relocate service activity to primary care, or proposed community located care hub and spoke models, whilst retaining core estate to provide more specialist and focussed care. We are investing in health hubs, formed from new and existing community-located assets, and may be comprised of more than one building in a 'Place' level setting. They will offer the opportunity to implement modern technologies and address digital deprivation across the ICS. Health & care estate will be developed to maximise integrated generic spaces in community settings. Bookable clinical and non-clinical rooms will act as a flexible resource for the wider health and social care community.

Our Net Zero Green Plan focus areas: Sustainable models of care (community hubs), Digital Transformation, Estates & Facilities, Medicine, Supply Chain and Procurement and a bespoke 10-point plan for Primary Care and GP Practices to reduce carbon emissions, including the development of their estates strategies

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People Plan: Primary Care Workforce Strategy: we will support workforce planning, recruitment, and retention, providing opportunities to all for education, training, and development of the whole primary care workforce.

Quality: Focussed on improving care quality and outcomes, using insights around health inequalities and population health to achieve fair outcomes and ensuring services are safe and sustainable for future generations

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Ambition 5 Improving Productivity & Efficiency
ICS Strategies that will support the Improving Productivity and Efficiency Ambition include: The joint HWB and Integrated Care Strategy for N&W priorities of **Driving Integration** by working in partnership on estates, medicines optimisation, workforce efficiency, and procurement; **Addressing Inequalities** by working better together it should improve accessibility to our services for those who need the most support and **Enabling Resilient Communities** by increasing our productivity and efficiency which in turn should enable people to live independent healthy lives in their communities for as long as possible. **Clinical Strategy Objectives**: See me as a whole person and ensuring the essential use of medicines (focussing on over treatment and polypharmacy), Be one high quality, resilient service focusing on integrated service development that strengthens organisations and brings systems and services together, Be reliable and agreeing and adopting a model of value based healthcare plan. **Digital Strategy & Roadmap**: A number of enablers within the digital strategy will release staff time and reduce duplication so more time can be spent with patients e.g. such as digitised patient records, shared information, data and analytics, citizen and patient tools and virtual health and care. Digital workforce tools and fully integrated infrastructure and connectivity will have a more direct benefit to this ambition as they are linked to the HR/People and Digital changes that we intend to make through the change programme. **Estates: TBC** **Our Net Zero Green Plan focus areas:** We have an over-arching vision for Net Zero and within that we state that we will be using what we have got to best effect across all partners - so investing in the right things at the right times and holding each other to account on the use of resources. This Ambition is based on the principle of sharing and collaboration of resources and there is real opportunity to ensure that Net Zero is embedded in this Ambition and aligned to the green plan. **Research: TBC once published** **People Plan** A number of programmes are being delivered to improve efficiency and productivity across the system. Our 'One-Workforce' programme is looking at how to streamline back office HR and workforce functions across the ICS to reduce

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duplication, a reduction in agency spend is required to meet national efficiency targets and integrated workforce plans including provider collaborations and working with the VCSFE sectors are to be developed at system level to support the delivery of the NHS Long Term Plan ambitions; Multi professional educational and training investment plans with sufficient clinical placement capacity are required to maintain education and training pipelines.

Quality Strategy: Focussed on improving care quality and outcomes and ensuring services are safe and sustainable for future generations. It is imperative that quality is a theme throughout the change programmes and that financial improvement does not override quality outcomes.

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Ambition 6 PHM, Reducing Inequalities and Supporting Prevention
ICS Strategies that will support the Ambition include: The joint HWB and Integrated Care Strategy for N&W priorities of **Driving Integration** by using and sharing data and evidence to inform planning; **Prioritising Prevention** by delivering the 3 work programmes to prevent people from becoming ill and promoting healthy lifestyles; **Addressing Inequalities** via the work programmes, targeting interventions to those that need it the most; and **Enabling Resilient Communities** by supporting people to live independent healthy lives by early cancer diagnosis and cardiovascular disease prevention. The Norfolk & Waveney Local Maternity and Neonatal System (LMNS) agreed a plan in September 2021 that sets out in detail what we would like to achieve and put in place locally: https://improvinglivesnw.org.uk/our-work/healthier-communities/maternity-services/local-maternity-and-neonatal-system-lmns/lmns-workstream-prevention/prevention-project-nhs-long-term-plan-smokefree-pregnancy/ . Population Health management is an enabler for all ICS strategies – but in particular there are links with: **Clinical Strategy objectives**: Act early to improve health by creating a health improvement and transformation partnership and a structured programme to increase vaccination. Plus tackle health inequalities by producing a plan to address CORE20PLUS5 to reduce inequalities through Place based partnerships and to consider resources to minimise the inequalities from the pandemic. **Digital Strategy & Roadmap**: There is a dedicated population health management priority which will apply a holistic view to our population, use data-driven insights to better engage with our citizens and system partners, and tailors system resources to better support people **Estates Strategy:** there is a focus on population health management through five key programmes of work that form the basis of our enabling work. These include: • Utilising comprehensive datasets to inform our decision making about investment and development. This includes developing digital tools to improve estate performance. • Convening a collaborative approach to workforce planning and management, aligning workforce in support of developing clinical services. • Collectively delivering cost improvement plans and removing unwarranted cost variation, helping reduce financial deficits, focussing our resource for frontline services.

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- Embedding policy and protocol to ensure population growth is planned for, and seeking funding through appropriate routes to support mitigation.
- Prioritising investment to best respond to system challenges and priorities, and identifying income opportunities to fund investment need.

Our Net Zero Green Plan focus areas: Sustainable models of care - we will embed prevention in the development of all models of care. (The NHS greatly influences the health and wellbeing of its communities and can make a meaningful impact on the economic, social, and environmental wellbeing of the population.
Our Green plan includes a focus on developing sustainable models of care which aim to embed prevention in the development of all models of care. This is exemplified by:

- Publication of the ICS Clinical Strategy that promotes new sustainable models of care;
- Supporting the Primary Care Network (PCN) development in ways that promote integrated services, closer to home;
- Prioritising investment that further enhances services in our local communities, for example the Primary Care Hub projects and the Community Diagnostic Centres;
- Launched an expanding virtual ward service enabling patients to recover and be monitored at home;
- Continuing to explore clinically equivalent lower-carbon interventions).

Research TBC once published

People Plan Creating a compassionate and inclusive environment will help support inclusion and belonging for all (internally and externally), and creating a great experience for staff through our people working and learning in the ICS can develop and thrive in a compassionate and inclusive environment. Issues of inequality and inequity are identified and addressed for all people working in the system. The workforce and leaders in the ICS will be representative of the diverse population they serve. Maximising our expertise throughout UEA, working as an Anchor Institute across the ICS to achieve sustainable growth across health and care systems focused on workforce and system transformation. The Rural and Coastal programme in collaboration with NHSE will help tackle and address health inequalities through education, training and use of digital technology.

Quality Strategy: Focussed on improving care quality and outcomes and using insights around health inequalities and population health to achieve fair outcomes

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Ambition 7 Improving Services for Babies, Children, Young People and Maternity (BCYPM)

ICS Strategies that will support the BCYPM Ambition include:
The joint HWB and Integrated Care Strategy for N&W priorities of **Driving Integration** by sharing data and evidence and working collaboratively to improve services for BCYP; **Prioritising Prevention** by a systematic approach to preventing ill health from birth through early years; **Addressing Inequalities** by reducing health inequalities; and **Enabling Resilient Communities** by support CYP and families to live independent healthy lives in their communities.

Clinical Strategy Objectives: See me as a whole person by developing an action plan for personalised care that embeds personalisation across the ICS services and agreeing a universal bio-psycho-social model of clinical assessment, working together as one high quality resilient service, acting early to improve health, reliable services and addressing health inequalities

Digital Transformation Strategic Plan and Roadmap: Digitised patient records, shared information and citizen and patient tools will support this objective. For example data sharing arrangements to capture 'whole family' needs, whichever part of the system families access. Empower people to manage their health and wellbeing through the use of patient portals and apps, together with ensuring each hospital has their Digital Maternity Strategies aligned.

Estates: Recent 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. The strategy recognises that more support is needed for communities, focussed on children and young people in the areas of prevention, early help, and health inequalities to promote healthier lifestyles and emotional wellbeing. To deliver the support in communities for children and young persons, partners across the ICS will need to work together focusing on the wider determinants of health to enable the best possible outcomes for residents. This strategy supports the improvements to health services available to patients by:

- Bidding for and developing extra resource to support greater community provision;
- Supporting access to accommodation for all providers using shared processes, opening capacity of our estate and maximising utilisation.
- Directing investment to create suitable environments that support earlier intervention before a person's condition develops to reduce the risk of conditions worsening and becoming entrenched, for example, in eating disorders.
- Direct extra resources to the communities and age groups most in need especially children and young people.

Our Net Zero Green Plan focus areas: Sustainable models of care (family hubs), through digital transformation as referenced in the digital roadmap and through medicines and the opportunity to reduce our carbon emissions related to prescribing and use of

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medicines and medical products e.g. the greener inhaler campaign for asthma. The NWICS Green Plan drives our journey toward achieving the Net Zero NHS between 2040-2045. In supporting users of health and care services the green plan provides a focus that influences other areas of ICS strategy, and the use of available resources. Examples include:

- Sustainable models of care' (community hubs) we define and implement 'health & care pathways' that enable integration with community based NHS services, seeing the patient as a person and supporting the notion of 'only telling the story once';
- Other parts of our Green plan include Digital Transformation – such as our electronic patient record programme – providing safe access to all clinical practitioners about a person's health conditions;
- Optimising medicines to minimise impacts on the environment – such as our inhalers programme changing to inhaler type that exclude harmful propellants;
- we use our programme for Nature Connection and Biodiversity to coordinate investment in our built environment to provide spaces that promote health and aid wellbeing).

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People Plan – Ensuring learnings from areas such as the Ockenden report and East Kent in relation to maternity failings and issues around culture and leadership are adopted across the workforce. Freedom to Speak Up Guardians will ensure everyone working within the ICS feels safe and confident to speak up and the creation of safe spaces to work will create a positive culture for staff.

Quality Strategy: Focussed on improving care quality and outcomes. Using insights around health inequalities and population health to achieve fair outcomes & ensuring services are safe and sustainable for future generations.

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Ambition 8 Transforming Care in Later Life
ICS Strategies that will support the Transforming Care in Later Life Ambition include: The joint HWB and Integrated Care Strategy for N&W priorities **of Driving Integration** by working in partnership to ensure people age well; **Prioritising Prevention** with a focus on enhancing access to early intervention and prevention; **Addressing Inequalities** by improving care for people most at risk of falls using a collaborative system approach and **Enabling Resilient Communities** by enhancing access to early intervention and prevention enabling people to remain independent whenever possible. **Clinical Strategy** objectives of Seeing me as a whole person which is about shared treatment plans, ensuring life circumstances are taken into account, that independence is prioritised and medication will be used where essential to avoid overdiagnosis and over treatment. We want to predict, detect and act early to improve health and prevent avoidable crisis where possible through working together to manage long term health conditions. **Digital Strategy & Roadmap:** Developing a digitised patient record and having shared information is key to be able to the clinical strategy objective of Seeing me as a whole person. Population Health Management applies a holistic view to our older population which will help to target interventions and virtual health and care is a key capability that can personalise care and support our population to receive care at home. **Estates Strategy**: Norfolk is particularly popular for people looking to retire meaning that many new residents are likely to be older. Our estate strategy includes focus on the effectiveness of available investment resources, by working with partners to enable more housing within public sector assets for the increasing population. We manage existing estate with shared clinical policy alignment, digital investment and management information to drive decision making. The ICS recognises the need to increase both the range and volume of options for older people to access our services and is committed to helping older people live independently for as long as possible. Our approach to managing our estate aims to reduce pressure on health and social care, impacting a reduction in A&E admissions, a reduction in falls, an increase in wellbeing and mental health, and a reduction in GP appointments. Extra care housing schemes include a variety of features depending on the scale, location, and stated purpose of individual developments. Development of ICS estate continues to consider alignment to this programme, liaising with developers to identify schemes that deliver stronger health outcomes to Norfolk residents.

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Green Plan / Net Zero: Our Green plan provides a point of focus and coordination across 11 key focus areas. Through this plan we bring clinical and operational service teams together to positively impact the journey towards net zero through innovative projects between our Health providers. In our focus area **'**Sustainable models of care' (community hubs) we define and implement 'health & care pathways' that enable integration with community based NHS services, seeing the patient as a person and to make sure that you only have to tell your story once. Other parts of our Green plan include Digital Transformation – such as our electronic patient record programme – providing safe access to all clinical practitioners about a person's health conditions. This is entirely aligned with the ICS Digital Strategy and Roadmap. Optimising medicines to minimise impacts on the environment – such as our inhalers programme changing to inhaler type that exclude harmful propellants. We use our programme for Nature Connection and Biodiversity to coordinate investment in our built environment to provide spaces that promote health and aid wellbeing.

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People Plan: Supports improved wellbeing of staff across the system by involving them in the redesign of services. For N&W the increasing older population will require a different type of workforce to the one it currently has. Changes in skill mix, re-designing of services and increasing the staffing mix will all form part of our immediate and longer term planning.

Quality Strategy: Focussed on improving care quality and outcomes, using insights around health inequalities and population health to achieve fair outcomes and ensuring services are safe and sustainable for future generations

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Norfolk and Waveney Joint Forward Plan

Part 2: Legal duties and other content

Contents

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Describing the health services for which the ICB proposes to make arrangements

Our Joint Forward Plan sets-out how we will meet the physical and mental health needs of the population and how we will transform services over the next five years.

The plan sets-out eight ambitions, aligned to the priorities in the transitional Integrated Care Strategy for Norfolk and Waveney, which is also our Joint Health and Well-Being Strategy. Our ambitions are:

1. Transforming Mental Health services
2. Improving Urgent and Emergency Care
3. Elective Recovery and Improvement
4. Primary Care Resilience and Transformation
5. Improving Productivity and Efficiency
6. Population Health Management (PHM), Reducing Inequalities and Supporting Prevention
7. Improving services for Babies, Children and Young People and developing our Local Maternity and Neonatal System (BCYPM)
8. Transforming care in later life

The eight ambitions are explained in detail in the Joint Forward Plan (JFP), including clear objectives, trajectories and milestones.

Duty to promote integration

Norfolk and Waveney is committed to integrated working and joint commissioning across the health and social care system. This is reflected in the local approach to the Better Care Fund (BCF) - a nationally mandated programme with the aim of joining up health and care services, so that people can manage their own health and wellbeing and live independently. The BCF is executed through three programmes of work under the BCF 'banner':

- Core BCF - bringing Local Authority and NHS partners together to agree integrated priorities, pool funding and jointly agree spending plans.
- Disabled Facilities Grant (DFG) - Help towards the costs of making changes to a person's home so they continue to live there, led by District, Borough and City Councils in Norfolk.
- iBCF - Available social care funds for meeting adult social care needs, ensuring that the social care provider market is supported, and reducing pressures on the NHS.

Locally the BCF is focused on the following priorities that reflect the wider strategic aims of our system and reinforce the importance of subsidiarity, where we are all working towards the same things:

- Prevention, including admission avoidance
- Sustainable systems
- Person-centred care and discharge

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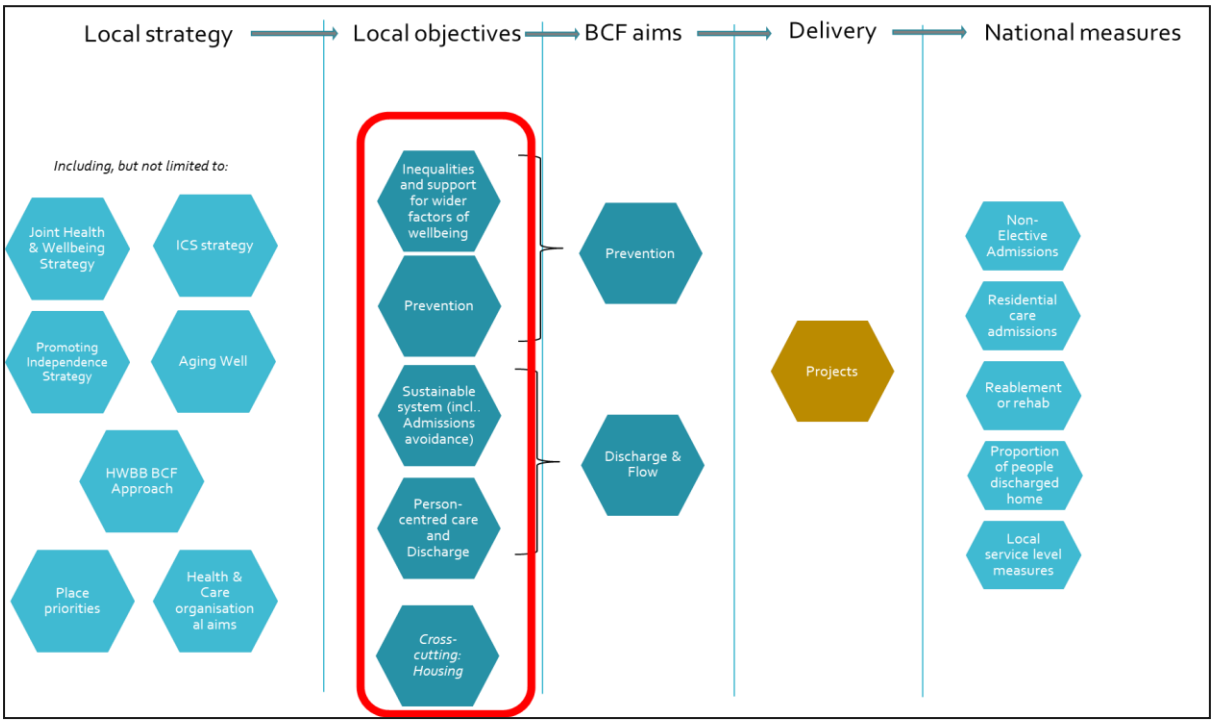
- Inequalities and support for the wider factors of wellbeing
- Housing, DFGs and overarching pieces of work.



The Norfolk BCF now acts as a delivery arm for integrated working across the system and supports Place-based priorities. Norfolk is aiming to increasingly align the BCF Plan with its Places and support important local areas of joint health and care working. Place-based working is also enabling the Norfolk and Waveney system to use the Core BCF guidance to involve and empower NHS Trusts, social care providers, voluntary and community service partners and other system partners in the development of the BCF. Funding through Norfolk's annual BCF uplift has been utilised to support delivery of the priorities at Place, with collaborative proposals developed that best support the delivery of the BCF metrics / aims at a more local level.

The development of the BCF approach, plan and submission brings Local Authority and ICB leaders with wider ICS partners in the Health and Wellbeing Board to make integrated financial and commissioning decisions, engaging with partners across the health and care system in those decisions. System partners in Norfolk have utilised the BCF to fund and develop critical services that support the health and wellbeing of our population, including care from the provider market, key health and care operational teams, and community-based support from the VCSE sector. Many of the BCF services are jointly funded and commissioned, including:

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- A Social Impact Bond for Carers – support carers with information, advice, support and Carers Assessments to improve their wellbeing and help them maintain their caring role. This is joint funded by NCC and NHS N&W, with joint membership at the Strategic Board.

- Norfolk Advice Network and Advocacy Partnership – this is a new service jointly funded by NCC and NHS N&W, which aims to provide a single point of contact for information, advice and advocacy in Norfolk.
- Intermediate Care – NCC and NHS N&W are working together to deliver appropriate, integrated intermediate care both preventing hospital admission and supporting discharge.

In addition to service development as part of the BCF our system is also working collaboratively on a number of other integrated programmes between health and social care, including a collaborative review of the Nursing Care Market; an Integrated Care Market Quality Improvement Programme; and the development of an All Age Carers Strategy. The ICS is committed to delivering an effective, integrated oversight of key integrated arrangements, including the BCF and other arrangements for pooling, sharing resources and joint commissioning.

Duty to have regard to wider effect of decisions

The triple aim requires NHS bodies to consider the effects of their decisions on:

- people's health and wellbeing (including inequalities in that health and wellbeing)
- the quality of services
- the sustainable and efficient use of resources.

Here is a summary of how we developed our plan in line with the triple aim and how the triple aim will be accounted for in ongoing decision-making and evaluation processes:

People's health and wellbeing:

- Our two local Joint Strategic Needs Assessments and a case for change have provided the foundation for ensuring that our Integrated Care Strategy and this plan are evidence-based, as set-out in the 'Why are we doing this?' section of this JFP.
- The case for change supports us to prioritise the actions we will take over the next five years to improve people's health and wellbeing, resulting in our eight ambitions and the clear objectives that sit underneath each ambition, that are articulated in this plan.
- We will use a wide range of mechanisms to help us measure our progress with improving the health and wellbeing of local people, to understand the effectiveness of the decisions we've made and to help us decide what we need to do next. These will include future Joint Strategic Needs Assessments, our quality objectives and processes, and the work of the ICB's committees (including the ICB's Patients and Communities Committee which will support us to ensure we understand the views of local people and communities). Importantly, this will include our progress with reducing health inequalities.

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The quality of services:

- This plan has been developed in line with our quality objectives and processes, which are detailed in the quality section of this plan.
- Alongside our system's Quality Management Approach, the CQC's assessments of individual providers / services and our Integrated Care System, will help us to collectively understand and drive improvement in the quality of local health and care services.

The sustainable and efficient use of resources:

- This plan has been developed in line with our Medium-Term Financial Plan to ensure that it is costed and affordable, and that it supports our system to achieve our duty to deliver financial balance.
- Our Medium-Term Financial Plan sets-out how we will create more efficient services through integration, innovation, and better use of data to improve productivity, ensuring that we spend every pound effectively. Our work to implement new technology and tools, as outlined in the digital section, will greatly support this work.
- We have a Chief Finance Officer forum which ensures that our planning is coordinated, and our progress is measured together, helping us to really understand where we can drive efficiencies and avoid cost-shunting between organisations.

In addition, all ICB Board and committee reports are required to set-out the implications and risks of decisions on a range of aspects. Reports include the impact on clinical outcomes and the quality of care, delivery of the NHS Constitution, the financial and performance implications and the environmental and equalities impacts.

All proposals to change or develop new services, including those which will deliver this plan, are informed by environmental and equalities impact assessments, engagement, an understanding of the impact on the health and wellbeing of local people (including health inequalities) and our use of resources.

Overall, the duty aims to foster collaboration between local health and care organisations in the interests of the populations they serve. To achieve this, we will need to do more than put in place effective governance arrangements and clear processes; it will also require a cultural change and for people working in health and care services to think and behave differently. As outlined in this plan, we have a significant organisational development programme to accomplish this.

Financial duties

The ICB and its NHS partner organisations have collective local accountability and responsibility for delivering NHS services within the financial resources available.

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The 'Revenue finance and contracting guidance for 2023/24' sets out that each ICB and its partner trusts must exercise their functions with a view to ensuring that, in respect of each financial year:

- local capital resource use does not exceed a limit set by NHS England
- local revenue resource use does not exceed a limit set by NHS England.

To achieve this the ICB supports the financial planning process across all NHS organisations within the Norfolk and Waveney system.

The financial resources of the N&W ICB are in two key streams, these are capital and revenue. Capital resources are the funds assigned to improve the infrastructure of the NHS, for example replacing large pieces of medical equipment or building a new hospital and health and social care facilities. Revenue funding is for the ongoing provision of healthcare services on an annual basis, for example paying the salaries of NHS staff and the consumable items such as needles and dressings.

Capital resource planning and approvals

Capital resources are distributed via the Norfolk and Waveney Strategic Capital Board (SCB), which includes representatives of all NHS providers, as well as speciality experts in digital and estates. All parties across the system identify their priorities and the SCB considers these to ensure that the available resource gets assigned to the most important capital requirements. Examples of high priority investment programmes could be those where the Care Quality Commission (CQC) has reported that an area or location is now unfit for modern patient care, or national priorities and ring-fenced money for elective recovery, such as Diagnostic Assessment Centres. Once the SCB has determined the priorities then it makes a recommendation to the Finance Committee and the ICB Board for approval. ICBs and their partner NHS trusts and NHS foundation trusts are also required to share their joint capital resource use plans and any revisions with each relevant Health and Wellbeing Board

Once approved, organisations have the authority to proceed and spend the capital resource on the agreed schemes and this is monitored and reviewed. Any in-year negotiations on under or potential over-spends are led by Chief Finance Officer forum, which comprise the Directors of Finance from each of the NHS partners, together with any subject matter experts through the relevant programme boards.

Revenue resource planning and approvals

The majority of the Norfolk and Waveney revenue resource is already committed to hospitals and services, since running these services is an ongoing commitment. From the annual planning perspective, each NHS organisation is required to produce a financial, activity and workforce plan that delivers the overall objectives set out in the annual planning guidance.

To determine the final annual revenue plan, each organisation considers and prepares its financial position with regard to the allocations and requirements as set out in the annual Revenue Finance and Contracting Guidance documents. This document indicates specific factors such as tariff changes, growth funding, efficiency and convergence requirements which are managed through the annual planning round.

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The Chief Finance Officer forum is the initial place where organisational and system wide revenue financial plans are assessed, scrutinised and challenged with peers. The process is collaborative; system wide transformation schemes from the Norfolk and Waveney Productivity Programme Board and other strategic system wide investments are also included to create the complete annual revenue plan. The plan is then considered across a range of groups including with the NHS partners themselves, at the ICS Executive Management Team and with the chief operating officers and workforce leads. Once individual NHS provider boards and the ICB Board are satisfied that the NHS Norfolk and Waveney system revenue plan is complete, it is then submitted to NHS England for final approval.

During the year operational delivery of the plan and achievement of financial objectives are manged via the Chief Finance Officer forum and the ICB Finance Committee, both meet and review progress on a monthly basis. The financial values that have been agreed flow into contracts signed between the ICB and the providers.

The provider contracts are in turn supported with the System Collaboration Financial Management Agreement (SCFMA), which is similar to a Memorandum of Understanding, setting out principles of working together. Where financial plans are not being delivered or are at risk of not being delivered, the first action is to review within the organisation and across the system collectively. We are working to a system control total, so the accountability for the under or overspend is shared and collective decisions have to be made as to how to manage this through risk / investment sharing. Reviewing all current areas of spend would be an immediate priority to see what can be paused or stopped. However, the overriding management approach is to set a robust budget from the outset, with realistic transformation opportunities profiled across the year, with mitigations, escalation and ongoing dialogue so there is transparency and visibility of any emerging divergence from plan.

Ratification for any subsequent decisions or changes to the plan would be via the ICB Finance Committee and the ICB Board, working with NHS England during this time.

Duty to improve quality of services

The Norfolk and Waveney ICS Quality Strategy 2022-25 outlines our quality priorities and makes a commitment to the people of Norfolk and Waveney to deliver quality care, based on what matters most to the people using our services and the friends and family who support them.

Shared Commitment to Quality

We should all expect to receive care and support that is consistently safe, effective, equitable and evidence based. Our experience of this should be positive and personalised, empowering us to make informed decisions about how we access timely care and support. Our Quality Strategy outlines our commitment to deliver care that is:

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Our Quality Strategy will support **integration**, **personalisation**, and **outcomes-based commissioning**, as a driver to transform and develop local teams, services and communities that promote wellbeing and prevent adverse health outcomes, equitably, for all people who live in Norfolk and Waveney. As a system, we will ensure that we examine patient experience and outcome metrics and encourage the public to be involved with quality improvement, patient safety, innovation and learning, in a way that is meaningful.

The ICS Quality Strategy is underpinned by continuous development of the ICS model for clinical leadership, quality governance, management and assurance, and research, evaluation and innovation. It is championed and led by the ICB Executive Director of Nursing, as executive lead for Quality and Safety, working closely with the wider Executive Management Team and the system's Director of Nursing Network.

Well-led through a culture of compassionate leadership

There is clear evidence that compassionate leadership results in more engaged and motivated staff with higher levels of wellbeing, which in turn results in higher quality care. According to The King's Fund (What is Compassionate Leadership?) compassionate leaders empathise with their colleagues and seek to understand the challenges they face. They are committed to supporting others to cope with and respond successfully to work challenges and they are focused on enabling those they lead to be effective and thrive in their work.

For leadership to be compassionate, it must also be inclusive; promoting belonging, trust, understanding and mutual support across our system. This needs to be delivered by a compassionate culture that underpins these values and develops people into effective leadership roles. From a quality perspective this means that we will support and empower people to work in a way that is transparent, accountable, and reflective.

Local implementation of the Professional Nurse Advocate (PNA) role will develop skills to facilitate restorative supervision, within nursing and beyond, to improve staff wellbeing and retention, alongside improved patient outcomes, using values of compassionate leadership to understand challenges and demands, and to lead support and deliver quality improvement initiatives in response.

The establishment of a Norfolk and Waveney Allied Healthcare Professional (AHP) Council and Faculty provides a system platform for the development of AHP leadership skills, as well as a scaled-up coordination and delivery arm for Health Education England opportunities for AHP skills, training and leadership development.

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The emerging Norfolk & Waveney Clinical and Care Professional (CCP) Leadership Framework puts CCP leadership at the heart of our discussions at every level of our system so that it becomes integral to our culture and how we work together. This is described in the section on People and Culture in the JFP.

The regional East of England Clinical Senate also provides opportunities for collaboration and clinical leadership through cross-system working and strategic alliances, bringing together health and social care leaders, professionals, and patient representatives to provide independent advice and guidance to commissioners and providers on specific transformational work.

Alongside developing leadership skills across our system, we are building system structures that allow us to identify and grow leadership talent across our clinical and non-clinical staff groups and provide a platform for clinical and non-clinical workforce voices, ideas and skills for collaborative quality improvement.

Improving Care Quality and Outcomes

Quality Management Approach

While ownership of quality within services, networks, and organisations needs to start internally, the system will be able to facilitate quality management at scale when required, to improve safety, health and wellbeing for the local population and share learning and good practice. Clear and transparent accountability and decision-making for and by system partners is essential, particularly when serious quality concerns are identified.

Our key partners in quality include people and communities, professionals and staff, provider organisations, commissioners and funders (including NHS England), CQC and other regulators, Healthwatch, research and innovation partners and the voluntary, community, and social enterprise (VCSE) sector.

The **ICS Quality Management Approach Hub** facilitates a systemwide approach to quality management. Through its Quality Faculty, it brings system partners together to share insight and good practice in quality improvement (QI). Staff from across the ICS can access shared QI training and resources via the Hub to support cross-organisational and system-wide QI. A similar system approach will be taken to sharing quality control best practice. The Hub has led on the development and roll-out of a prioritisation matrix to support the system with quality planning and is supporting co-production of QI programmes across the ICS.

Being people-centred is a key part of our quality journey and culture of improvement, acknowledging the value of people's lived experiences as a powerful driver for change. If our co-production work is effective, our people, communities and ICS partners will be able to see that:

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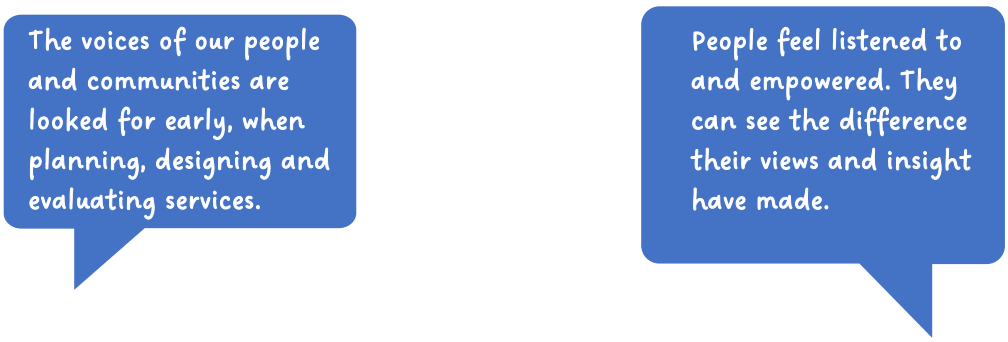

Healthwatch Norfolk and Suffolk are key partners in designing, facilitating and reporting on coproduction, offering expert independent advice and developing coproduction skills and confidence. Co-production is referenced in section 6.6 [check] within the JFP.

Quality And Addressing Health Inequalities

There is a strong relationship between service quality, including a service users experience of and equity of access to health and care with the underlying health needs of our population. Quality supports key elements of our populations' health and longer term health outcomes by enabling the delivery of safe, timely, accessible and evidence-based care and support. Further a joined-up approach to quality allows the system to:

- Look at what influences quality and length of life across the whole life course.
- Understand people's health behaviours and improve patient experiences of care.
- Support a healthy standard of living for all, whilst also understanding the 'social gradient' and working to reduce disparities in health outcomes.
- Understand the impact of health conditions on the demand and need for healthcare and the role of high-quality treatment and support as a prevention for further illness.

One of our eight ambitions is PHM, Reducing Inequalities and Supporting Prevention and we have set ourselves an objective to develop and Norfolk & Waveney Health Inequalities Strategy by March 2024, which will include our approach to CORE20PLUS5 Health Inequality Improvement framework for both Adults and Children and Young People.

Quality will be central to our approach to responding to the Core20PLUS5 healthcare inequalities Improvement Framework and our systems workstreams through quality improvement, service user engagement and workforce skills development. We have some specific objectives in our JFP that respond to these such as an initial focus on asthma, epilepsy and mental health in children. The quality approach will be key to the delivery of this objective within the BCYPM ambition as just one example.

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Safe System

Defining and Measuring Quality and Patient Safety
Norfolk and Waveney ICB are in the process of developing a System Quality Dashboard, with a suite of metrics already identified. These metrics align to the NHSE System Oversight Framework, ICB statutory duties and CQC Quality Statements:

- Embedding a learning culture
- Supporting people to live healthier lives
- Safeguarding
- Safe and effective staffing
- Equity in access
- Equity in experience and outcomes

The System Quality Dashboard remains in the development phase. The dashboard will be used to support quality assurance and quality improvement priorities through a number of key forums including the System Quality Group and ICB Quality and Safety Committee.

The dashboard will also be shared with other key groups such as the Primary Care Commissioning Committee, recognising the importance of the breadth of quality across everything the ICB does. The dashboard will continue to evolve and will reflect the priorities identified through the transition to the Patient Safety Incident Response Framework which is anticipated to take place in September 2023.

Patient Safety Incident Response Framework
The new national framework represents a significant shift in the way the NHS responds to patient safety incidents and local implementation is a major step towards establishing a joined-up approach to safety management across our system, in line with the NHS Patient Safety Strategy.

Quality Governance and Escalation
Governance and escalation arrangements for quality oversight are developing across our system, linked to regional quality oversight arrangements:

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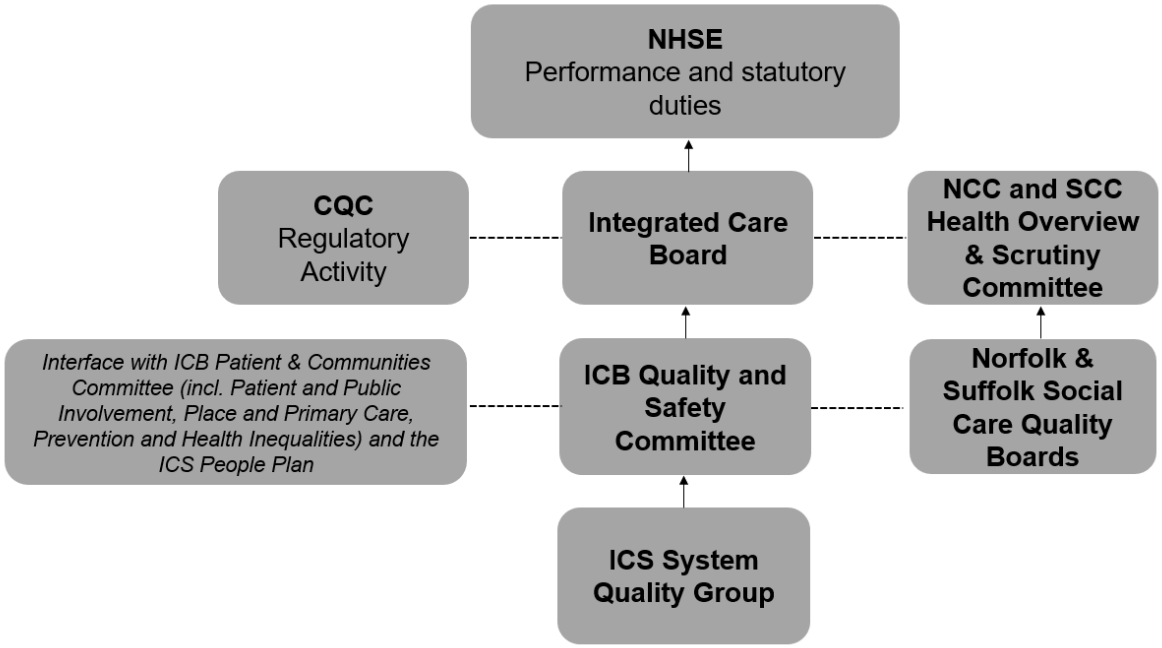

In addition to and alongside the ICS System Quality Group, the following portfolios also report into the ICB Quality and Safety Committee:

- Safeguarding Partnerships
- Local Maternity and Neonatal System
- ICS Learning from Deaths Group
- ICS Infection Prevention & Control Partnership
- Health Protection Assurance Board
- ICB Research and Evaluation Team
- ICS Quality Management Approach Hub
- ICS transformation Programme Boards, including UEC, Mental Health, Children and Young People and Learning Disabilities & Autism

The **ICS System Quality Group** enables routine and systematic triangulation of intelligence and insight across the system, to identify ICS quality concerns and risks. It provides a forum to develop actions to enable improvement, mitigate risk and measure impact and facilitates the testing of new ideas, sharing learning and celebrating best practice.

The **ICB Quality and Safety Committee** has accountability for scrutiny and assurance of quality governance and the internal controls that support the ICB to effectively deliver its statutory duties and strategic objectives to provide sustainable, high-quality care. Representation from all the providers enables a partner overview of quality and safety risks, to ensure they are addressed and that improvement plans are having the desired effect. The committee also has delegated authority to approve ICB arrangements and policies to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes. This includes arrangements for discharging statutory duty associated with its commissioning functions to act with a view to securing continuous improvements to the quality of services.

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Sustainable System

As a system we recognise the impact of social and environmental challenges, including carbon footprint, within healthcare. Quality will be central to delivery of our Net Zero Green Plan through quality improvement, service user engagement and workforce skills development. There is more about our Net Zero Green plan later in this section.

Duty to reduce inequalities

We are already taking action to reduce health inequalities across Norfolk and Waveney, but we want and need to do more. This is reflected in our 'Population Health Management, Reducing Inequalities and Supporting Prevention' ambition.

As part of this, we will be developing a new strategy for reducing health inequalities, which will be ready by April 2024. This will set out how we plan to reduce health inequalities across Norfolk and Waveney. It will include our approach to the NHS Health Inequality Improvement framework "Core20Plus5" and also addressing wider issues that affect health, including housing, employment, and the environment in which we live.

The actions that will deliver the Health Inequalities strategy will be included in future versions of our Joint Forward Plan, informing all elements of what we do and how we work. More information about this is included in section 4.0. [check]

The following information sets out how we will meet our legal duty.

Using data to identify the needs of communities experiencing inequalities

We use local data to identify the needs of communities experiencing inequalities in access, experience and outcomes. Part 1 of our JFP has more information relating to inequalities.

In addition to the people living in the 20% most deprived communities in Norfolk and Waveney (The "Core20" in the Core20Plus5 NHS approach to reducing health inequalities), we have identified the following "Plus" groups of people who also experience poorer health outcomes and for whom we will focus our programmes of work:

- People living with a learning disability and autistic people.
- People from Minority Ethnic groups, such as Eastern European Communities.
- Inclusion Health groups (including people experiencing homelessness, drug and alcohol dependence, Asylum seekers and vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups).
- Coastal and rural communities where there are areas of deprivation hidden amongst relative affluence.
- Young carers and looked after children/care leavers.

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This is alongside the “5” clinical areas of focus for adults (maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension case-finding and optimal management and lipid optimal management) and the “5” clinical areas of focus for children and young people in the Core20Plus5 approach (asthma, diabetes, epilepsy, oral health and mental health). NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people

A number of these are reflected within specific objectives in this plan, which complement the established work that is already ongoing within the system, for example in relation to diabetes, respiratory disease and medicines management, together with the Protect NoW approach that is described in the Population Health management section.

Working with and listening to people experiencing inequalities

It is vital that alongside using data, local people and communities inform our decision-making and the development of services. Section 6.6 [check] of our Joint Forward Plan sets-out our approach to working with local people and communities, including our “Community Voices” programme and how we will work with and listen to people who experience health inequalities.

The five strategic priorities for healthcare inequalities

There are five national priorities for reducing healthcare inequalities. Here is a summary of the work we are doing against these:

Priority 1: Restore NHS services inclusively

- Continuing to review inequalities data as part of elective recovery programme and ambition
- Developing an Equalities Impact Assessment and action plan for the elective recovery programme

Priority 2: Mitigate against digital exclusion

- Implementing our digital transformation strategic plan and roadmap that is referenced within the digital and data content of these legal duties. Alongside our core digital initiatives, we will implement a set of underpinning system-wide enablers that include digital and data skills and inclusion

Priority 3: Ensure datasets are complete and timely

- Improving recording of ethnicity data, to allow better analysis of health inequalities and targeting of interventions

Priority 4: Accelerating preventative programmes (including Core20PLUS5 approach)

- **Vaccine inequalities** – a programme to improve the uptake of vaccines, including flu and COVID-19 – including data analysis, using local and national data resources; a roving model has been developed to target and achieve positive outcomes for underserved communities; development of Wellness

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Hubs to make every contact count and to offer a wider range of immunisations to local children and young people.

- **Core 20 PLUS 5** – co-ordination and monitoring of progress against all Core 20 Plus 5 programmes, including data analysis and dashboard development.
- **Clinically focussed projects including:** Cancer – addressing inequalities in screening uptake; Cardiovascular disease, NHS Health Checks; Smoking and Physical Activity.

Priority 5: Strengthening leadership and accountability
The Population Health and Health Inequalities Board has been established, this will maintain oversight of our developing Health Inequalities and Population Health Management strategies and work programmes, including:

- Developing our JSNA, to expand our analysis on health outcomes and inequalities and evidence how to address them
- Our inclusion health work, driven by a group of partners that seek to improve health outcomes for inclusion health communities
- Community Voices, which builds capacity in our VCSE sector to have conversations about health and care in communities of interest through trusted communicators, providing a mechanism for insights to be gathered to inform future strategy, planning and decision making and improve access to services.
- Developing our Core20plus5 programme, which includes developing key leaders across the system as Core20 Ambassadors to support the implementation of the Core20plus5 health improvement frameworks.
- Continuing to develop projects relating to the NHS role as an Anchor Institution. The legal duty in relation to social and economic develop also refers to this.

It is important that we recognise the role of the Place Boards and HWP's across Norfolk and Waveney in identifying and addressing health inequalities, including the wider determinants of health. This role will be reflected in our strategies and work programmes, with a focus on providing the infrastructure to enable and empower the place-based approach.

Duty to promote involvement of each patient

Norfolk and Waveney Integrated Care System (ICS) supports the delivery of the Universal Personalised Care Model, building on current developments and existing local good practice, particularly around social prescribing, personal health budgets, shared decision making and personalised care and support plans, addressing health inequalities and promoting preventative health and wellbeing models through personalised care. In turn, supporting people to stay well for longer, utilising and encouraging the use of the expertise, capacity and potential of people, families and communities in delivering better health and wellbeing outcomes and experiences, focussing on population health one individual at a time.

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Norfolk and Waveney ICS is fostering a new relationship between people, professionals and the health and care system. This change shifts the power and

decision making to enable people to feel informed and empowered to have a voice by working in partnership, connected to being focussed on a positive patient experience through their local communities having choice on control of health and wellbeing outcomes that are important to them.

Norfolk and Waveney ICS strives to involve patients, their families and carers in all decisions regarding their physical, mental and wellbeing health outcomes and shape individualised personalisation. Our aim is for personalised conversations around someone's health and wellbeing to happen at all ages and in all parts of the health and care system, working together with equal voice and influence to achieve the individual's vision and goals.

The strength of personalised approaches is demonstrated through current good practice in maternity services and with our carers as demonstrated in the case study example below, where shared decision-making discussions are documented on a Personalised Care and Support Plan with all the vital information of '*what matters to you'* conversation being entered.

Our whole population can access social prescribing, a standard model of which has been developed by NHS England in partnership with stakeholders, which shows the elements that need to be in place for effective social prescribing to happen. Norfolk and Waveney continue to mature and develop in an all age, whole population approach. There is still work to do, and why a working group has been set up in 2023, where those who have lived experience are invited to participate in developing a sustainable social prescribing model over the next 3 to 5 years.

Personalisation for carers

When a person goes into hospital, it can be a challenging time for their carer. Many carers want to be involved, informed, and continue to provide care. Carers are real experts and know the person they care for well, including complex conditions, learning or communication difficulties or memory loss. They often know about medication, side-effects and how the patient wishes to be cared for.

In 2022, Norfolk and Waveney acknowledged a gap in communication and provision of carers support. A thorough and wide-ranging process of co-production commenced comprising of carers, system engagement leads and chaired by a carers organisation "Carers Voice". A 'Carers Identity Passport' was launched on Carers Rights day (24th November 2022), including 'Carer Awareness training' which has also been developed with experts by experience involved in design and delivery. A Clinician in relations who was part of the co-production work said, *"Thank you to everyone for sharing their experiences, highlighting things that have not gone so well and letting us listen and learn and improve."*

Norfolk and Waveney are making good progress in personalisation and will continue to grow and expand in promoting personalised care with patients, their families and carers at the centre of all discussions about them. Local health and care intelligence highlights there is still work to do in supporting people to self-manage their conditions and non-clinical concerns no matter where they are in a demographic. As a system we will come together to understand how our population would like to do this

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ensuring supported self-management and shared decision-making being first option people choose. This will include giving people the right skills and knowledge to do so, through coaching, peer support and educating through collaborative and partnership approach, with patient's voice being heard in decision making and having more choice and control about their health and wellbeing needs.

Duty to involve the public

The Norfolk and Waveney Integrated Care System is passionate about working with people and communities to ensure we all live longer, happier, and healthier lives. The only way we can do this is by working together.

The overarching vision for working with people and communities in Norfolk and Waveney is that all partner organisations will consistently work together, with the public, to share insight and learning. This will maximise resources and ensure that the voice of local people, especially some of our quieter voices that do not always engage with health and social care services, are heard and shared as widely as possible.

Our approach to Working with People and Communities can be read in full or as an Easy Read summary. It has been tested with our local people and partners and will continue to develop and adapt as a working draft, to reflect local aspirations as needed. It received very positive feedback from NHS England when assessed in 2022 and singles us out as a national exemplar for our work with inclusion health groups. You can read the full feedback from NHS England here.

At system level, partners who are working in Communications and Engagement or communities' functions are coming together regularly to join as a system. The Norfolk and Waveney ICS Communications and Engagement Group meets every six weeks and is proving a useful forum for joint working and sharing of insight. Alongside this, the Norfolk and Waveney Patient Experience and Engagement Leads meetings have been taking place weekly for several years and give an opportunity for people working in NHS provider trusts to meet and share practice across the system. They have been a vital opportunity to begin to test and develop the idea of the 'wider team' working with people and communities across the ICS to listen to and involve patient experience feedback in quality and wider commissioning.

The ICS website has become a vital focal point for communications and engagement activity since the ICS was formed in July 2022. It is well designed, easy to navigate and is becoming a trusted source for information or links to information. This website now hosts the people and communities hub for Norfolk and Waveney, which aims to develop and maintain a shared vision in listening to and working with local people across the ICS. It includes live projects from across the system that give local people the opportunity to participate, and helped promote some high level engagement on our priorities for our Joint Forward Plan. The You Said, We Did/We Will/We Can't section is designed to feed back on the difference participation has made, and will be a useful focal point for engagement and co-production around the Joint Forward Plan as it develops.

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The ICB Communications and Engagement Team is divided into two key areas - Partnerships and Programmes – that work closely together to ensure that the ICB maintains focus on the strategic People and Communities work as well as offering professional support and guidance for the day to day and transformational work undertaken by the ICB staff. A toolkit has been developed and is being refined to enable communications and engagement to become part of everyone's core business.

The promotion of health equality is a high priority for Norfolk and Waveney, and so communications and engagement links have been developed over the last couple of years with our Health Inclusion Group. This is a multi-agency group that builds on partnership working during the COVID-19 pandemic and includes many ICS partners outside the NHS. Professionals from statutory and VCSE organisations come together to hear the voice of and understand the needs of vulnerable and health inclusion groups and align services accordingly. This group offers grassroots support to work with health inclusion groups to understand what matters to them as part of the people and communities work in Norfolk and Waveney. They help us access the views of some of our quietest voices, such as refugees and asylum seekers, sex workers and homeless and rough sleepers, i.e. people who do not usually come forward to share their views.

To ensure that the voices of people and communities are at the centre of decision making and governance, at every level of the ICS, we have appointed a Director of Patients and Communities to oversee the all the work with our people and communities. The Director is a participant in ICB Board meetings and is a member of the system's Executive Management Team.

A newly formed Patients and Communities Committee meets every other month in public and reports into the ICB Board. The Committee will include lived experience members. A recruitment pack is being developed in partnership with local people and system partners to ensure it is as accessible and open as possible. Lived experience members will then be recruited to the committee which will regularly review and update the ICB's People and Communities approach. This committee will apply the 'so what' principle to the insight received by the ICB to ensure it leads to change. It will also play a key part in monitoring the on-going participation that will take place surrounding the Joint Forward Plan as it is planned and delivered.

Duty as to patient choice

Norfolk and Waveney ICS is committed to ensuring that the patient has the right to choice of GP and provider, is provided with the necessary information to ensure that they are choosing the most appropriate organisation for their specific needs and requirements, and that they are able to take an active part in the decision making process about their care.

Our demographics mean it is very important that we provide realistic options for enabling patient choice, for example for people living in areas of deprivation and in rural areas with limited public transport. We must take this into account when commissioning new services. This means that the location of new services such as

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Community Diagnostic Centres and community dermatology clinics for example need to be easy for patients to access with extended opening hours, and that a wider range of services can be delivered closer to home, or, by maximising use of new technology, in the patient's home. The use of Equality Impact Statements when designing new services or reviewing existing ones helps to focus attention on the needs of different patient groups and how best to deliver services that are inclusive and accessible to all.

The ICS is transforming the knowledge repository used by professionals and patients when making a referral or deciding on the next stage of treatment. The current website is being updated to provide more information in Accessible Information Standard formats and in different languages. Updating this will help to ensure that a wider range of patients, and carers, have access to the information that they need to help them make an informed choice about their care.

The knowledge repository also contains details of all the services in the ICS, including community services, voluntary services, and independent sector providers. This is used as the central source for all referral forms, clinical pathway information, and patient information leaflets etc. The updated search facility will make it quicker, and easier for GPs, and patients, to identify the best service for their needs and have the right information available to help patients make an informed choice about their care and treatment.

Some services are not able to offer choice of provider at source, for example, high street optometrists. To ensure that the patient still has informed choice, the ICS commissions a cataract triage service for optometrist referrals. Patients are provided with information such as waiting times, location, opening times, transport options and if there are any clinical restrictions which might limit choice of provider. Patients are contacted by telephone and offered choice of provider and interpreter services used where appropriate. The call handers are also able to identify if patients can use services virtually, and flag to the providers if this is not an option.

The ICS is aware that there are significant numbers of patients who are unable to access digital technology. This means that some patients may not be able to access services such as virtual outpatients or virtual wards. The ICS continues to work with partners to reduce the impact of digital exclusion by ensuring that patients still have a choice to access services on a face-to-face basis and promoting use of "Connect" pilots with the Norfolk Library Service to support digital access.

Elective recovery is one of our eight ambitions and reducing the variation on waiting times across the ICS is part of that objective, through a single waiting list. Many patients may be unaware that they have the right to choose an alternative hospital if the waiting time for treatment is longer than 18-weeks. The ICS has taken a proactive approach by contacting long wait patients to identify if treatment is still required and if the patient would like the opportunity to be seen elsewhere. Specialist call handlers have been commissioned to provide additional support to those patients who require additional assistance with completing the questionnaires and ensuring that all residents of Norfolk and Waveney have a choice of where to be treated.

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Duty to obtain appropriate advice

The ICB and its partner NHS trusts and foundation trusts have strong relationships with and significant involvement from clinical and care professionals, including public health colleagues, which enable the organisations to obtain appropriate advice to effectively discharge their responsibilities. This involvement is evident in our Joint Forward Plan, which is based on evidence provided by public health and shaped by the knowledge and experience of a wide range of clinical and care professionals.

Membership of the ICB Board includes the director of nursing, medical director and a member nominated by primary care (currently a GP). The ICB Board also benefits from the input of the director of public health for Norfolk, who is participant in Board meetings. Although this isn't a requirement of the role, the current partner member for NHS trusts is also a registered mental health nurse.

In addition to the ICB Board, clinical and care professionals are involved in the ICB's committees, the boards of our trusts and foundation trusts, our Integrated Care Partnership, health and wellbeing boards, place-based arrangements, the system's Executive Management Team, and in projects and programmes of work.

We have a comprehensive Clinical and Care Professional Leadership Programme to further develop our approach. This is explained in more detail in the System Transformation and Culture section of the JFP. As part of this, the ICB has recently conducted a review of its clinical advisors to ensure the organisation has the right expert advice to effectively discharge its functions effectively.

All of our work with professionals is complemented by research, co-production, engagement, consultation and co-production with local people – this includes the involvement of experts by experience.

Introduction to duties to promote research and innovation

The ICS research and innovation strategy was finalised and published in May 2023. [check for latest update] It sets-out how we will strengthen research and innovation activity across our system – see below for more detail. There are many opportunities locally to embed research and innovation in all that we do. We have great assets, including the University of East Anglia with a large Faculty of Medicine and Health Sciences and a health and care workforce of over 55,000 people.

Duty to promote innovation

Innovation is central to addressing the challenges facing our health and care system. Innovation is a broad term, and to us, means new ways of doing things. This could be a new technology or treatment, a new service or even implementing an existing service in a new setting.

Innovation is a cross-cutting theme within the ICB and across the ICS, and we aspire for it to be integral to everything we do. We wish to ensure that the opportunities for

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receiving innovative services are equitable across the ICB boundary and will consider mechanisms to support the adoption and spread of innovations.

Our collaboratively developed strategy will ensure we have actions in place to work together, in conjunction with the Eastern Academic Health Science Network (AHSN), to identify innovation opportunities, promote innovation adoption and spread and ensure equitable access for our population. We will carefully consider innovations to be implemented to reduce the risk that they exacerbate existing health outcomes.

One of our mechanisms to ensure our commitment for innovation will be delivered is through a new and jointly funded role (with Eastern AHSN). The Head of Innovation role will facilitate the introduction of proven innovations in medicine, technology, and care pathways. The Head of Innovation will be fully embedded within the ICS and hence will have the local relationships to understand the most relevant challenges to be addressed. They will also work closely alongside Eastern AHSN to gain access to Eastern's curated pipeline of solutions, which also contains local and national learnings on how to introduce and implement these solutions in a local context. Eastern AHSN will also support the ICS to leverage industry support and investment.

Duty to promote research

Norfolk and Waveney ICS is committed to embedding a culture of research and evidence use for the benefit of our communities and workforce. Health and care research is fundamental to our health and wellbeing. It provides the evidence base which underpins how services are designed and delivered and helps us to tackle unequal health and care outcomes.

The ICB has a dedicated research and evaluation team which supports research and evidence use within the ICB and across the ICS. Board level representation is via the ICB Medical Director, ensuring research has visibility across the Executive Team.

Core R&D functions are provided by the research and evaluation team for primary and community care and non-NHS settings, including care homes, working in partnership with the Clinical Research Network for the East of England (CRN EoE). The team also works collaboratively alongside R&D offices within the three acute trusts, the ambulance service and the mental health trust. These collaborative working arrangements will continue.

Five of our NHS trusts and the ICB are full members of UEA Health and Social Care Partners, which also includes Norfolk County Council. The partnership facilitates collaborative, practice-led research, linking frontline staff with academic researchers, seed-funding early collaborations and maximising the impact of research across our system.

NWICS Research and Innovation Strategy 2023-2028

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The strategy is being developed via a series of collaborative workshops with patients and the public, our partner trusts, primary care, the National Institute for Health and Care Research (NIHR) infrastructure partners, VCSE partners and higher education institutions. It will set out how we will ensure that research and innovation is focused

on our communities, that we have a confident and capable workforce, that research and innovation is collaborative and coordinated and that evidence is incorporated in the commissioning and delivery of services and infrastructure.

We will engage with NIHR supported research networks and infrastructure located in Norfolk and Waveney and the East of England, such as the Clinical Research Network, Research Design Service, Applied Research Collaboration and the Norfolk Clinical Research Facility, so as to leverage expertise and resources and facilitate access to research for our workforce and communities.

We will develop a rolling programme of public participation involvement and engagement activities to disseminate information about research, working towards ensuring our research is reflective of the communities we serve.

Duty to promote education and training, and other information about our workforce plans

#WeCareTogether, the Norfolk and Waveney People Plan

#WeCareTogether, the Norfolk and Waveney People Plan for 2020-2025, sets-out our ambition for the Norfolk and Waveney system to be best place to work. We are currently refreshing the plan looking forward to 2028. It is important that we take account of our experience of the pandemic, and that our People Plan accurately reflects our new reality and updated national guidance for the NHS, social care and volunteer workforce.

#WeCareTogether refresh

We know that the vacancies, staff absence and turnover rates for people working in health and care have remained the same or worsened for some areas since 2020. Our refresh of #WeCareTogether will take a structured and collaborative system approach to build capacity, capability, competencies, career structures and the infrastructure towards creating a ‘One Workforce’ approach across our ICS. Our provider partners are also refreshing their local plans, and through our People Board infrastructure and networks, we will utilise the principle of subsidiarity to streamline transformation at the right place and at the right time.

A priority focus in 2023/24 will be to continue to build on the existing work underway and incorporate these activities into the broader strategic priorities for the ICS. We will ensure our plan is evidence-based and closely aligned to finance and activity planning as set out in our operational planning submission.

Our planning is informed by the work the system has done with a range of organisations. Insights and recommendations from Viridian and the Boston Consulting Group will support a focus on efficiencies, particularly for reducing how much we spend on bank and agency staff. The work we have undertaken through the Improving Lives Together programme on our corporate HR services will similarly aim to improve quality and the experience for our workforce, whilst also making sure

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we use the system's resources efficiently. This is one of our eight ambitions, Improving Productivity and Efficiency.

The 10 ICS People Function Outcomes

The 10 ICS People Function Outcomes are set-out in 'Building strong integrated care systems everywhere: guidance on the ICS people function'. In all areas of transformation, we will take a long-term view using evidence-based modelling to re-design routes into careers. This will help to create a workforce who are trained not just clinically, but who also have a greater understanding of population health and inequalities, so that staff treat the whole person with both compassion and care.

This work will include updating the way we attract and retain staff, refreshing education programmes (including lifelong learning and quality improvement), changing the shape of existing services and developing new ones, and using technology to take over tasks (not jobs) to release capacity. The activities below will form a key part of the delivery plan to achieving an integrated workforce across health and social care, and will be incorporated into the #WeCareTogether refresh.

Here is a summary of how we are working towards the 10 ICS People Function Outcomes:

Supporting the health and wellbeing of all staff

We know that if people feel safe and supported with their physical and mental wellbeing, they are better able to deliver excellent health and care. Over the last three years, individual employers and as a system, we have supported the physical and mental health of our staff, as well as the social and financial wellbeing needs of our workforce. The national restoration requirements for the NHS and more recently industrial action mean that, alongside our current workforce vacancy levels and system flow challenges, people's wellbeing continues to be impacted. Low morale, attrition from learners, burn out and moral injury are growing challenges which we must recognise and address openly across health and social care.

We know there is an urgent need to do more for our people and our ICS Health and Wellbeing Group will continue to challenge, innovate and promote equitable offers for our whole workforce. We have also worked with partners to update policies, procedures and access for health and wellbeing support; embraced a culture of flexible working arrangements; initiated financial support schemes through Vivup; and offered trauma based coaching programmes for front line leaders. System support has included the establishment of a Mental Health Hub and COVID-19 service for our health, social care and VCSE workforce.

Growing the workforce for the future and enabling adequate workforce supply

Our integrated workforce planning approach is multi-faceted and relies on each of the 10 People Function Outcomes converging. Working with health and social care partners to 'check and challenge' plans, we will identify system level opportunities and challenges, streamline our approaches to recruitment and retention, develop an at scale attraction plan for core roles such as nurses, allied health professionals and learners, to ensure education pathways are fully subscribed and talent retained in our system. Our role as an anchor institution will focus on widening participation,

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recruiting for values and experience, and supporting people to develop core skills and competencies ‘on the job’.

Supporting inclusion and belonging for all, and creating a great experience for staff

The Norfolk and Waveney culture for inclusion continues to develop, but we recognise there is much more to do over the coming years so that our people may thrive and develop in compassionate and inclusive environments. The last Workforce Race Equality Standards (WRES) report for the ICS has highlighted significant challenges for our staff from ethnic minority backgrounds, centring around harassment, bullying or abuse from patients, relatives, the public and other staff. It also highlights higher than average levels of discrimination for these staff from a manager/team leader or other colleagues in last 12 months. The WRES does also highlight areas of best performance being career progression in non-clinical roles (lower to middle to upper levels).

Anti-racism

Over the last 12 months we have worked as system to deliver the NHS East of England Anti--Racism plan. We have developed a de-biasing of recruitment toolkit which is now being implemented through a train the trainer model to providers; developed and matured staff networks across protected characteristics; and increased our approach to education and knowledge through the launch of our Equality, Diversity and Inclusion Resource Hub, which is open to both the workforce and the public. We launched our ‘Stop the abuse’ anti-bullying campaign in May this year. EDI Resource Hub - Norfolk and Waveney ICS (improvinglivesnw.org.uk).

Widening our EDI lens

We recognise that in addition to racism, the ICS needs to focus this year in particular on women, age and the impact of inequalities for our coastal populations. Our ambition is to bring together the pillars of health inequalities, population health management and workforce so that we can consider this cultural transformation wholistically. This will form part our ICB Change Programme, so that we ensure as an organisation, our infrastructure enables us to work with system partners and our local communities to tackle some of our biggest challenges, including racism and inequalities.

Creating a great experience

The NHS staff survey has highlighted three key themes of safety, recognition and compassion. Staff experience is an organisational responsibility but as an ICS we are committed to ensure that our ‘one workforce’ ambition allows us to work with partner organisations to agree some core principles for staff experience. The staff survey reports that we need to focus more on safety, recognition, and compassion, and we will work though our networks to identify opportunities for collaborative ways to improve in these areas.

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Valuing and supporting leadership at all levels, and lifelong learning

We will continue to invest in leadership and management development programmes, mentorship opportunities and other initiatives to support the growth and development of our staff right across the ICS, particularly to ensure our leaders are representative

of the workforce and population we serve. The health and wellbeing of our leaders will be a core thread of all programmes to ensure people have the tools and support to remain resilient.

Leading workforce transformation and new ways of working

Our #WeCareTogether refresh will include a spotlight on driving efficiency through our HR teams through automation of processes and by streamlining our teams. This, alongside the ICS Digital strategy, will enable service redesign through new ways of working, making the most of people's skills and time, and the better use of technology.

Educating, training and developing people, and managing talent

We will work closely with educational providers supporting our medical and non-medical learners, to ensure programmes are reflective of local plans. We shall also work and listen to learners to ensure consistency and quality of experience during training and having regular careers conversations to support individuals to wish to remain working in our system after they have completed training.

Driving and supporting broader social and economic development

As the largest "employer brand" in Norfolk and Waveney, our health and social care organisations collectively employ the largest number of staff in Norfolk and Waveney. As such the ICS takes its responsibility as the largest employer seriously to create a vibrant local labour market, promote local social and economic growth, and to work to address the wider determinants of health and inequalities. Investment in Anchor Institutions locally provides us with unique opportunities to accelerate this ambition over the next few years. Working with UEA, we are taking a research-led focus on recruitment, retention and continuous development of our clinical workforce. Working with East Coast College we are actively co-designing as a system a holistic offer to local residents to widen participation into health, social care and voluntary sector roles.

Transforming people services and supporting the people profession

The Future of HR and Organisational Development Framework, alongside the ambition to Improve Productivity and Efficiency, will enable us to develop a multi-year plan for new ways of working to maximising resources, efficiencies and staff experience. This will include how we recruit, train, develop careers and take care of our people through occupational health and other wellbeing offers.

We will continue our commitment to identifying opportunities to integrate workforces. We will take a systematic and collaborative approach to workforce analysis, reviewing service delivery models, identifying areas of overlap, engaging with staff and stakeholders, developing multi-professional teams and implementing workforce integration strategies.
We will build the infrastructure, and develop our systems and processes, to embed the changes to enable our people to work seamlessly across the system.

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Leading coordinated workforce planning using analysis and intelligence

Our NHS provider workforce planning submissions this year have been collated and show the NHS ambition for workforce growth in 2023/24 to deliver operational priorities aligned to finance and activity. Plans are ambitious and centre on

significant growth in the number of staff in post in registered nursing and those roles providing support to clinical staff. This is also referenced in the 2023/24 immediate priorities section of the JFP.

We recognise that this in isolation is not enough, and as such, we are working as a system to develop an evidence-based, integrated and inclusive workforce planning approach. This will include the way in which we commission education programmes, the importance of retention and career development of our medical and non-medical learners, and it will underpin our ambition to reduce agency and bank spend.

We have identified several workforce priorities for the next five years, such as 'over recruiting' to key roles at system level to achieve greater month by month net gains, growing the assistant and associate roles, and acting fast to build a pipeline of younger people (18 years plus) coming into health and care roles.

We note that while the system is intrinsically linked, core values are aligned and work is underway to support the 'one workforce' agenda, there are distinct differences across health and social care which need to be acknowledged and navigated, as these can act as a barrier to fully integrated working. For example, the number of small to medium sized enterprises in the social care market makes the transformation at scale seen in the NHS much harder, and so we will work closer working with Norfolk and Suffolk County Councils to centrally attract and provide opportunities to retain our social care workforce.

Supporting system design and development

Our approach to delivering this outcome is set out in section 5.5 of our Joint Forward Plan about people and culture.

Duty as to climate change

Climate change poses an existential threat to the whole planet and Norfolk and Waveney is not immune from its consequences. Taking decisive action to reduce our contribution to climate change will save lives, improve people's health and benefit health services.

The organisations responsible for health and care in Norfolk and Waveney have made significant steps towards more sustainable ways of operating. Our system's Green Plans take this further, establishing the bedrock for achieving Net Zero, and meeting the commitment set out in the Climate Change Act 2008 and the Environment Act 2021.

Our Green Plan for the Norfolk and Waveney Integrated Care System sets out how the NHS will work together and with system partners towards Net Zero, by sharing best practice, collaborating and holding each other to account. This has been referenced in each of the ambitions in our JFP. By working together to deliver our Green Plans, we will deliver against the targets and actions in the 'Delivering a Net Zero NHS' report, as well as the four core purposes of an integrated care system by:

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- **Improving outcomes in population health and healthcare:** Adopting activities and interventions which slow the associated health impacts of

climate change will help to improve population health, for example by reducing the number of heatwave-related excess deaths and the number of pollution-related respiratory illnesses.

- **Tackling inequalities in outcomes, experience and access:** Supporting action to address poor air quality, which disproportionally affects vulnerable and deprived communities through higher prevalence of respiratory illnesses, will help to tackle health inequalities. Through their transport strategies, the county councils aim to reduce local air pollution as well as transport-related carbon emissions and to encourage active travel for both carbon and health reasons.
- **Enhancing productivity and value for money:** Improving energy efficiency and using renewable energy sources across the ICS estate footprint will reduce long-term energy bills for the NHS and local councils.
- **Helping the NHS support broader social and economic development:** Ensuring all NHS procurements include a minimum 10% net zero and social value weighting will help to achieve this, as will adhering to future requirements set out in the NHS Net Zero Supplier Roadmap. Council procurements similarly place emphasis on reducing scope 3 carbon emissions and both the NHS and county councils require that bidders for contracts valued at over £5m per annum have a carbon reduction plan in place.

Governance

Our system ensures that appropriate board-level oversight and accountability of priorities are clearly stated by setting out management arrangements in the Green Plan. The ICS Green Plan is co-ordinated through the ICS Estates team and delivered by the ICS Green Plan Delivery Group. The group membership is made up of focus area subject matter experts from across the ICS and ICB, and Green Plan leads from member organisations.

The system's Green Plan meets the requirements for ICSs as set out by the NHS. Significant engagement with public sector colleagues is bringing the system's Net Zero process into alignment with the wider work of the Norfolk Climate Change Partnership and the Suffolk Climate Change Partnership, to create close collaboration on the net zero.

The ICS Net Zero green plan delivery group's role is to maintain the plan through working with member organisations, ensuring Government, NHS and local Net Zero ambitions are met.

Monitoring of progress against the system action plan and objectives is co-ordinated by the ICS Estates team, with regular input from focus area leads, subject matter experts and member organisation leads. Progress reports are provided via frequent updates and data collections and are monitored via the ICS Green Plan Delivery Group. These feed into ICS Programme Board meetings and Executive Management Teams accordingly. Each county council reports progress on its respective climate commitments to its elected members.

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Annual reporting (introduced from 2023), identifying movement in carbon emissions, programme progress and our journey towards Net Zero ensures the Executive Management Team of the ICS remain sighted on the plan and action required. The update of the operating plan highlights the planned focus and deliverables for the upcoming 12-month period. Both county councils have published dashboards showing their progress in reducing carbon emissions.

We will utilise all national data collections, and build on local benchmarking and analysis practices, to measure and report our success to stakeholders.

Collaboration

Our system's Net Zero Green Plan provides the ICS with a co-ordinated and strategic approach to the net zero programme and sets out how we embed, respond to, and deliver the NHS net zero ambition. The plan sits alongside, and complements individual organisations' plans and focuses on enabling without duplicating, achievement of Net Zero together. The plan identifies key areas to focus on over the next three years, and initiates action around what we will do, and are already doing, to respond to the environment and climate emergency.

The system works with partners to reduce system-wide emissions, including local authorities and the voluntary, community and social enterprise (VCSE) sector, patients and the public. The Norfolk Climate Change Partnership and the Suffolk Climate Change Partnership support local government in Norfolk and Waveney to deliver Net Zero objectives and their objectives align well with the NHS Net Zero ambitions. This programme of work is integral to our forward plan to reduce impacts on the environment and embed a 'one public estate' approach that positively impacts our journey toward net zero.

The Integrated Care Board has moved into Norfolk County Council's headquarters, helping to share the building's carbon footprint as well as encouraging collaboration. Joint procurement is driving carbon reductions in our supply chain. For example, joint procurement of the integrated community equipment stores for Norfolk and Waveney involving the ICB and both county councils resulted in a new contract with a carbon reduction plan that includes reducing delivery mileage through more-efficient routing; the phased introduction of electric vans; a move into a more-energy-efficient warehouse; and a range of measures to reduce the contractor's Scope 3 emissions.

Workforce and Resources

We cannot deliver our Net Zero ambitions without our workforce. It is therefore vital that the system continues to inform, mobilise and train our staff so that they have the knowledge and skills required to help us on our journey. Net Zero is a priority and, accordingly, is led at Board level by the Director of Finance.

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The system is engaged with the regional Greener NHS team and neighbouring ICSs to learn and share ideas and best practice. Through the green plan delivery group work the subject matter experts and sustainability leads collaborate to develop enable ICS Green Plan and Operating plan delivery. Existing pilot programmes for

green initiatives are captured to harness their benefit to enhance positively, impacts on climate change and the environment.

The system has recruited resource to lead the delivery of ICS and organisations' Green Plans. These leads work collaboratively in the development and scaling of pilots and programmes that enable our net zero ambitions.

An ambitious programme of training has been identified to upskill the workforce at all levels, through use of best practice carbon literacy, to grow the knowledge and capacity to address the climate emergency. The ICB and Norfolk County Council have agreed to pursue joint carbon literacy training for senior executives across the system.

As part of our communications and engagement programme, the NHS workforce is supported by pledge platforms and incentives to inspire contribution from all.

Adapting to the impact of climate change

There is a time lag between cause and effect in the climate system, which means that we will continue to be affected by past emissions for years to come. Consequently, adapting to the impacts of climate change is important for business continuity. Strategies to adapt to climate change are therefore part of local planning and decision making, bringing multiple benefits to the physical and mental health of the Norfolk and Waveney population.

Taking action on adaptation will improve the resilience of our services and the communities they serve, lessen the burden of illness and disease, and reduce health inequalities. Adaptation also means developing positive networks and sound communication between organisations and local communities, encouraging self-service and the resilience of local communities. Local action on adaptation will support requirements of the Public Health Outcomes Framework.

Norfolk and Waveney already experiences the effects of considerable coastal erosion, and is subject to many flood areas associated with increases in sea levels. Many of the impacts of climate change, including those for health, will be felt locally. Therefore, the system needs to develop responses which encompass national guidance and yet are specific to our local circumstances. The system's Green Plan sets out the approach to mitigating climate change emissions from our activities and ensuring business continuity in a changing climate and includes a focus on increased readiness for changing times.

Both county councils have broader responsibilities for adaptation. These include steps to promote nature recovery, mitigate flooding and support sustainable development.

Addressing the particular needs of children and young people

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Leadership has been identified in health and social care to drive forward the agenda and to ensure that the voice of children, young people and families is represented at the most senior level. The Children and Young People's Strategic Alliance Board

provides oversight and assurance and is underpinned by thematic sub-groups leading on priority workstreams.

The voice of children, young people and their families

We have invested in a participation and recovery model to ensure that transformation of services is co-produced and enables children and young people to hold us to account through strong and well-established forums. This enables children and young people to be heard by those who commission and deliver services in both Norfolk and Suffolk. We also have well-established parent carer forums to ensure the voices and needs of parents and carers are included in our planning and delivery of support.

Next steps will be to increase our reach into communities who are seldom heard to ensure that the experience of all our communities are captured and help to shape the future support to ensure the best start in life.

Data and insight

Our system approach, and the ongoing monitoring of its delivery, will be increasingly informed by data and evidence. We are developing a systematic whole-partnership monitoring framework alongside the FLOURISH outcomes, to enable the Strategic Alliance to track progress against each outcome, and as a whole, using data and evidence.

This will enable system understanding and oversight of where babies, children and young people are waiting to access care and support, and to inform our focus areas for recovery including access to mental health support, diagnostic delays, workforce information and an ability to focus system resource to the greatest areas of need.

Reducing health inequalities

The CORE20Plus5 approach (described in the 'Duty to reduce inequalities' section) will support us to ensure that healthcare inequalities improvement is built into our strategies, policies, initiatives and programmes.

In addition to those areas identified within Core20PLUS5, our Flourish strategy identifies four priority areas for system focus:

- Prevention and early help
- Mental health and emotional wellbeing
- Special Educational Needs and Disabilities (SEND)
- Addressing gaps in learning following the pandemic

Family Hubs

Norfolk and Waveney system partners will further develop the Family Hub model and this is an objective within the Improving Services for Babies, Children and Young People ambition.

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Safeguarding

All systems have a statutory duty to safeguard. The Designated Safeguarding and Looked After Children teams influence, advise and support us to ensure it accords with the principles of the Children Act 1989 and is aligned to the Norfolk and Suffolk Safeguarding Children Partnership and priorities. The Teams ensure health and care services meet the statutory requirements of Section 11 of the Children Act 2004. The priority is to ensure 'safeguarding is everyone's' business' and remains at the heart of service delivery.

Our safeguarding teams work in collaboration with all partners in Norfolk and Waveney in the early identification of children at risk, including risk of exploitation, and recognition of all types of abuse and non-accidental injury promoting the needs of looked after children, those within the youth justice system and unaccompanied asylum seekers. Integrated working will support colleagues to work and communicate effectively across organisational boundaries, to ensure safety and provide child-centred care.

Safeguarding teams support information sharing and provide training to recognise presentations that are safeguarding relevant primary care through training to help GPs to prioritise safeguarding relevant meetings, and to efficiently complete requested reports and this will be further strengthened by the development of Family Hubs which will be vital in the development of early intervention and prevention.

Going forward our teams will drive greater integration through matrix working and multi-agency collaboration. Digital solutions to enable safeguarding information to be disseminated will be further developed and sharing data will be integral to the partnership approach.

Safeguarding professionals will advocate for babies, children and young people, and champion early intervention and prevention services to avoid long term damage that has implications across society. We aspire to be a trauma informed system, recognising the importance of the early days of a child's life and development, and impact of adverse childhood experience on long term health and economy.

Continuing care for children and young people, including palliative and end of life care

The Council for Disabled Children describes a vision of a society in which "children's needs are met, aspirations supported, their rights respected, and life chances assured" (https://councilfordisabledchildren.org.uk/about-us). This underpins the work of our Children and Young People's Continuing Care Team where the aim is to achieve "gloriously ordinary" lives for the babies, children and young people.

Continuing care packages are required "when a child or young person has needs arising from a disability, accident or illness that cannot be met by existing universal or specialist services alone" (NSF for Children and Young People's (CYP) Continuing Care 2016, p5). Unlike adult continuing healthcare packages, which are entirely NHS funded, these packages can be jointly funded with education and social care and are very complex.

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Norfolk and Waveney ICB currently offer two main approaches to the provision of continuing care – either a personal health budget (PHB) or a commissioned package of care, delivered by one of five agencies procured specifically for care of children.

Palliative care is a low volume, but significant part of the care delivered to babies, children and young people with continuing care needs. Our fast-track system in place complies with statutory guidance.

Partners have developed joint commissioning and quality oversight arrangements to ensure that all agencies are working together to meet the holistic needs of babies, children, young people and their families. We collaborate with regard to quality assurance and improvement and work together to develop provision closer to home.

Special Educational Needs and Disabilities (SEND)

The Children and Families Act 2014 is a statutory framework for the integration and personalisation of services for children and young people that require education, health, and care services. To fulfil this statutory duty, we work collaboratively with children and young people with SEND and their families, alongside education and social care services to provide the right support. This must be using the key principle of co-production and be person centred.

This includes identification of children and young people with SEND and to support them to access everyday activities with the right support and adjustments. We share support and resources across agencies for those on NHS waiting lists and skilling-up those working with children and young with key neurodevelopment difficulties, such as autism. We are committed to developing the wider workforce on key areas of SEND and to support workers to understand their duties and responsibilities. Children and young people with SEND are a vulnerable group and work will continue to drive equity of services and resources by raising awareness of the need and duty on services to make reasonable adjustments.

There will be key contact points across the health system to provide communication and support for children, young people and their families on health pathways. This will ensure families, young people and those working in education and the care system know where to go to get NHS health advice and resources.

We will continue to ensure that there are opportunities for children, young people and their families to contribute to service development and to ensure their lived experience is heard and understood.

There is a programme to review and improve health pathways. Publications on local websites and Just One Norfolk will also be reviewed and improved.

Working with local authorities and wider stakeholders, we will further develop the SEND annual survey, increase the survey response rate and disseminate the learning to further influence commissioning.

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Joint quality assurance visits will take place into complex needs schools to further strengthen quality improvement and build confidence within settings to manage heath/medical needs.

Work is underway to strengthen the use of shared data and analysis to inform commissioning of services for children and young people with SEND.
We aim to have a multi-agency SEND training platform that is accessible to all stakeholders, including children, young people and their families.

We will develop a shared understanding and vision across children, young people and adult commissioning to ensure SEND is seen as everyone's business.

Partnership working will be strengthened through the SEND Partnership board, multi-agency working, and we will feed in regional and national systems to develop innovations and initiatives.

System partners will work together to develop high quality information and support for children and young people with SEND, so that they know what can be accessed, what they can do to self-serve and to signpost to the most appropriate service when it is needed.

We will work as a system to become needs led and not medical and diagnostic driven and we will build confidence in the services and resources available by celebrating difference and individuality.

Autistic Spectrum Disorder (ASD) and Learning Disability (LD)

Individuals with Autistic Spectrum Disorder (ASD) and Learning Disability (LD) face significant health inequalities compared with the rest of the population. The NHS Long Term Plan states a commitment for the NHS to do more to ensure that all people with a learning disability, autism, or both can live happier, healthier, longer lives. This means that we must provide timely support to children and young people and their families and ensure health and care services are accessible and make reasonable adjustments.

As part of the system commitment to improving quality and outcomes through the learning from deaths process, we will continue to contribute to the Learning Disabilities Mortality Review Programme (LeDeR), to ensure that health improvements can be targeted to those areas which will have the biggest impact. Working as a system, we will aim to meet emerging need early.

Children and young people's mental health

We aim to prevent mental illness, early identification of need and the promotion of initiatives that increase resilience to ensure children and young people are supported earlier around their wellbeing needs and reduce the burden on specialist mental health services in the future. Priority areas of focus include:

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- Increasing access to mental health services through the Talking Therapies Collaborative to deliver an integrated service offer from VCSE sector and

independent partners, where therapeutic care can be accessed from a range of providers.

- Providing early support in schools through Mental Health Support Teams
- By 2030 we aim to have 100% coverage of mental health support teams across all schools in Norfolk and Waveney and we will adopt a whole family approach to meeting mental health needs across Norfolk and Waveney, with a focus on communities and primary care.
- Providing 24/7 assessment and care to children and young people presenting in a crisis through an Integrated Practice Model, bringing together system partners to support children and young people with complex needs that present in crisis.
- To support early intervention and prevention, we will develop an all-age social prescribing offer ensuring that access to positive activities that improve wellbeing is tailored and accessible to all.
- Building on the use of the Just One Norfolk Platform and Kooth, we will develop a digital strategy ensuring all CYP have access to self-help resources and information about resources and support within Norfolk and Waveney.
- Working with the Anna Freud Centre, The Charlie Waller Trust, The National Children's Bureau and NHS England, we will co-produce, deliver and evaluate a whole system mental health training offer for the wider children's workforce.

Through the Strategic Alliance, decisions are made at a system level and challenges within the system are discussed and resolved in collaboration. To support the integration of services we are launching an integrated front door for all emotional wellbeing and mental health services, providing a trusted assessment and onward referral to the most appropriate service. The integrated front door is an objective within the Transforming Mental Health Services ambition in the JFP.

Local Maternity and Neonatal System (LMNS)

The LMNS brings together the NHS, local authorities and other local partners with the aim of ensuring women and their families receive seamless care, including when moving between maternity or neonatal services or to other services such as primary care or health visiting.

Alongside this, NHS England will publish a single delivery plan (SDP) for maternity and neonatal services in Spring 2023 from which the recommendations will be implemented.

We will continue to focus on addressing exclusion and inequalities. The LMNS has undertaken analysis of the needs and characteristics of its communities and has published an action plan to address these (Norfolk and Waveney Maternity Equity and Equality action plan).

The LMNS will continue to put in place the infrastructure needed to enable rollout of Midwifery Continuity of Carer, so it is the default model for all women and so that 75% of women of Black, Asian and Mixed ethnicity and from the most deprived neighbourhoods are placed on pathways.

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Addressing the particular needs of victims of abuse

The ICB is committed to working with all partners across Norfolk and Waveney to consider the needs of and provide support to victims of abuse (including victims of domestic abuse and sexual abuse, both children and adults).

We have important arrangements in place in Norfolk and Waveney for partnership working on this agenda:

- The ICB is an active member of our two local Community Safety Partnerships:
    - Norfolk County Community Safety Partnership (NCCSP), which sits under the jurisdiction of the Office of the Police and Crime Commissioner for Norfolk (OPCCN).
    - East Suffolk Community Partnership (ESCSP), which is hosted by the Suffolk County Council.
- The ICB is represented on the Norfolk Domestic Abuse and Sexual Violence Group (DASVG) by the Adult Safeguarding Lead (who represents the health sector).
- The Adult Safeguarding Lead also chairs the Norfolk and Waveney Domestic Abuse and Sexual Violence Health Action Forum sub-group of the DASVG, and the sub-group tackling Honour Based Abuse, Female Genital Mutilation and Forced Marriage.
- The ICB is represented by the Safeguarding Teams at the DASVG's Adult and Children's sub-groups.
- The ICB has strong links with the OPCCN and the Norfolk Integrated Domestic Abuse Service.

Here are some examples of the work we are doing as a system in Norfolk and Waveney, and ways in which the ICB is delivering against its duty to address the particular needs of victims of abuse:

- The ICB undertook a stocktake review of health services and responses to domestic abuse and sexual violence, in the summer of 2022.
- With system partners, the ICB signed-up to and widely promoted the HEAR campaign – Norfolk County Council's commitment to zero tolerance of domestic abuse in the workforce.
- There are appropriate policies in place in large NHS organisations.
- A template policy has been created for primary care and dedicated domestic abuse training sessions have been held for Lead Safeguarding GPs.
- There is full and active engagement with the Domestic Homicide Review process, that also coordinates and supports the engagement of providers of health services.
- The ICB led work to ensure our three acute hospital trusts provide monthly anonymised assault data, as per the NHS Digital 'Information Sharing to Tackle Violence Minimum Dataset ISB1594'.

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- The ICB commissions a range of health specific pathways within a portfolio designed to support children and young people who are victim to serious violence. This includes but is not limited to: talking therapies for victims of and witnesses to sexual violence, trauma informed mental health provision and targeted support for children exposed to and at risk of displaying harmful sexual behaviours.
- The ICB also engages with relevant Suffolk workstreams, in tandem with NHS Suffolk and North East Essex ICB Safeguarding Leads.

The Serious Violence Duty

In December 2022, guidance on the Serious Violence Duty was published by the Home Office. The 'lead' authority for meeting the Serious Violence Duty in Norfolk is the Office of Police and Crime Commissioner, while in Suffolk it is the county council. Each lead agency has convened a partnership group that the ICB attends through its Safeguarding Adult and Children and Young People's Teams.

In line with the duty and the guidance, the ICBs is undertaking a strategic needs assessment and producing a plan to tackle 'serious violence' with partners such as local authorities and the police. The definition of 'serious violence' includes domestic abuse and sexual offences.

This work is being further supported by Crest Advisory, who have been commissioned by the Home Office. There will be two phases of support: Phase 1 is a readiness assessment designed to understand the preparedness of local areas to comply with the Serious Violence Duty, and Phase 2 is tailored support that will be based on the findings of the readiness assessment. The ICB's Adult Safeguarding Lead is engaged in the readiness assessment workshops being held in the first and second quarters of 2023.

The strategic needs assessment and publication of the two local strategies must be completed and published by 31 January 2024.

The ICB is committed to engaging in the regional led scoping and mapping exercises and attending the relevant events being hosted to support the implementation of the duty. This will support us to plan and deliver preventative action and a focus on training, data collection and analysis.

Services commissioned by the ICB that fall within the scope of the NHS Standard Contract must comply with the Domestic Abuse Act 2021 and associated guidance from April 2023.

Implementing any joint local health and wellbeing strategy

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The Norfolk and Waveney Integrated Care System covers the whole of Norfolk and part of Suffolk. As upper-tier local authorities, Norfolk and Suffolk each have their own joint health and wellbeing strategy:

- Norfolk's Joint Health and Wellbeing Strategy (which is also the Integrated Care Strategy for Norfolk and Waveney)

- Suffolk's Joint Health and Wellbeing Strategy

There is close alignment between the priorities in the Norfolk strategy and the cross-cutting themes in the Suffolk strategy:

Norfolk priority	**Suffolk cross-cutting themes**
Driving integration	Greater collaboration and system working
Prioritising prevention	Prevention: stabilising need and demand
Addressing inequalities	Reducing inequalities
Enabling resilient communities	Connected, resilient and thriving communities

The JFP is a delivery mechanism for these local Health and Well-Being Strategies and the Norfolk and Waveney Integrated Care Strategy is specifically referred to in Section 1.2 of the JFP.

We are committed to supporting the implementation of both strategies and the Joint Forward Plan sets-out how health services in Norfolk and Waveney will do this. We have involved both health and wellbeing boards in the development of our JFP, asking for their views on the draft document and including their opinions in the document. There is further detail in the JFP about how our eight ambitions align to both Strategies.

We will continue to involve the health and wellbeing boards through the annual refreshing of our JFP (and if we choose to update the plan mid-year). As part of the development of the ICB's Annual Report, the organisation will report to the health and wellbeing boards how they contributed to delivering the priorities in each joint health and wellbeing strategy.

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Other content

Digital and data

We are committed to investing in and using technology to improve people's health, wellbeing and care. Our Digital Transformation Strategic Plan and Roadmap sets-out how we will digitise services and connect them to support integration. This will enable new ways of working that can increase efficiency, improve patient experience and outcomes, plus reduce workforce burdens, and help to address health inequalities.

The plan and roadmap are in line with national guidance, such as the NHS Long Term Plan and the NHSX What Good Looks Like framework, as well as the Digital Health and Social Care Plan.

The digital plan and roadmap are a key enabler to the delivery of the eight ambitions in the JFP. Each ambition is co-dependent with digital and our plans for improvement are consistent so we can ensure all our efforts are joined up and focused in the right areas. You can read more about this within the ambitions as we have mapped the dependencies across to all the relevant ICS strategies to show them in more detail.

This diagram sets-out our vision and strategic priorities for Norfolk and Waveney:

Using digital systems, we will:

- Enable people to access their health and care records securely, quickly and when they want to see information or data.
- Support clinical and strategic decision making through technology, providing health and social care organisations who deliver care access to relevant, accurate and up-to-date information.
- Improve system wide IT services to increase safety and people's health and care experiences, whilst reducing duplication and waste.
- Support and empower people to maintain their health and wellbeing through digital solutions.
- Enable health and care staff and services to provide the best care in all settings, particularly via the use of mobile technology.
- Ensure personal health and care information is kept safe and secure.

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- Invest in the infrastructure and technologies needed to help drive improvements to services and provide better care.

Our roadmap details the key milestones for 2022-26:

Estates

Add Hyperlink and review this section: Estates Strategy

Our Estates Strategy sets-out how we will create stronger, greener buildings, enable smarter, better health and care infrastructure, and use system resources fairly and more efficiently. It is based on extensive engagement, and a review of clinical strategies and investment requirements across the ICS.

The vision in our five-year strategy is of providing estate that allows delivery of the right care in the right place, enables better patient outcomes, and empowers health, social care and third sector staff to provide the best possible care.

Our strategic estate objectives are:

- **Improving Access** – Ensuring that the right services are delivered in the right place, matching demand and capacity, delivering multi-disciplinary working in 'Places' and 'PCNs'.
- **Improving Quality and Condition** – Providing safe, flexible, modern, and fit-for-purpose estate and supporting services for our patients, visitors, and staff.
- **Improving Sustainability** – Implementing interventions to decarbonise our estate and reduce carbon emissions arising from our buildings, infrastructure, and services.
- **Improving Efficiency** – Providing a right sized estate and supporting services that deliver value for money and long-term financial sustainability.

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During 2023 – 2024, the development of detailed delivery plans will demonstrate the programmes of work and investment to implement our Estates Strategy. The ICB's strategic estates team provides leadership through an integrated programme of planning, improving and adapting the estate to support and enable health and care services to meet the needs of the Norfolk and Waveney population.

Development and use of the Health in Planning Protocol will continue to manage and underpin NHS engagements with the planning process and the development of our communities across Norfolk and Waveney, enabling us to plan sufficient facilities for the delivery of health services.

Systemwide, Person-Centred Estate

We have a significant part to play in supporting and enabling the delivery of a system-wide person-centred estate that serves the needs of all its users, enhancing both patient and staff experience. We will enable the integrated care strategy by:

- Developing a collaborative and joined-up approach across the NHS to estates and facilities service provision, ensuring our assets enable integrated accessible services.
- Ensuring that our estate supports the provision of preventative models of care.
- Working with local planning authorities and public health to ensure their programmes of work and ours are linked and we cooperatively help people live in healthy places, promote healthy lifestyles, prevent ill-health and reduce health inequalities.
- Support delivery of specialist housing programmes that enable people to remain independent and reduce demand on services.
- Enabling relocation of services closer to areas of high need, where clinically appropriate, and supported by investment decisions.
- Reducing the negative impact of wider determinants of health by providing equitable access to care.
- Delivering our Net Zero Green Plan to reduce our carbon footprint and emissions, and tackle the negative impact this has on health and our communities.

Managing the Estate Portfolio

We have established a robust governance process for a systemwide estates team which will enable collaborative working at a system level and make investment decisions for the benefit of the system and our population as a whole. The Estates workstream links operationally to the ICS Executive for its direction through its Senior Responsible Officer.

The Estates Programme Board is an enabling service function within the ICS. Its main role is to bring key system partners together to develop and deliver the strategic estates vision and objectives that support the Norfolk and Waveney Integrated Care System to realise its vision, purpose, goals, and deliver upon its priorities. Our Estates Programme Board is comprised of members leading the estate function across system partners, including links to local authorities and One Public Estate (OPE) partners.

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Empowered and Skilled Estates Workforce

In order to provide an effective, safe, and efficient service, now and in the future, we need to have the right estates and facilities resource and expertise available. The ICS Estates workstream will develop an estates and facilities workforce plan and policy that builds on and further promotes system wide workforce planning. It will align with the Norfolk and Waveney People Plan, as well as the national estates and facilities workforce strategies.

Net Zero Estate

Our Net Zero Green Plan is described in the Legal Duty as to climate change. Emissions resulting from NHS building energy, water, and waste account for 11% of our total emissions, and 55% of the emissions we control directly. The Estates 'Net Zero' Carbon Delivery Plan provides a managed approach that will embed and enable the decarbonisation of the estate across the ICS.

Working through the ICS Green Plan delivery group, we will explore and implement interventions to decarbonise our estate and reduce carbon emissions arising from our buildings, infrastructure, and services.

Adapting to Climate Change

Climate change adaptation means responding to both the projected and current impacts of climate change and adverse weather events. Adaptation for our health and care estate is two-fold:

Health and Wellbeing:

- Investing in and managing estate that avoids negatively impacting the physical and mental health and wellbeing of our population.
- Flexibly managing our estate so that our health and care system can respond to different volumes and patterns of demand.

Operational delivery:

- The system infrastructure (such as buildings and transport) and supply chain (for example fuel, food and care supplies) need to be prepared for and resilient to weather events and other crises.

Transformed Models of Care

Transforming through the national New Hospital Programme

The New Hospital Programme delivers Government investment in the replacement of aged NHS hospital estate across the NHS. Within the programme Reinforced Autoclaved Aerated Concrete (RAAC) affected estate has been included for replacement and has included the James Paget Hospital. An extension of the programme includes a bid to bring the Queen Elizabeth Hospital into the replacement programme, and outcome on this is awaited.

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Transforming through digital infrastructure and SMART buildings

The use of digital infrastructure and technology is important in delivering our vision and objectives. Digital innovation and enhanced infrastructure, devices, and information systems will help form SMART buildings that advance the experiences of our building users, improve sustainability, and drive financial efficiency.

SMART buildings will monitor, measure, and manage key aspects of a building's fabric and operational use, providing the data and knowledge to drive improvement. Good estates and facilities management can be ensured through the ongoing monitoring of maintenance, operations, and utilisation data generated by SMART building technology.

Digital infrastructure and platforms will include proactive use of digital systems to improve the performance, reliability, quality, and productivity of our estate, and reduce reactive and backlog maintenance costs. This is consistent with our Digital Strategy and Roadmap.

Infrastructure Design and Investment

Improving integration through One Public Estate

One Public Estate (OPE) is an established national programme delivered in partnership by the Office of Government Property and the Local Government Association. We have been an integral part of this programme for a number of years and we will continue this work. The OPE Board provides practical and technical support and funding to councils and other public organisations to deliver ambitious, property-focused programmes in collaboration with central government and other public sector partners.

Procurement / supply chain

Our local NHS providers established the Norfolk and Waveney Procurement Collaborative (NWPC) in 2020. This is bringing provider purchasing teams closer together under a formal agreement to buy in common wherever possible and they have already agreed common standing financial instructions. As our frontline teams work more flexibly across the system, this will help us improve clinical effectiveness through use of standard equipment and products across all our sites. To ensure we maximise these opportunities our clinically led, system wide Clinical Product Evaluation Group will review all proposed purchasing decisions to ensure every opportunity for standardisation has been taken.

This collaboration has already delivered over £4m of procurement savings in 2022/23 and will continue to ensure we get the very best value from our non-pay spend by aggregating our volumes such that suppliers see us as an important strategic customer and all trusts gain the benefit of the best available prices. We have developed category strategies for each of our key spend areas and will deliver a programme of product range consolidation, volume aggregation and commitment to strategic supplier partnerships across the system to support the development of integrated patient pathways.

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We will also collaborate regionally with partners across the East of England where this makes sense, notably in the areas of cardiology and diagnostics where we

already work very closely with other trusts, such as Royal Papworth Hospital NHS Foundation Trust and the East of England Collaborative Procurement Hub. We will continue our support for the NHS England strategy of using NHS Supply Chain wherever possible, so that nationally there is the greatest opportunity for the NHS as a whole to leverage its buying power.

Procurement will also make a vital system contribution to key strategic programmes, such as Diagnostic Assessment Centres and the Electronic Patient Record, to ensure we secure value from long term partnership agreements.

We are fully engaged with the new NHS Central Commercial Function and will ensure our procurement services our assessed and showing improvement against the UK Government's Commercial Continuing Improvement Assessment Framework. Currently all our provider procurement teams are rated as 'Good' and we will seek to achieve 'Better' status in 2023/24.

This improvement will be enabled in part through significant development of our procurement information toolkit. NWPC has taken a lead in the NHS's development and deployment of the UK government commercial system known as Atamis. All contract information is now shared across the system's providers with spend analytics to provide in depth analysis on where we can further improve our spend efficiency. We will use this intelligence to prioritise our procurement resources effectively as we align our contracts.

Following our successful partnering with NHS Shared Business Services to provide efficient transactional purchasing services across the system, we will be upgrading our ordering system to offer end users a more 'Amazon' style service. This will help front line teams identify the products they need more quickly and reduce waste across the system. We will also reduce waste through further deployment of modern inventory management systems and NWPC are part of a pilot project with NHS Supply Chain reviewing distribution logistics, which will inform a system strategy on how we should efficiently maintain resilient stock levels, learning important lessons from the COVID-19 pandemic.

Social value and sustainability will be an increasingly important factor in our procurement decision making. 62% of NHS carbon emissions occur in the supply chain, with many of these emissions occurring in the UK. As part of our sustainability commitment, we will work with our supply partners to reduce our packaging and transport carbon impacts. For all contracts over £5m per annum, we will require the supplier to provide a carbon reduction plan.

We will also ensure our procurement tender activity supports UK government social value targets, the Greener NHS Programme to deliver a net zero health service and the drive to eliminate modern day slavery. For each tender we initiate we will evaluate prospective supplier's proposals against requirements in some or all of the following criteria:

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- Fighting climate change
- Wellbeing
- Equal opportunity

- Tackling economic inequality
- COVID-19 recovery

This is consistent with our Net Zero Green Plan which is within the legal duty as to climate change.

We will proactively engage with small to medium enterprises in the local area and will publish our forward pipeline of potential procurement activity so that there is greater visibility of opportunities to work in partnership with the NHS in Norfolk and Waveney.

We are fortunate to have skilled and experienced commercial professionals available across the NWPC partners, with a number of 'MCIPS' qualified staff which is the gold standard for procurement. We will continue to invest in the professional development of our commercial team as this is a growing key strategic competence required across the NHS.

The ICB continues to directly host its own procurement function. This manages predominantly procurements for healthcare and non-healthcare services reflecting the commissioning responsibilities of the ICB. The focus of the ICB procurement team is to ensure that the ICB complies with the legal requirements for awarding service contracts that deliver the best services for patients at the best value for the system. We will review our approach to this in the light of prospective new 'provider selection regime' legislation currently making its way through parliament.

As separate legal entities and to reflect the different obligations of commissioning and provider organisations, to date the ICB and provider collaborative procurement functions have operated independently. These teams are however in regular dialogue and work together to identify the most efficient and effective routes to complying with our responsibilities under legislation to the benefit of the whole system. As the system continues to develop, the way in which procurement activities are undertaken and responsibilities for specific programmes of work will continue to be reviewed to ensure that the procurement function is being delivered in the most effective way.

Population Health Management

Population Health Management (PHM) is a way of working, using joined-up local data and information to better understand the health and care needs of our local people and proactively put in place new models of care to deliver improvements in health and wellbeing.

Our newly created ICS Population Health and Inequalities Board is leading the development and implementation of a strategy for Population Health Management, which will be in place by April 2024. This is a specific objective within the PHM, Reducing Inequalities and Supporting Prevention ambition.

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The new strategy will set out our ambitions in relation to the delivery of population health management, our priorities and plans for a system level programme and our

approaches for all partners within the system to take forward their own programmes of population health management, focussing on local communities.

By focussing on prevention and health inequalities, and by partners working together to identify new things that can really help to improve health, the strategy will support people to live as healthy a life as possible. It will impact on the way we plan, prioritise and deliver care. It will be one of the key ways we can act together to improve health and wellbeing, making the best use of the resources we have available to us, removing barriers and supporting integrated working across our system.

The strategy will set out our approaches to use joined up data and information to better identify and understand the health and care needs of our population, to identify opportunities for improvements and put in place targeted interventions to support these.

We will be aspiring to a reduction in the differences in outcomes we currently experience in terms of accessing services and improvements in the health care processes for our most deprived populations.

We will also be seeking to prioritise prevention activities, particularly relating to smoking, alcohol, diet and physical activity and uptake of cancer screening and immunisations.

Our approach will also be driven by the needs of local communities and interventions designed to support them. We will be supporting place-led projects to deliver local priorities and to support working with wider partners to develop joint initiatives to address the wider determinants of health, such as housing.

Our strategy will include an ongoing programme of evaluation to measure progress and impact. Progress reports will be received by the newly established ICB Population Health and Inequalities Board, led by our Executive Medical Director, which have a broad membership of ICS representatives, including county council, adult social care and Children's Services, Public Health, NHS providers, and place board and health and wellbeing partnership representatives. In addition, there will be workshops held to develop the strategy and the Clinical Care Assembly will be a key consultative forum. Primary Care Networks, place boards and health and wellbeing partnerships will also be consulted.

We have identified initial Population Health Management priorities at a system level to address health inequalities and meet the Core 20 plus 5 priorities, which will have the greatest impact and where we know there are opportunities to improve. These are:

- Smoking, especially smoking in pregnancy,
- Serious Mental Illness,
- Chronic conditions – cancer (including earlier diagnosis), cardiovascular and respiratory

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We already have an approved ICS PHM "roadmap" and our dedicated PHM team have achieved a number of improvements as part of our "Protect NoW" programme of work. This programme is a collaboration between NHS organisations, local

authorities, the voluntary sector and independent partners working across Norfolk and Waveney. It comprises a growing number of projects, each focused on optimising physical and/or mental health and wellbeing. Alongside clinical leadership, our PHM digital supplier provides the bespoke data analysis, technical solutions and digital platforms that underpin the “Protect NoW” projects.
Projects to date have included topics such as:

- **COVID-19 vaccination uptake**- Increasing vaccine uptake and gaining insight into how we can support people to take up the vaccine offer.
- **Falls prevention**- Engaging with people who are vulnerable to having a fall or waiting for a hip or knee operation and assessing if any adaptations or equipment are required, in partnership with the Local Authority Home Adaptations team.
- **Pain management**- Triaging patients on the pain waiting list so that those suffering the most pain are prioritised.
- **Improving Access to Psychological Therapies *(*IAPT) uptake**- Increasing referrals to the wellbeing service and addressing clinical variation.
- **Cervical screening uptake**- Increasing the uptake of Cervical Cancer Screening - reducing inequalities and unwarranted clinical variation.
- **Long Covid clinic design**- Gaining insight from those with lived experience of Long Covid to inform design of service specification for commissioning Long Covid clinics from the community provider.
- **Diabetes prevention**- Increasing referrals into the National Diabetes Prevention Programme to prevent / reverse type 2 diabetes and address clinical variation.
- **Priority Patient Review**- Reducing hospital admissions through primary care risk alerts relating to six biomedical markers. The pilot is seeking to demonstrate that the proactive management of patients with reversible risk across six clinical pathways will result in reduced hospital admissions.
- **ActiveNOW** - focused on supporting health and care professionals to quickly and easily refer patients into suitable physical activities based on their needs.

In order to better understand the health needs of our population and plan and deliver the PHM programme in an integrated way, we need to further develop our infrastructure that underpins it. The development of this infrastructure is closely linked to our ICS digital strategy.

At the moment, data is mostly held within separate organisations and this limits the ability to see the bigger picture. PHM will be optimised when we can join up data sources (including hospital, general practice and social care) to analyse need and plan care at a population level. This includes accessing linked-up data across our system using the ICS’s new data hub. More details about how we are doing this can be found in our Digital Transformation Strategic Plan and Roadmap.

Clear and robust information governance systems and agreements enable us to share and analyse data safely and appropriately. As we develop our PHM programme, we will be ensuring that our cross-system information governance systems and safe access controls are clear and communicated to all partners and break down existing barriers to sharing data.

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Access to such data will allow us to undertake sophisticated analysis, modelling future demand, and using techniques known as “population segmentation”, “risk stratification” and “financial risk modelling”- identifying where we can make the most impact and supporting more personalised care. We will be supported to do this by skilled analytical support from our ICS-wide intelligence function. We will also be training our wider workforce to interpret the available information and identify their own, more local, priorities for action.

System Development

To create the change that we want to see and to make the most of the opportunity arising from the transition to an Integrated Care System, it is vital that we look at and understand what needs changing in our governance, processes, leadership and culture. This is why we are going to undertake a governance review in 2023/24, to make sure that we are operating as effectively as possible and are seizing all the new opportunities available to us.

The governance review will build on the plans we already have in place for developing and strengthening how our system works. Information about our plans for the future can be found in the following sections of this plan:

- **Neighbourhood level working:** Working at this very local level is a theme throughout our ambitions and underpinning objectives which are about ensuring provision is very accessible, is what our population needs, and finding out what matters most so it can be delivered as effectively as possible. Examples of this include the Family Hub, starting our journey to develop integrated neighbourhood teams and the maternity pathway to reduce tobacco dependency.
- **Place level working:** Our place-based approach is set out in section 5.1 of our Joint Forward Plan.
- **Closer working between providers of health and care services:** Our plans for working collaboratively are set out in section 5.2 of our Joint Forward Plan.
- **Working with the Voluntary, Community and Social Enterprise (VCSE) sector:** Our plans for developing how we work with the sector, including through our VCSE Assembly, are set out in section 5.8 of our Joint Forward Plan.
- **Improving the quality of care:** Our plans for how our system will build our capability to identify and address quality challenges are set out in the section about our legal duty to improve quality of services included in these appendices to our plan.
- **Our financial performance:** Our plans for how our system will build our capability to identify and address financial challenges are set out in the section about our financial duties included in these appendices to our JFP.

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Our Integrated Care Partnership was built on the well-established Norfolk Health and Wellbeing Board, incorporating additional members from Suffolk to cover the Waveney part of our system. We put considerable thought and effort into developing our partnership in advance of its launch, so it is in a good position to deliver its key

functions. How the system relates to the partnership will be considered as part of the governance review. For 2023/24 though, we have adjusted the membership slightly, adding the chairs of our place boards to further strengthen the relationships and links between system and place level.

For Norfolk and Waveney to be a really thriving system, staff need to be supported to work in different ways and this is why we have put in place a comprehensive organisational development programme for our system and for staff at all levels. Specific programmes of work have been developed for the ICB Board, the ICB's senior managers and the system's Executive Management Team, along with training packages and support for the wider workforce, all of which is complemented by the Clinical and Care Professionals' Leadership Programme.

This organisational development work started well before the Health and Care Act (2022) came into force and has played an important role as our system has moved towards greater collaboration over the past few years. The work will continue as our system develops and matures.

Supporting wider social and economic development

We recognise our role as anchor institutions to explore opportunities to collaborate to influence the wider determinants of health within the heart of communities. This ranges from creating opportunities to listen and hear the voice of citizens, sharing data to alleviate respiratory conditions and improve the quality of housing, to accessing and signposting to partners' skills, training and employment pathways in order to grow our system's workforce and create a vibrant local employment market.

Our work to support wider social and economic development will be underpinned by asset-based community development principles, utilising all of our collective assets including workforce, estates and the people themselves to create system change. We will utilise tools such as the Community Voices programme to listen to communities and empower them to be their own agents for change, utilising their insights to influence the services and interventions we develop.

Our eight Health and Wellbeing Partnerships (HWPs) play a significant role in supporting decision making that reflects community need, assets and strengths. They provide a platform to engage a wide range of partners at a local level, that can support the design and transformation of health and care services, whilst ensuring connectivity to other services that can support their wider needs. These HWPs will provide the vital infrastructure, expertise and reach to support development and delivery of the proposed system Health Inequalities and PHM strategies.

Over the coming months we will co-ordinate baselining activity utilising the NHSE measurement framework currently in development, to understand the relationship between employment in the NHS and our local communities, particularly those that experience the greatest inequalities, as well as how we procure and how we currently utilise our estates.

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Through this baselining exercise we will determine where we can improve our employment strategies in collaboration with our HWPs, seeking to work alongside the Department of Work and Pensions, local government, educational settings and VCSE organisations to proactively target those furthest away from the labour market and promote access to good, inclusive employment, skills development, and career progression.

Through our HWPs and Place Boards strong equitable relationships exist with local government. Working together we can influence, support and add value to a wide range of programmes that seek to improve access to green spaces, provide access to our collective facilities to support health and wellbeing, support local regeneration and generally provide opportunities for residents to improve their own health and wellbeing. An example of this is the adoption by Norfolk's seven Local Planning Authorities of the 'Norfolk Planning in Health Protocol' (2019).

Through our system Health Inequalities governance arrangements will seek to scale up the projects being delivered through a place-based approach, such as the James Paget University Hospital 'Anchor Pilot' that works with local VCSE organisations and communities in Great Yarmouth. This project is creating accessible green spaces on hospital owned land that can support the health and wellbeing of staff and visitors, which enables local procurement of services whilst supporting local volunteers to access employment skills and training and empowering them to access local job opportunities.

Our Net Zero Green Plan which is described in the legal duty as to climate change, sets out how we seek to reduce our environmental impact across the system. Underpinned by a robust communications and engagement plan, we will coalesce partners around shared ambitions, providing the tools and expertise to effect change.

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JFP Case Studies

1	**Providing multi-agency support to ensure people can live in warm, comfortable homes, reducing the impact on their health** Cold homes and Chronic respiratory illness is an issue for many areas across the country. In Great Yarmouth and Waveney, the local health and wellbeing partnerships are building on the approach developed in Gloucestershire, which focused on the direct correlation between cold, damp living conditions, exacerbation of respiratory illness and increased risk of hospital admission. These partnerships are made up of Local Authorities, VCSE and NHS organisations, primary care and others who are truly working together to wrap services around our people and communities. Clinically led by Dr Sarah Flindall, East Norfolk Medical Practice, the project has been supported through ringfenced funding agreed between Great Yarmouth Borough Council and East Suffolk Council and has supported approximately 750 people this winter. The project is reducing respiratory ill health caused by cold homes, by seeking out vulnerable people with chronic respiratory conditions who are living with fuel poverty, providing them with financial support from the national Household Support Fund. The project is also linking individuals with other support services for their wider health and wellbeing needs, with the intention of helping people to lead longer, healthier and happier lives. This project has a big focus on prevention, helping to reduce the number of related hospital admissions and supporting people to help prevent respiratory illness from starting or indeed getting worse.
2	**Working together to reduce re-offending, substance misuse and supporting better mental health** As a result of working together, a new clinical psychologist role has been rolled out across the Norfolk and Waveney ICS, commissioned by Norfolk County Council, employed by Norfolk and Suffolk NHS Foundation Trust, and deployed into the Project ADDER team within our VCSE-provided local drug and alcohol service (Change Grow Live). Project ADDER aims to reduce re-offending, reduce substance misuse and promote mental health in service users with complex emotional needs, substance misuse and a history of contact with the criminal justice system. In this role, the psychologist works directly with individuals to provide intervention and indirectly with staff to increase the provision of brief psychologically informed treatments. This reduces barriers to access as service users with high levels of complexity can be seen in a setting they are familiar with where they are used to engaging with support. The role also forms a bridge for service users to access more specialist mental health treatment within the mental health trust as needed, and a channel for specialist resources and training from within the mental health trust to be made available to project ADDER and CGL staff.

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3	**New mental health roles working in mental health services based in the community** Mental health transformation of services within the heart of local communities has provided several new mental health roles to diversify the mental health offer within primary care and to increase the provision of psychological intervention. These roles are providing a more accessible and recovery-oriented offer within and across primary care networks. Peer support workers and Enhanced Recovery Workers and now working alongside Mental Health Practitioners (CMHNs and other mental health professions) within GP surgeries to provide a range of mental health support. Additionally, Clinical Associate Psychologists have been employed by Norfolk and Suffolk NHS Foundation Trust to boost the provision of psychological intervention for those service users who have complex mental health needs but may not meet threshold for local secondary care services (CMHT).
4	**I-statements – working with our experts by experience** Through a series of workshops and discussions with Experts by Experience, facilitated by Rethink Mental Illness and NHS Norfolk and Waveney's Mental Health programme team, a set of I-Statements, tailored to Community Transformation (CT) were developed during 2022-23. We are now taking steps to ensure service provision is aligned with the I-Statements. A project is now being planned to develop an outcomes-based commissioning approach, building on this work. **An expert by experience said**: "Working with NHS Norfolk and Waveney and the wider Norfolk and Waveney ICS has really helped bring the views and experiences of people who have experienced mental ill health. "This is a fresh, new innovative approach which is valuing the views and experiences of people with lived experience."
5	**Wellbeing hubs putting mental health front and centre of the community** Wellbeing hubs across Norfolk and Waveney are breaking down barriers and putting mental health front and centre of the community. Dr Ardyn Ross, Mental Health Clinical Lead for NHS Norfolk and Waveney said: "Having community wellbeing hubs where people can drop in, without an appointment, to discuss their health and wellbeing and any issues that are affecting their mental health is invaluable in removing the stigma around mental health. "After all we all have mental health – sometimes it's good and sometimes we need support with it to stay well."

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	The fifth NHS-funded hub - REST Aylsham opened in July – joining REST Norwich and Kings Lynn and Steam House Café Gorleston and Kings Lynn. The wellbeing hubs may be branded differently but they all have one thing in common – they're a safe space for people to get support for their mental health and wellbeing in their community. Including people experiencing significant mental distress. With a focus on wellness, not illness, there's always a warm welcome and supportive staff to offer help, advice, or a listening ear. The Steam House Café in Gorleston – run by Access Community Trust has been a lifesaver for Lynn White. She says: "I have a mental health problem and the staff here are absolutely brilliant. I come every day and they listen, and they are so kind and helpful. If you come in and just want to chat, you can. "If it wasn't for this place, I'm not sure I would have coped with my health. I have dissociative disorder and I do have bad attacks and they know what to do if I have one. It's so relaxed and a perfect place to come."
6	**Working in the Voluntary, community and social enterprises (VCSE) sector there is so much to be gained. Meet Joe.** Joe Worsley is on a Health Leadership, Graduate Management Scheme with an interest in the charity sector and was pleased to take a flexi opportunity and work at Access Community Trust. Joe helped to develop and roll out their Customer Relationship Management system which hopes to measure the social value of the work that Access do. The Access Community Trust's vision is to promote social inclusion for the community benefit by preventing people from becoming socially excluded, relieving the needs of those who are socially excluded and assisting them to integrate into society. Aimed at young people and adults they provide a range of services from house related support, learning, development, employment and providing support with mental health and wellbeing. With social enterprises such as the STEAM house cafes offering a safe space for those in mental health crisis day and night. Joe says "that it is important that Access can measure the social value of the work they do, so they can demonstrate the value their work provides the Community which often goes far beyond their initial remit. This will help to secure further government funding and enable them to self-evaluate where they need to further focus their efforts, continuing to reduce health inequalities by providing essential services to customers at risk of social exclusion.

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	The work of Access is vital as it supports complex customers who otherwise might fall through the gaps between health and social care and multiple providers. Access can support a customer's journey from sleeping rough to temporary accommodation, permanent accommodation, and employment. Joe says, "this placement gave me a real insight into how much value the 'third sector' can bring and how much there is to be gained by integrating the Voluntary Sector and Social Enterprises such as Access, with all healthcare providers".
7	**Working together to reduce unnecessary hospital admission** John is a 46-year-old man with cerebral palsy and epilepsy who called 999 with a head injury after a fall. John was assessed through the 999-triage process as requiring a category 3 response. This is a lower acuity response with a target response time of 2 hours. Within the Ambulance Control Room, this case was discussed with partner organisations – 999, Community Teams and the Clinical Assessment Service (CAS) – to determine whether a 999 response would be best, or whether a different service could respond to John in the allocated time. John lives with his mum and both John and his mum were testing positive for COVID-19 at the time of the call. The Community team had resources available in the area who could visit John and his mum at home. A Community Matron called John prior to visiting to explain it would be the community team who would visit, not an ambulance. John's mum was relieved by this as she said she hadn't wanted to call an ambulance but wasn't sure what she should do instead. The Community Matron arrived at John's home within two hours and carried out an assessment. A clinical assessment was completed for the head injury, as well as wounds and bruises to the body that were caused during the fall. The Matron was able to dress the wounds and complete a chest examination and COVID-19 assessment. John was found to have no clinical red flags that would be a reason for a hospital admission. The cause of the fall was also assessed and found to be caused be COVID-19 symptoms exacerbating John's existing mobility difficulties. Mobility aids and equipment options were discussed, and equipment from community stores was collected and loaned. Medication advice was given to help with COVID-19 symptoms and some pain from the bruising. John was able to stay at home, which both he and his mum were relived about, as they were concerned about John having to go alone to hospital while his mum was also covid positive. The Matron have advice for what to do and who to contract if the situation deteriorated and a follow up later that week confirmed that John was back to his usual level of mobility, his wounds and bruising was healing and he had no further concerns.

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8	**Embracing the use of digital technology to care for people in the community** Melanie attended the James Paget University Hospital NHS Foundation Trust Emergency Department with acute breathlessness, chest and abdominal pain two weeks post-COVID-19. A diagnosis of significant pneumonia was confirmed. Melanie was reviewed by the Acute Medical Consultant on call and it was decided that Melanie could be cared for at home, with remote monitoring on the Virtual Ward with oral antibiotics. Melanie was monitored on the Virtual Ward for a total of nine days, during which time she had repeat bloods taken. Melanie's response to oral antibiotic treatment worked well and her condition improved. Daily clinical monitoring enabled clear planning to ensure this patient was able to be managed safely in the comfort of her own home. Melanie said this had a positive impact on her mental and physical wellbeing. She was able to contact the virtual wards team for 30 days post discharge during a patient initiative follow-up period. During this time, Melanie called for a further review. This resulted in a face-to-face doctor review at the Same Day Emergency Care unit. Melanie was assessed and discharged after review with reassurance. Melanie later called JPUH to thank them for their support and was able to return to work in a primary school as a teaching assistant.
9	**Virtual ward prevents admission to hospital** John was referred to the Virtual Ward by his local GP. At the point of referral to the Virtual Ward John had a history of respiratory and cardiac issues. John was referred to the Virtual Ward by his GP in light of two recent emergency department attendances which John found distressing and disorientating. Upon referral to the Virtual Ward, John was triaged and onboarded at the Virtual Ward Hub. This included a review of health care records which reveal that he had attended A&E multiple times in the last two years with chest pain. Remote monitoring equipment was delivered and setup for John in his home within two hours of being onboarded to the Virtual Ward and an initial assessment undertaking blood analysis was performed. Through Multi-Disciplinary Team (MDT) input of the Virtual Ward, a healthcare plan was developed with the aim of avoiding A&E attendance and possible subsequent hospital admission.

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	As a result of admission to the Virtual Ward John experienced timely specialist assessment and care delivered in his preferred place of care, increased MDT input and consequently increased levels of holistic care and increased involvement of family members in decisions about his care. With good medicines management and early efficient treatment, holistic care based on John's needs, he was considered well enough that he would not require admission to an acute bed.
10	**Head and neck cancer clinics benefit patients in North Norfolk** The Head and Neck Cancer team is bringing services closer to home for patients living on the coast with the launch of two clinics at Cromer Hospital. The team consists of Erica Everitt, Senior Matron for Head and Neck Cancer Services and Tracheostomy Support Services, and Head and Neck Specialist Nurses Cristina Fernandes, Astra Rutherford-Hall and Helen Goward with Cristina and Astra's roles originally funded by the Macmillan charity. They run two parallel clinics, a nurse-led clinic focusing on general well-being, ongoing assessment, giving advice, and aimed at helping patients with their ongoing management of their condition. The other is a consultant-led clinic run by Dr Alfred Addison, ENT Consultant, who will see patients who need more expert clinical input such as reviewing a change in their cancer status, or who need more exploratory work or follow-up procedures. The two clinics look after between eight and 10 patients. Cristina has five slots in her clinics with two of the slots taken up with new referrals and three patients with ongoing maintenance. When she has two new patients, she will focus on pre-surgery preparation and ensuring the patient is psychologically ready. She also helps them prepare physically for their procedure. She will inform them of what to expect immediately after the operation. For the three existing patients Cristina will support them and also carry out 'Moving Forward' sessions with them. "Moving Forward" sessions focus on helping the patient become more proactive with their ongoing cancer care; learning how to check for changes and making sure they contact the hospital immediately if they have any concerns about their recovery or wellbeing and supports them in planning their lives for the future after cancer. Patients come from a wide area and are referred to the team from The Queen Elizabeth Hospital King's Lynn and the James Paget University Hospital as well as from the Ipswich and Colchester area. Having been given the opportunity to take clinic space in the new Macmillan Centre in Cromer, patients living on the coast no longer have to travel to NNUH for follow-up clinics, making clinics more

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	accessible. Waiting times in clinics are shorter because they involve fewer patients and the Cromer clinics free up valuable space at the main site where follow-up clinics also take place. A large part of the “Moving Forward” sessions is to help the patients psychologically as their wellbeing is of particular importance. Treatment and follow-up support can be quite intensive and when this is removed, it can have a negative effect. It is hoped that once the clinics are more established, the nurse specialists will undertake training to be able to carry out some clinical procedures such as nasal endoscopies which will also speed up patients’ ongoing care issues. There are also plans for nurse-led clinics to be created at the Norfolk and Norwich which does not currently have a dedicated Head and Neck department. The learning in Cromer will be used to inform best practice at the hospital’s main site when setting up new clinics.
11	**Lung health checks launched in a drive to save more lives** Past and current smokers in Great Yarmouth are being invited to an NHS lung health check in a drive to improve earlier diagnosis of lung cancer and save more lives. With one of the highest mortality rates for lung cancer in England, Great Yarmouth is one of 43 places across the country to launch the Targeted Lung Health Check programme. The initiative means around 13,750 past and current smokers aged 55 to 74 years of age in Great Yarmouth are being invited to a lung health check by their GP. This will identify lung cancer earlier than it would have been otherwise. People diagnosed with lung cancer at the earliest stage are nearly 20 times more likely to survive for five years than those whose cancer is caught late. **A patient who has had a lung health check, said**: “This is an excellent scheme and I was so pleased to be invited to attend this check up. Prevention is always better than the cure and this is a great example of the NHS, working together to help identify cancer much earlier. I am so grateful.”
12	**Primary Care Network (PCNs) providing more appointments – Enhanced Access** All 17 Primary Care Networks (PCN) in Norfolk and Waveney have agreed to deliver Enhanced Access Hours. This is in addition to core contracted hours to support improved access in general practice.

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	Since 1 October 2022, PCNs have agreed to provide Enhanced Access appointments between the hours of 6.30pm and 8pm Monday to Friday and between 9am and 5pm on Saturday. As a result, we have since seen improvements an increase in the numbers of appointments available for patients in general practice, with more patients being able to access appointments face to face, via telephone or video consultation. The total number of appointments with general practice in Norfolk and Waveney is higher than before the pandemic. In 2019-20 there were 6.3 million appointments; in 2021-22 there were 6.5 million appointments – on top of this general practice also delivered over 700,000 COVID-19 vaccinations in 2021-22. In January 2023 there were over 600,000 appointments (an increase of 6.5% compared with the same month in 2020), and almost 41% of these were same day appointments. More patients are being seen face-to-face in Norfolk and Waveney than in other parts of the country: • While 76% of our patients were seen in person in January 2023, the national average was 69%. • In the last two months of 2022, more than 14,500 face-to-face appointments were delivered than in the same period in 2019. This is a result of the hard work of local GP practices working together in PCNs, in more collaborative and flexible ways.
13	**Shared Care Record sets to transform care in Norfolk and Waveney** The Shared Care Record is a way of bringing together the most important records from the different organisations involved in the health and care of our people and communities in Norfolk and Waveney. These records are then visible to frontline health and social care professionals, at the point of care, in a read-only view. Our aim is to help our frontline health and care services by providing important information about you and your care, from your interactions with the following professional care services: • GP • NHS 111/out of hours service • community services • emergency department • outpatient appointment • hospital stays • maternity service • mental health practitioner or care practitioners

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	Patients' information will only be made available when needed at the point of care and will only be used by staff members with a legitimate basis to do so. The Norfolk and Waveney Shared Care Record helps meet this aim by reducing the time needed to learn about important health and care information, particularly in a time sensitive situation. This can be particularly helpful when patients, their families and carers may not be able to answer specific health and care questions.
14	**Supporting people to get more active in Norfolk and Waveney** Launched in January 2023, Active NoW is a whole system physical activity model that has been co-developed by NHS Norfolk and Waveney, Active Partnerships, County Council's, all 8 district councils and parts of the VCSE sector. The model seeks to improve health and wellbeing and reduce inequalities in access to physical activity through a service that unites the physical activity sector under one single point of referral. Taking a population health management approach, the programme seeks to identify those people in Norfolk and Waveney that will benefit most from increasing their activity levels, either to prevent or manage their long-term condition, and particularly focuses on our Core20 population. To date, focus has been given to aligning the model with diabetes pathways. In 2023-24, this partnership will be expanded to integrate with hypertension, falls and weight management pathways and, through a link with the Health and Wellbeing Partnerships, develop a wider range of services and opportunities that can support access. The programme is already supporting hundreds of people across Norfolk and Waveney to lead a better, healthier lifestyle.
15	**Bringing health and care support, advice and treatment services to the high street** Since the end of January 2023, partner organisations from across the Norfolk and Waveney ICS have been delivering COVID-19 vaccinations at a new site, based at Castle Quarter in Norwich. The new centre is a lot more than just a vaccination centre. This is the start of a new initiative where NHS Norfolk and Waveney, working with partner organisations, including public health teams will support health and care in local communities.

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	The new Wellness Hubs will continue the delivery of the COVID-19 vaccinations, but they will also offer access to wider health support, lifestyle and wellbeing advice, along with dedicated welfare support to ensure our local communities can access even more health and care services in more of a one stop shop. Our Wellness Hubs will also work closely with our WoW Bus (Wellness on Wheels) which travels across Norfolk and Waveney reaching those who do not access health in more traditional ways. The bus provides vaccination and other interventions, focusing on our inclusion health groups such as those experiencing homelessness.
16	**Listening and reaching out to those we would not normally hear from** Piloted through the pandemic to increase access to COVID-19 vaccination through trusted communicators in VCSE and local government organisations, Norfolk and Waveney ICS has secured external funding to support the continuation and expansion of this programme over the next 12 months. Working with the VCSE sector, we will be expanding our reach through the future development of a network of champions that have trusted relationships within communities of interest. This network will listen to the concerns and issues within communities and feed their insights back through a central insight bank, and we will be offering awareness training around a range of long-term conditions and services through a training programme and suite of accessible resources to build confidence and capability to have a conversation about health in local communities, and support residents to take action. Two pilot projects will be implemented as part of the ongoing programme – one looking at whether the model can support access to bowel cancer screening in Core20plus groups, and increasing participation in medical research in diverse coastal communities.

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17	**What Should Quality Feel Like? Visit Canary Care** **Canary Care*** is a home care provider. It is a big local employer that provides opportunities for its staff to develop skills for caring, working as compassionate professionals who help to keep people healthy, happy and independent, in their own homes.  For the **staff at Canary Care**, quality feels like being able to provide care in a joined up system, with clear communication and processes shared with other partners, like hospitals, discharge teams and GP surgeries. It means that there are career pathways at all levels and recognition of social care talent and skills. Quality means taking pride in your work and having the right values, tools and resources to meet the needs of your service users. It means being part of a professional and well managed company that values and rewards your work. For **Canary Care service users**, quality feels like being safe, healthy and having personal needs met by people that you can trust. It feels like being able to keep connected with friends, family and community and be a part of planning and decision making about your own life; from 'what's for dinner' to 'where do I live'. Quality means feeling safe, respected and involved in choices about your care. It means having equal access to a healthy, active lifestyle and a rich and fulfilling life.

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18	**What Should Quality Feel Like? Meet Charlie** Charlie, aged 19, has been a family carer for most of her life and a member of Norfolk Young Carers' Forum, supported by the charity Caring Together as part of Norfolk and Waveney ICS. The Forum helps to recognise the lives of young carers and ensure that health, care and education services across Norfolk understand their needs. The Forum has carried out surveys of young carers and ran a conference for people working across the health and care system. Forum members have recorded videos, shared their experiences and reviewed all of the materials which are used in carer-awareness training. Charlie has put a lot into the forum, and got a lot out of it too.  Charlie says: "At first I was surprised they gave a 15-year-old the responsibility of doing the lectures, but I'm used to it now. It's still nerve-wracking but I know exactly what I am doing. I was a shy kid, but when I joined the Forum, I felt a real surge in confidence; it gave me a voice. In the Forum, everyone accepts who you are. Everyone is in a similar boat. They all just get it. I've made a lot of friends that I will be friends with for the rest of my life and pushed me to do what I want to do." Charlie's caring role continues and when she reflects on five years in the Forum, she is positive about the changes that have happened in that time. She remains committed to driving further change for young carers.
19	**Working differently to respond to urgent care issues in local communities** Jim is 77 years old and has advanced dementia. He lives at home with his wife. Jim's wife called 999 as Jim had facial swelling and was drooling. Jim's wife was worried as in the past these had been signs of infection. The 999 service triaged this call as a Category 3 urgent call, requiring a response within 2 hours. Within the Ambulance Control Room, Jim's call was passed to an Open Room for clinical discussion between partner organisations, including 999, Community Teams and the Clinical Assessment Service (CAS), to determine whether a 999 response would be best, or whether a different service could respond to Jim in the allocated time. The discussion found that Jim's wife often called 999 reporting these symptoms.

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	A community Matron visited Jim and his wife at home within 30 minutes. Jim's wife was very concerned as Jim has been drooling overnight, and previously this was what happened when Jim was diagnosed with urosepsis. Jim's wife was worried this was happening again. An assessment was carried out which identified Jim used a urethral catheter, had swallowing difficulties and that they hadn't been able to remove his dentures for many weeks. The Matron completed a clinical examination and observations, including a chest examination. The Matron was able to remove the dentures to examine Jim's mouth and found that there were no issues of concern to be worried about. Jim was alert, happy and well, eating and drinking normally with no signs of infection found. The matron discussed Jim's dementia diagnosis with his wife and explained the symptoms are likely related to this, but to rule out infection took a urine sample for testing and issued a delayed prescription for anti-biotics to be used if any other symptoms were to develop whilst awaiting the results. The result was returned the following day and Jim was called to advise him that that the result for infection was negative. Jim continued to receive care in the community.
20	**Reducing isolation and depression by increasing connections in the community** Anne is a 77-year-old lady who regularly attended her GP surgery. She has had to deal with several health conditions including cancer, diabetes, angina, and back pain after surgery. Anne had been feeling isolated, depressed, and just wanted human contact to help her with these feelings. Anne's GP referred her to a Social Prescribing Link Worker. The Link worker helped Anne, by forwarding her to a local befriending project in the area. The project aims to connect people to reduce loneliness and isolation by hosting walk and talk sessions. Anne now attends these sessions once a week and really enjoys them. Anne feels a lot happier now, has reduced her social isolation, gained greater confidence and a wider social network. She also feels fitter, evidenced through lower blood sugar levels. Anne now attends fewer GP appointments.
21	**Personalisation for carers**

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	The Carers Identity Passport project continues to be an important programme, whereby carers receive a card which makes them known to NHS services across Norfolk and Waveney. This programme began as a result of direct feedback to help reduce carers having to reduce the number of times they have to tell their story and identify themselves as a carer, making it easier for them to engage with health and care services. The card and scheme was co-produced with carers across Norfolk and Waveney and resourced appropriately. So far, more than 1,000 cards have been issued to carers across Norfolk and Waveney. “I am so grateful that carers have people who recognise the challenges carers face, and are able to represent us, to help our voice be heard.” – Carer
22	**Personalised care through Personal Health Budgets** 2022 saw the launch of Social Prescribing and One-Off Personal Health Budgets, a collaboration between Norfolk and Waveney’s three acute trusts. This vital scheme enables shared decision-making conversations to take place, with a focus on helping to facilitate a discharge from hospital, support admission avoidance or provide someone with the links and tools to help keep as well as possible whilst waiting for surgery or treatment. To help with this, a small one-off Personalised Health Budget can be issued, alongside social prescribing approaches and completion of a Personalised care and support plan. **PHBs and personalisation in action**: An individual with leukaemia was medically optimised for discharge from hospital. They were immunosuppressed and unable to return to their family who had COVID. Following the principles of personalised care, the individual and healthcare professionals thought about creative ideas to find an intermediate solution rather than extend a hospital stay. A one-off personal health budget was used to purchase six bed days in a local bed and breakfast. This saved six hospital bed days and the individual was able to self-manage other aspects of their health and wellbeing needs. Not being in hospital for longer than needed helped to keep the individual active and supported the individual to recover in a more familiar and appropriate environment. The individual said: “I was very happy with outcome, it was more than I ever expected. This not only helped me, but it gave my whole family peace of mind. “I was able to return home after six days back to my family, both COVID and infection free. Thank you so much!”

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23	**Supporting individuals to stay well whilst waiting for surgery** Ceri was awaiting knee replacement surgery but had been temporarily removed from the waiting list due to having a BMI of 45. Ceri was upset that she had no quality of life and felt she was largely inactive and unable to lose weight. Ceri had tried an exercise class but found this was too intense. A Social Prescriber was matched to Ceri and discussed opportunities and interests and a 'Dance to Health' class was identified which was of particular interest as Ceri took part in dance groups in the past and could enrol as a seated member. This, alongside signposting for benefits and a self-referral to Slimming World was discussed and agreed would provide the opportunity for improved health and wellbeing outcomes, and effective weight management which would lead to the goal of being more active and being added back onto the list for knee surgery. **Ceri said**: "The support I received from my social prescriber was fantastic. Being supported to make own decisions, where once I felt hopeless and lost hope has given me the energy and optimism to get my health and wellbeing back on track, I am excited by the future."
24	**Going above and beyond to increase COVID-19 vaccination uptake** The Protect Norfolk and Waveney (NoW) team exists to look at some of the barriers that exist to helping people access health and care services across Norfolk and Waveney. Adopting Population Health Management principles has enabled a truly focussed and innovative approach to helping people improve their health and wellbeing and focus on prevention rather than the cure. COVID-19 vaccination continues to be an area of focus for the Protect NoW team. Protect NoW used vaccination data to draft undertake targeted text message contact with individuals encouraging uptake and signposting to vaccination bookings and walk-in opportunities. Cohorts in scope included the Clinically Extremely Vulnerable, potentially housebound (to encourage alternatives to home visits), health and social care staff, unpaid carers, and areas of greatest deprivation and those where uptake was lower. The project saw a significant spike in traffic to Norfolk County Council's walk-in clinic finder webpage following each text burst, resulting in more people, particularly those who were more vulnerable to access a COVID-19 vaccination. In addition to text messages, letters were also issued and 45,000 direct patient calls were undertaken with this cohort. **A vulnerable service user said**: "I can't thank the Protect NoW team enough – I really valued the call from the team – they calmed my nerves and helped me access a clinic which was quieter and tailored to my needs and requirements. This is a brilliant approach."

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25	**Reducing Type 2 diabetes and supporting people to lead healthier lives** The Protect NoW team have worked with patients who may be more at risk of developing Type 2 diabetes. Working with GP practices across Norfolk and Waveney, the team have helped to reduce inequality and unwarranted clinical variation by increasing referrals to lifestyle change support. 15,000 pre-diabetic patients were identified through their recent GP blood glucose results. The Protect NoW team contacted patients most at risk of developing diabetes on behalf of primary care to encourage them to join the National Diabetes Prevention Programme (NDPP) to prevent / reverse their diabetes risk. More than 7,000 patients responded, a huge 49% of patients contacted, with more than 3,000 people referred onto the programme. This direct action has helped reduce the number of people in Norfolk and Waveney who may have developed Type 2 diabetes, helping them to lose weight and choose healthier lifestyle choices.
39	**Flourish – supporting our young people to lead healthy, fulfilling lives** Organisations across Norfolk and Waveney have come together to create a set of data indicators across the eight Flourish domains and four strategic priorities that will be used to answer the question “Are children and young people in Norfolk Flourishing?”. The data will be used to inform the Children and Young People’s Alliance’s priorities moving forward. To date, over 150 organisations have made a FLOURISH pledge, with around 60 more in the pipeline. Examples include: 1. James Paget University Hospital pledged to create employment opportunities for young people with SEND on one of its wards (Opportunity area of flourish impact) 2. John Lewis Norwich has pledged to create a community hub area in its store and open this up to community groups for their use, free of charge, and its staff will also deliver workshops (Learning area of flourish impact) 3. Norse Commercial has pledged to consult with school children and develop school menus from this (Healthy area of flourish impact). The Director of Public Health for Norfolk leads a health improvement transformation group, which is a multi-agency group with a clear focus on leading cross-system strategy on adult healthy lifestyle and behaviour change (primary prevention), focussing on tobacco, nutrition and healthy weight, cardio-vascular disease, mental health and wellbeing, physical activity, health checks and alcohol. The group agreed Smoking and Physical Activity as priority subjects, along with a dedicated action plan to monitor progress against group priorities and plans and measure impact, develop workforce behaviour change knowledge to increase capacity, align priorities as part of a forward plan to increase efficiency, as well as influencing the whole system to create the conditions to develop and normalise a prevention approach.

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40	The Norfolk and Waveney Community Voices (NWCV) Project was started during the COVID-19 pandemic and has gone a long way to developing these relationships in Norfolk and Waveney. Our system has many different communities of interest often living alongside and merging with each other. This can make talking and listening to the different people very challenging. We are aware that although they still provide useful insight, the more traditional methods of engaging mean it is more likely you will hear from people if they are better educated, older, wealthier and white British. Using trusted communicators at very local levels, often street by street or village by village, can help overcome this bias and help us reach the quieter, underserved and more vulnerable groups, by actively going to them to find out what their priorities are. Building on the success of the Great Yarmouth Community Champions, Norfolk and Waveney is developing the Community Voices Project. A network of community champions and connectors takes conversations out into the community to promote health messages and learn about what matters to people in relation to their wellbeing. Part of this work is to promote the Making Every Contact Count (MECC) principles through training of staff across the system in partnership with colleagues in Public Health. Using MECC principles helps to build a 3-dimensional picture of lived experience and help us understand our community's needs, experience and aspirations for health and care. By using continued engagement, we can find out if change is having the desired effect. Although work has started on developing the insight bank as part of the Community Voices project, there is a long way to go before it can reach its full potential and offer the depth and breadth of insight for the system that we aspire to. It is first necessary to make sure that the qualitative insight being gathered can be turned into information that can drive change. This includes promoting skills in the analysis of qualitative data and storing the insight so it can be shared and used by partners effectively. This could become a place for any members of staff across the system who work with local people and communities, and hear valuable insight into people's lived experience, are able to 'bank' this learning, which would otherwise be lost or become anecdote that cannot truly inform change. The idea is that training would be given to those who wish to upload to the insight bank so that they feedback they bank is the best possible quality. We hope to include partners from across they system for example people who work in housing, benefits and debt advice, health and social care staff, advocacy organisations. The vision is that the data would be searchable on place and neighbourhood levels and could be used both locally to drive change on the ground and strategically to inform decision makers of the issues that are of most concern to local people.

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	As well as the Community Voices project, there is huge potential for the VCSE Assembly to become a channel for the voice of the people who interact with the various Voluntary and Community organisations and charities within their local communities. This will help strengthen our work to work with our quieter communities and will continue to theme of working through trusted communicators. **Is this a case study instead?**

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Norfolk and Waveney
Integrated Care Board

Agenda item: 7

Subject:	**Complaints and Enquiries Report – Q4 2022-23 and policy changes**
Presented by:	**Jon Punt, Complaints and Enquiries Manager**
Prepared by:	**Jon Punt, Complaints and Enquiries Manager**
Submitted to:	**Patient & Communities Committee**
Date:	**22 May 2023**

Purpose of paper:

To provide information about the ICB's complaints and informal enquiries, lessons learned and performance against the organisation's Complaints Handling Policy.

Executive Summary:

This report provides an overview of complaints and enquiries received by the ICB during quarter 4 of the previous financial year. It also details themes arising from those concerns raised and lessons learned.

In addition, proposed amendments have been made to the organisation's Complaints Handling Policy for consideration.

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Figure 1 shows the number of Formal Complaints, Enquiries and MP Enquiries received during 2022-23

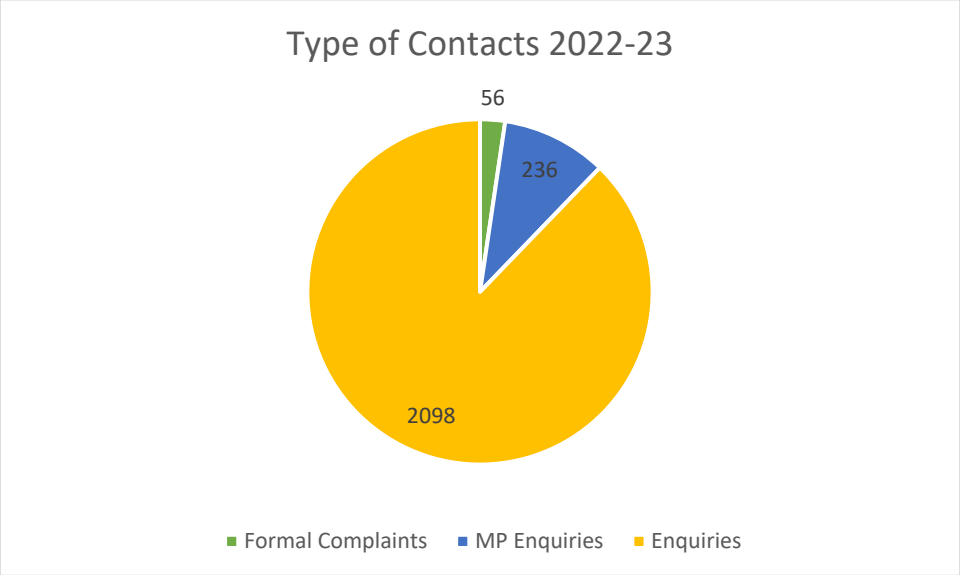
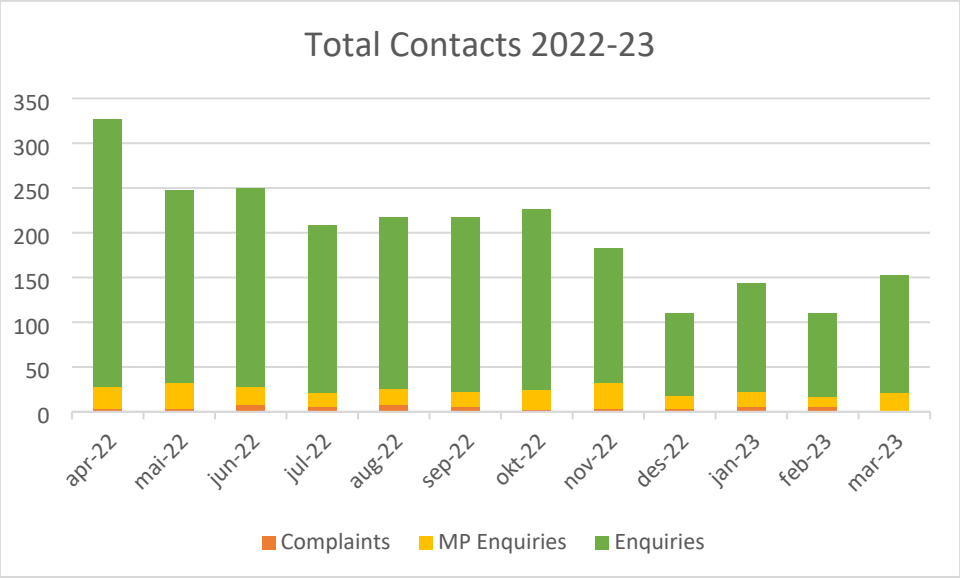


Figure 2 shows the volume of contacts (including Formal Complaints, Enquiries and MP Enquiries) across the reporting period.



Formal Complaints Received

During the reporting period, the ICB received 12 formal complaints, with 56 received across the entirety of 2022-23. This is a reduction on the volumes seen in 2021-22, where 73 formal complaints were processed.

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NHS Complaints regulations state formal complaints should be acknowledged within three working days. Of the 56 complaints received during the reporting period, 96.4% were acknowledged within this timescale. The remaining two complaints were

acknowledged later because one was received late from another team, the other was due to an administrative error.

Of the 56 complaints received during 2022-23, 46 have received a response, 3 are still under investigation and 7 have been stood down.

Of the 46 responses issued, 45 percent have been completed within the ICB's target response time of 30 working days. This has primarily been down to information being received late back from departments or providers. The ICB are looking to establish a more robust escalation route for complaints that are about to breach timescales.

Enquiries

344 enquiries, which can be queries, requests for help or informal concerns, were received during the reporting period. 2098 were received across 2022-23, compared to 3681 in 2021-22. This is still significantly higher that prior to the COVID-19 pandemic. However, activity across Q4 specifically has slowed compared to previous years and may be an indicator that the volume of contacts received is starting to return to pre-pandemic levels.

The ICB has no target timescale in place for responding to these enquiries, as each case is treated on its merits. 2095 have been responded to and closed at the time of writing.

MP Enquiries

In addition to formal complaints and enquiries, the ICB receives contact from local MPs and their caseworkers. These are logged separately and will often consist of concerns raised on behalf of constituents.

During the reporting period 49 MP enquiries were received, with a total of 236 over 2022-23. At the time of writing, 234 of these have been responded to and/or closed.

Primary Care Complaints and Concerns update

As of 1 July 2023, the full delegation of primary care complaints and concerns from NHS England to ICBs will occur.

This delegation happened in shadow form from 1 April 2023, with NHS England preparing responses and ICB Chief Executives signing these off.

The ICB is engaged in weekly contact with regional colleagues at NHS England, to ensure a smooth transfer takes place. This contact will continue post transfer until such time all parties are comfortable.

From 1 July 2023 two members of staff will TUPE into the ICB's Complaints and Enquiries team from NHS England, it is anticipated these will be sufficient resource to deal with the additional activity. However, this will require regular monitoring as the staff transfer was based on NHS England retaining their contact centre function,

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which deals with a large proportion of concerns and enquiries at first point of contact. It remains to be seen how quickly these types of contact may gravitate towards ICBs.

With these changes taking place, small amendments have been made to the ICB's complaints handling policy. The committee is asked to approve these arrangements.

Themes identified

NHS Continuing Healthcare (CHC) – As identified in the last report, the largest area of formal complaint continues to be CHC. Six new formal complaints were received in the reporting period, along with one query from a MP and eight informal concerns. Three of these contacts were around funding, while a further five cited perceived delays in processes.

GP Practice Concerns – Access to appointments continues to be a regular point of dissatisfaction, which is being reflected by both direct patient contact and in feedback from local MPs. 11 contacts cited access to their practice as a problem.

21 enquirers were unhappy with the care and treatment provided by their practice, although these were varied in nature and locality.

Walk-in Centre consultation – 33 contacts were received by the team from members of the public requiring assistance in participating in the recent consultation about the proposed changes to the way in which the Norwich Walk-In Centre operated.

Lessons Learned from Complaints

Some of the lessons learned from complaints and concerns during the reporting period are reflected below:

- Arranging direct supplies of continence products to the appropriate community nursing teams for urgent situations, while prescriptions are awaited
- ICB staff to be provided with refresher material around the importance of ensuring Subject Access Requests are processed correctly and promptly
- Updated guidance to be issued to ICB CHC staff around the importance of recording work and actions undertaken
- Referral processes into community urgent eye care services will be considered with a view to making them simpler and more effective

Recommendation to the Committee:

To note the contents of the report and consider approving the proposed Complaints Handling Policy, which would subsequently be implemented on 1 July 2023.

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Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	N/A
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	

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Norfolk and Waveney
Integrated Care Board

Norfolk and Waveney ICB

Complaints Handling Policy and Procedure

Document Control Sheet

This document can only be considered valid when viewed via the ICB's intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one online.

Approved documents are valid for use after their approval date and remain in force beyond any expiry of their review date until a new version is available.

Name of document:	**Complaints Handling Policy and Procedure**
Version:	**3**
Date of this version:	**July 2023**
Produced by:	Corporate Affairs
What is it for?	If a person is unhappy about any matter reasonably connected with the exercise of the Integrated Care Board's (ICB's) functions, they are entitled to make a complaint, have it considered, and receive a response. This policy details that process.
Evidence base:	Parliamentary and Health Service Ombudsman – Principles for Remedy

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Who is it aimed at and which settings?	The policy is for use by all patients, carers and service users of Norfolk and Waveney.
Impact Assessment:	N/A
Other relevant approved documents	N/A
References:	• The Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009 • Mental Capacity Act 2005 • Human Rights Act 1998 • Data Protection Act 1998 / 2018 • Freedom of Information Act 2000.
Monitoring and Evaluation	This policy will be monitored and reviewed for effectiveness by the Complaints and Enquiries Manager in August 2023.
Training and competences	N/A
Consultation	N/A
Reviewed by:	
Approved by:	ICB Board
Date approved:	
Signed:	
Dissemination:	NWICB Intranet and Internet
Date disseminated:	
Review Date:	July 2025
Contact for Review:	Corporate Affairs

Version Control

Revision History	Summary of changes	Author(s)	Version No
November 22	Voiceability updated to POHWER.	Jon Punt	2
July 23	Policy updated to reflect primary care commissioning functions now fully delegated to ICB	Jon Punt	3

Parker Rachael
16/05/2023 10:51:02

Contents

Parker Rachael 16/05/2023 10:51:02

1. INTRODUCTION

NHS Norfolk and Waveney Integrated Care Board (hereafter known as 'the ICB') complaints policy and procedure is written in accordance with **The Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009** which came into force on 1st April 2009.

If a person is unhappy about any matter reasonably connected with the exercise of the ICB's functions, they are entitled to make a complaint, have it considered, and receive a response. In particular, these complaints may relate to the commissioning of health care or other services under an NHS contract, or making arrangements for the provision of such care or other services with an independent provider or with an NHS trust,

Matters excluded from consideration under these arrangements are listed in Appendix 4.

The ICB aims to manage complaints by the procedure of local resolution. The primary objective of this process is to provide the opportunity for investigation and resolution of the complaint, as quickly as is sensible in the circumstances and minimising the need for the complainant to escalate concerns to the Parliamentary and Health Service Ombudsman (PHSO). It aims to satisfy the complainant while being fair to staff. Local resolution should be open, honest, fair, flexible and conciliatory.

Complaints are recognised by the ICB as a vital form of feedback to help improve both the service the organisation and providers offer. The ICB aims to ensure all complainants feel listened to, have their complaint investigated thoroughly and that any response is delivered in a personalised way.

2. POLICY STATEMENT

NHS Norfolk and Waveney ICB is committed to providing an accessible, fair and effective means for people (and/or their representatives) to express their views. It is also recognised staff have the right to make a complaint to senior managers on behalf of, or in the interests of, a patient.

The ICB aims to promote a culture in which all forms of feedback are listened to and acted upon. Complaints, compliments, general comments and suggestions are encouraged. It is recognised such information is invaluable as a means of identifying both problems and areas of good practice and as such can be used as a tool for improving services.

Being open: Often, all that is required is a simple apology and/or explanation. This should, wherever possible, be given at the earliest opportunity by all front-line staff. Patients have a right to expect openness in their healthcare.

No discrimination: Patients should always be reassured that making a complaint will not affect their eligibility for, or the nature of, current or future treatment. This is achieved through the complete separation of complaint documentation from the patient's medical records. Complainants and members of staff are asked to inform the ICB's Complaints and Enquiries Manager if they have any concerns about this.

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Complaints about care that is felt to discriminate against a person will be reported to the ICB's Patient and Communities Committee.

Dignity and respect: Complaints about care that compromises the dignity of, or respect shown to, a person will be overtly reported to the ICB's Patient and Communities Committee.

Mindful of people's human rights: The ICB respects and observes the Absolute, Limited, and Qualified Rights contained in legislation and applies these rights to all its business undertakings. The Rights are set out at Appendix 1.

Mental Capacity Act 2005, revised 2007: The ICB is also mindful of the statutory principles contained in this legislation, an overview of which is set out at Appendix 2.

Legal Action: Should a complainant explicitly indicate an intention to take any form of legal action the matter will be treated under the appropriate procedure.

The ICB's Complaints and Enquiries Manager may investigate the complaint if it does not compromise or prejudice the concurrent investigation, but this can be discontinued at any time if circumstances change.

3. COMPLAINTS HANDLING POLICY

3.1 Responsibilities

The Chief Executive is accountable for the quality of the care commissioned and will, therefore, have an overview of all recorded dissatisfaction expressed by patients and service users.

Director for Corporate Affairs and ICS Development is the senior person appointed by the Chief Executive to ensure the process for handling and reporting on complaints on behalf of the ICB complies with this policy.

3.2 What is a complaint?

A complaint is a verbal or written expression of concern or dissatisfaction about a matter relative to the ICB's functions or decisions, which requires a response and/or redress.

3.3 Who can complain?

A complaint can be made under this policy by:

- A patient or person affected or likely to be affected by the actions or decisions of the ICB;
- someone acting on behalf of the patient or person concerned, with their consent;
- someone acting on behalf of a person mentioned above, and in any case where that person has died;
- a child, or in the case of a child, someone acting on their behalf, who must be a parent, legal guardian or other adult person who has care of the child. Where the child is in the care of a local authority or a voluntary organisation, the representative must be an authorised person identified by the local authority or voluntary organisation, and must be making the complaint in the best interests of the child;
- someone who is unable by reasons of physical or mental incapacity to make the complaint themselves.

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3.4 Local Resolution

The first stage of the NHS complaints procedure is called 'local resolution' and concerns should be brought to the attention, in the first instance, to the organisation providing the service.

Local resolution aims to resolve complaints quickly and as close to the source of the complaint as possible, using the most appropriate means; for example, the use of conciliation. Local resolution enables concerns to be raised immediately by speaking to a member of staff who may be able to resolve issues without the need to make a formal complaint.

3.5 Making a Formal Complaint

A complaint about the ICB or a service the ICB pays for can be made in writing, including by email, over the phone or in person / remotely via an online meeting upon request.

If local resolution does not resolve matters and the complainant wishes to continue with their complaint they can do this formally to the organisation concerned or, if the complainant wishes, to the ICB. This can be done orally or in writing (including e-mail) to the Complaints and Enquiries Manager for NHS Norfolk and Waveney ICB at the following address:

The Complaints and Enquiries Manager
Norfolk and Waveney Integrated Care Board
County Hall
Norwich
Martineau Lane
NR1 2DH

Tel - 01603 595857

Email – nwicb.complaintsservice@nhs.net

The complaint will be recorded as being made on the date on which it was received by the Complaints and Enquiries Manager.

3.6 Time limit for making a complaint

A complaint should be made within 12 months of the event(s) concerned, or within 12 months of the date on which the matter came to the notice of the complainant. The Complaints and Enquiries Manager has discretion to waive this time limit if there are good reasons for the complaint not having been made within that time frame.

3.7 Duty of Candour

The ICB welcomes the government's commitment to introducing a duty of candour within the NHS. This recommends that all providers of NHS care should owe a duty of candour to their commissioners under which they provide, amongst others;

- Timely reports, prepared to an agreed protocol, of all complaints made by NHS patients;
- In cases when complaints are upheld, Complaints Action Plans to address the weaknesses that have been identified;

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- Progress reports in relation to implementation of complaints action plans

The ICB is committed to improving the quality of care and the services it commissions. The Clinical Quality team will review and monitor the reports received from providers and will report to the Patient and Communities Committee to ensure the quality of services provided is of a high standard and they continually strive for further improvement. This will be addressed with providers through the existing quality monitoring mechanisms.

4. COMPLAINTS HANDLING PROCEDURE

4.1 Acknowledgement and record of complaint

The Complaints and Enquiries Team will send to the complainant a written acknowledgement of the complaint within **three working days** of the date on which the complaint was received. This acknowledgement will include:

- if necessary, a consent form to be signed and returned by the patient if they are not the person who has identified the concerns to be investigated;
- information concerning how to access the local NHS advocacy provider, POHWER
- information concerning how to access the Parliamentary and Health Service Ombudsman;

4.2 Complaints in Writing

The ICB's Complaints and Enquiries Team will review the complaint, then identify the appropriate senior manager to investigate the matter.

Where the complaint involves services or care commissioned from or provided by more than one organisation, the ICB's Complaints and Enquiries Manager will liaise with the complaints manager(s) of the other organisation(s) to ensure all aspects of the complaint are appropriately investigated and responded to. This is provided appropriate consent has been provided by the complainant/patient to do so.

4.3 Verbal Complaints

When a verbal complaint is made to the ICB's Complaints and Enquiries Team, the letter of acknowledgement and associated enclosures must be accompanied by a written file note summarising the issues raised, with an invitation to the complainant to sign and return it. This will ensure all aspects of the complaint have been thoroughly understood.

4.4 Investigation

The ICB's Complaints and Enquiries Manager will discuss the investigation of high-risk cases with the ICB's Chief Executive and Director of Nursing. The investigation must be of sufficient rigour and detail to enable the ICB to provide an open, honest and comprehensive response to the complainant. The investigating officer will request the review of patient records and statements from the staff involved as necessary and provide a response to the complaint to the ICB's Complaints and Enquiries Manager.

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Investigating managers will share a copy of the written complaint response with any person who was the subject of the complaint.

4.5 Response

The complainant should receive a full written response from the ICB's Chief Executive as soon as reasonably practical following completion of the investigation and within a preferred timescale of 30 working days following receipt of the complaint if possible. It should be noted that in stances where consent is required from a complainant to proceed with the complaint, the 30 working day timescale will start on the date formal consent is received.

If it is not achievable to respond with the target timescale, the ICB's Complaints and Enquiries Team will write to the complainant explaining the reason, and an achievable date will be negotiated. A response must be sent within six months of the date of a complaint being received.

If a complainant is not happy with aspects of the response, they are encouraged to contact the ICB's Complaints Team in the first instance, but they will also have the option of escalation to the PHSO.

5. PHSO AND PRINCIPLES FOR REMEDY

The ICB will follow the principles of good administration outlined by the PHSO and will consider the impact of the organisation's actions on the individual concerned. The key principles are as follows:

i. Getting it right

- Acting in accordance with the law and with due regard for the rights of those concerned
- Acting in accordance with the public body's policy and guidance (published or internal)
- Taking proper account of established good practice
- Providing effective services, using appropriately trained and competent staff
- Taking reasonable decisions, based on all relevant considerations

ii. Being customer focused

- Ensuring people can access services easily
- Informing customers what they can expect and what the public body expects of them
- Keeping to its commitments, including any published service standards
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly including, where appropriate, co-ordinating a response with other providers

iii. Being open and accountable

- Being open and clear about policies, procedures and decisions, and ensuring that information and any advice provided is clear, accurate and complete
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately
- Keeping proper and appropriate records
- Taking responsibility for its actions

iv. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests
- Dealing with people and issues objectively and consistently

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- Ensuring that decisions and actions are proportionate, appropriate and fair

v. Putting things right

- Acknowledging mistakes and apologising where appropriate
- Putting mistakes right quickly and effectively
- Providing clear and timely information on how and when to appeal or complain
- Operating an effective complaints procedure, this includes offering a fair and appropriate remedy when a complaint is upheld

vi. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective
- Asking for feedback and using it to improve services and performance
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

6. ROLE OF THE PHSO

The PHSO is completely independent of the NHS and of government and derives his powers from the Health Service Commissioners Act 1993. The Ombudsman is the final arbiter in the complaints process where it has not been possible to resolve concerns locally. The ICB will co-operate fully with any investigation undertaken by the Ombudsman. Further information on the role and work of the Ombudsman is available at:

Parliamentary and Health Service Ombudsman
Citygate
Mosley Street
Manchester
M2 3HQ

Tel: 0345 015 4033
e-mail: phso.enquiries@ombudsman.org.uk Website: www.ombudsman.org.uk

7. ROLE OF THE COMPLAINTS ADVOCACY SERVICE (POHWER)

POHWER have an important role in helping complainants at each stage of the process. Their contact details can be found below:

POHWER

- Telephone: 0300 456 2370
- Email: pohwer@pohwer.net
- Letter: PO Box 14043, Birmingham, B6 9BL

Under the Mental Capacity Act 2005, the role of advocacy for patients who lack capacity is undertaken by the Independent Mental Capacity Advocate Service (IMCA). All complainants are sent information with POHWER's details to inform them of their role in providing support and information.

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8. COMPLAINTS AND DISCIPLINARY PROCEDURES

The complaints procedure is concerned only with resolving complaints and not with investigating disciplinary matters. Whether disciplinary action is warranted is a separate matter for management outside of the Complaints Procedure and there must be a separate process of investigation.

9. MONITORING AND LEARNING FROM COMPLAINTS

- All complaints will be recorded on the ICB's database and complaint files maintained for a period of not less than ten years;
- The Complaints and Enquiries Manager will provide regular reports, to the Patient and Communities Committee. The report will provide information about the number of complaints; the services involved; the reasons for complaints and any ongoing trends.
- The ICB's Complaints and Enquiries Manager will prepare information regarding complaints handling which will be included in the ICB's Annual Report as and where necessary.

10. STAFF SUPPORT

The ICB acknowledges the importance of supporting those involved in complaints and recognises the need to ensure that all parties are provided with timely and appropriate support.

11. HABITUAL, UNNECESSARILY AGGRESSIVE OR REPETITIVE COMPLAINANTS

Habitual, unnecessarily aggressive or repetitive complainants are an increasing problem for staff, reflecting a pattern experienced throughout the NHS. The difficulty in handling such complainants can place a strain on time and resources and cause undue stress for staff that may need support in difficult situations. Staff are trained to respond in a professional and helpful manner to the needs of all complainants. However, there are times where nothing further can reasonably be done to assist the complainant or to rectify a real or perceived problem. Appendix 3 sets out the procedure for the management of habitual, unnecessarily aggressive or repetitive complainants.

12. REVIEW

The Complaints Policy and Procedure will be reviewed every two years, or sooner, if changes occur in legislation. The effectiveness of the policy will be reviewed in the light of performance against response timeframes; numbers resolved and referred complaints as well as implementation of lessons learned.

The procedure will also be reviewed in the light of any audit recommendations, learning and developments cycles or changes to organisational structure that may impact on how the procedures operate.

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APPENDIX 1: ARTICLES OF HUMAN RIGHTS

Articles of Human Rights

The Human Rights Act 1998 gives further effect to the rights and freedoms contained in the European Convention on Human Rights. Article 1 of the European Convention is introductory and is not incorporated into the Human Rights Act.

Article 2: Right to Life
A person has the right to have their life protected by law. There are only certain very limited circumstances where it is acceptable for the state to take away someone's life, e.g. if a police officer acts justifiably in self-defence.

Article 3: Prohibition of Torture
A person has the absolute right not to be tortured or subjected to treatment or punishment which is inhuman or degrading.

Article 4: Prohibition of Slavery and Forced Labour
A person has the absolute right not to be treated as a slave or to be required to perform forced or compulsory labour.

Article 5: Right to Liberty and Security
A person has the right not to be deprived of their liberty except in limited cases and provided there is a proper legal basis in UK law.

Article 6: Right to a Fair Trial
A person has the right to a fair and public hearing within a reasonable period of time.

Article 7: No Punishment without Law
A person normally has the right not to be found guilty of a crime arising out of actions which, at the time they committed them, were not criminal.

Apart from the right to hold particular beliefs, the rights in Articles 8-11 may be limited where that is necessary to achieve an important objective.

Article 8: Right to Respect for Private and Family Life
A person has the right to respect for their private and family life, their home and their correspondence.

Article 9: Freedom of Thought, Conscience and Religion
A person is free to hold a broad range of views, beliefs and thoughts and to follow a religious faith.

Article 10: Freedom of Expression
A person has the right to hold opinions and express their views on their own or in a group. This applies even if those views are unpopular or disturbing.

Article 11: Freedom of Assembly and Association
A person has the right to assemble with other people in a peaceful way. They also have the right to associate with other people, including the right to form a trade union.

Party/Report/23/11.02

Article 12: Right to Marry
Men and women have the right to marry and start a family; however, national law will still govern how and at what age this can take place.
(Article 13 is not included in the Human Rights Act)

Article 14: Prohibition of Discrimination
A person has the right not to be treated differently because of their race, religion, sex, political views or any other personal status unless this can be justified objectively.

APPENDIX 2: MENTAL CAPACITY ACT 2005, REVISED 2007

Introduction

The Mental Capacity Act 2005 (the Act) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with this Act when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for themselves. The same rules apply whether the decisions are life-changing events or everyday matters.

The Act's starting point is to confirm in legislation that it should be assumed that an adult (aged 16 or over) has full legal capacity to make decisions for themselves (the right to autonomy) unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made. This is known as the presumption of capacity. The Act also states that people must be given all appropriate help and support to enable them to make their own decisions or to maximise their participation in any decision-making process.

The underlying philosophy of the Act is to ensure that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves is made in their best interests.

The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. But the Act also aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack capacity to make decisions to protect themselves.

The Act sets out a legal framework of how to act and make decisions on behalf of people who lack capacity to make specific decisions for themselves. It sets out some core principles and methods for making decisions and carrying out actions in relation to personal welfare, healthcare and financial matters affecting people who may lack capacity to make specific decisions about these issues for themselves.

Many of the provisions in the Act are based upon existing common law principles (i.e. principles that have been established through decisions made by courts in individual cases). The Act clarifies and improves upon these principles and builds on current good practice which is based on the principles.

The **five statutory principles**, contained in Section 1 of The Act, are:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Parker Borough Council
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APPENDIX 3: THE MANAGEMENT OF PERSONS WHO ARE IDENTIFIED AS HABITUAL, UNNECESSARILY AGGRESSIVE OR REPETITIVE COMPLAINANTS

1. Introduction

This guidance should only be used as a last resort and after all reasonable measures have been taken to assist the person concerned. All staff are expected to be familiar with the NHS Complaints Procedure.

The decision to categorise a person as a habitual, unnecessarily aggressive or repetitive complainant will follow discussion between the ICB's Chief Executive, Complaints and Enquiries Manager and an appropriate member of the Executive Management Team.

It should be emphasised that the classification of an individual as a 'habitual, unnecessarily aggressive or repetitive' complainant will NOT mean that any new issues, having no connection with original concerns, will not be dealt with through the usual process.

2. Criteria for definition of a habitual, unnecessarily aggressive or repetitive caller or complainant

Complainants may be deemed to be habitual, unnecessarily aggressive or repetitive callers where previous or current contact with them shows that they meet two or more of the following criteria:

- Persist in pursuing a complaint where the NHS Complaints Procedure has been fully and properly implemented and exhausted
- Change the substance of a complaint or continually raise new issues or seek to prolong contact by repeatedly raising further concerns or questions upon receipt of a response whilst the complaint is being addressed. (Care must be taken not to discard new issues that are significantly different from the original complaint. These might have to be addressed separately)
- Do not clearly identify the precise issues they wish to be investigated, despite reasonable efforts by staff and others (e.g. advocacy agencies) to help them specify their concerns
- The complaint or issue is trivial or appears to consume an excessive amount of resources
- Having, in pursuing their concerns, had an excessive number of contacts with the ICB by telephone, letter or fax. Staff should be instructed to keep a clear record of the number of contacts to demonstrate their excessive nature
- Display unreasonable demands or expectations and fail to accept these may be unreasonable, for example insist on immediate responses from senior staff when they are not available and this has been explained
- Have threatened or used actual physical violence. All such cases must be documented on an incident form in accordance with policy, in case of further action
- Have harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with them. All cases must be documented on an incident form in accordance with policy, in case of further action.

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16/05/2023 10:51:02

The use of actual physical violence, albeit on one occasion only, will result in the application of measures described under (3) to limit the personal contact ordinarily available to complainants.

2. Procedure for staff handling habitual, unnecessarily aggressive or repetitive callers or complainants

- Ensure all relevant procedures and reasonable action has been correctly implemented. If you are at all uncertain, please check with the ICB's Complaints and Enquiries Manager or Director for Corporate Affairs and ICS Development.

- Even the most difficult of callers may have issues that contain genuine substance.

- Remain professional and polite. This does not mean that you have to listen continually to the same story of complaint, nor that you cannot politely, but firmly terminate the call.

- Record the date, time and how long you were on the telephone and inform the ICB's Complaints and Enquiries Manager as soon as possible.

- When a caller has been officially declared a habitual, unnecessarily aggressive or repetitive caller, the ICB's Chief Executive may decide no further telephone communication will be accepted.

- Where there is ongoing correspondence or investigation, the ICB's Complaints and Enquiries Manager will write to the caller setting the parameters for a code of behaviour and the lines of communication. These will be communicated to all appropriate staff to ensure consistency of approach.

Where investigation or correspondence is completed, the ICB's Complaints and Enquiries Manager will, at an appropriate stage, write to the caller informing him/her the ICB has responded fully to the points raised and that there is nothing further that can be added, therefore correspondence is at an end. The ICB may wish to state that further correspondence will be acknowledged, but not answered.

It should be emphasised that the classification of an individual as habitual, unnecessarily aggressive or repetitive will not mean that any new issues having no connection with the original complaint or dispute will not be dealt with in the normal way.

APPENDIX 4: MATTERS EXCLUDED FROM CONSIDERATION UNDER THIS POLICY

The following complaints are excluded from the scope of the arrangements described within this policy:

- A complaint made by an NHS body which relates to the exercise of its functions by another NHS body.

- A complaint made by a primary care provider which relates either to the exercise of its functions by an NHS body or to the contract or arrangements under which it provides primary care services, unless those arrangements fall within the ICB's sphere of responsibility. In such cases, the ICB's Dispute Resolution Procedure should be invoked.

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- A complaint made by an employee about any matter relating to his/her contract of employment.
- A complaint made by an independent provider or an NHS trust about any matter relating to arrangements made by the ICB with that independent provider or NHS trust.
- A complaint which is being or has been investigated by the PHSO or Local Government Ombudsman.
- A complaint arising out of the ICB's alleged failure to comply with a data subject request under the Data Protection Act 1998 / 2018 or a request for information under the Freedom of Information Act 2000.
- A complaint about which the complainant has stated in writing that s/he intends to take legal proceedings.

Parker Rachael
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Improving lives **together**

Norfolk and Waveney Integrated Care System

Urgent & Emergency Care Update

Patients and Communities Committee
22 May 2023

Parker Rachael
16/05/2023 10:51:02

Executive Summary

- The number of ambulance dispatches has reduced
- The number of ambulances conveyed has reduced
- The number of emergency admissions has reduced
- Ambulance C2 response times are a concern
- Ambulance handover delays are a concern
- Acute length of stay has shown recent improvement
- There has been recent improvement in ED 4 hour performance
- There has been consistent improvement in our 2 Hour UCR response times
- There is recent deterioration in our 111 performance, following a national trend

Parker Rachael
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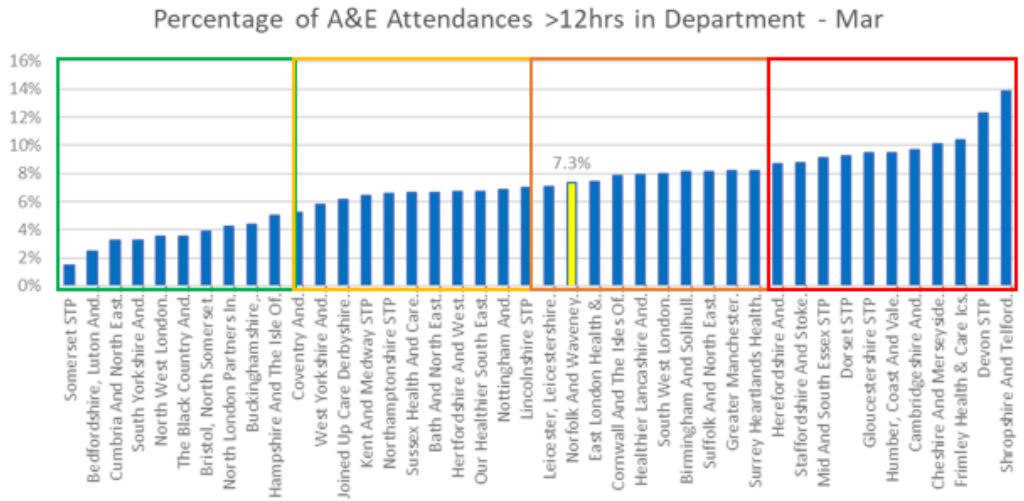
High Level Performance – March 2023

NHS Oversight Framework (NOF4) - Exit Criteria



NOF4 Exit Criteria: >12 hour in department

In March Norfolk and Waveney ranked 23rd out of 42 systems. This is the third consecutive month N&W performance has been in the third quartile.

March 2023 performance for 12 hour breaches was 7.3% against a target of 0% and no higher than 2%.

Rachel Parker
16/05/2023 10:55:02

23/24 Operational Planning Priority Targets

Combined ED 4 hour performance: Target 76%

In March Norfolk and Waveney achieve 4 hour ED performance of 70.9% against the 76% target. The national average for this period is 71.5% NNUH achieved 76%

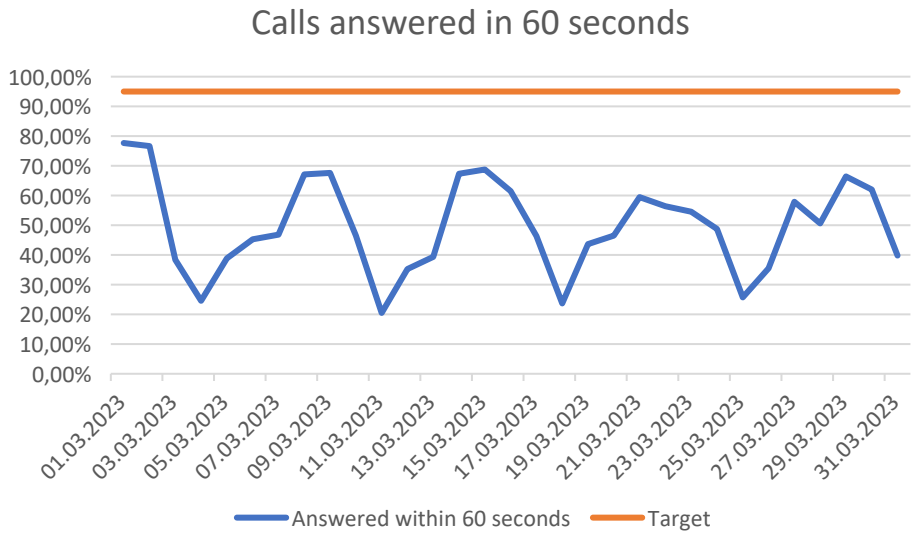
Hospital Occupancy: Target 92%

February 2023 ICS: 95.1%

2 Hour Urgent Community Response: Target: 70% in 2 hours

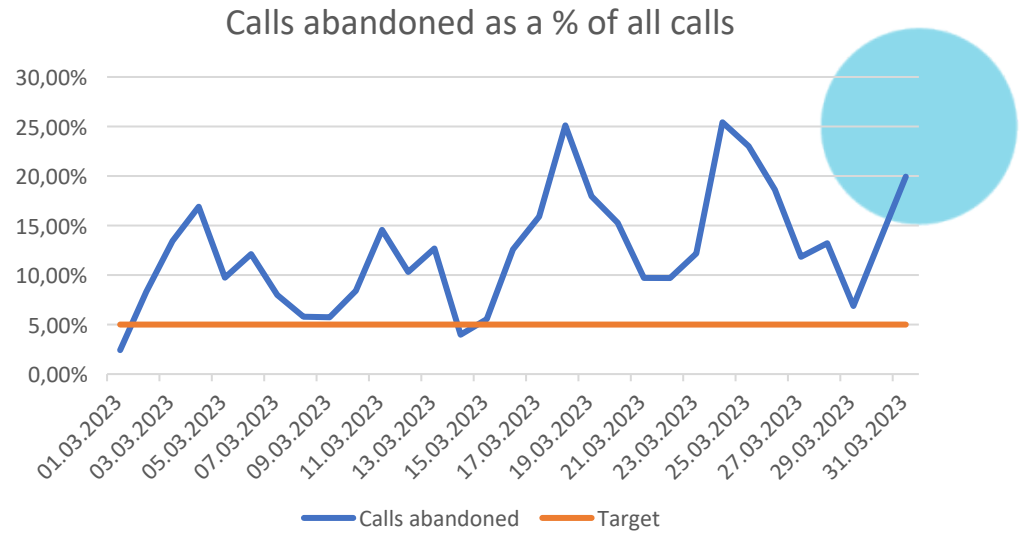
From January 2023 N&W has consistently met or exceeded the 70% target. Performance in March 2023 is 74%

Access standards - 111



60 second call answering performance: Target 95%

Call answering performance for March 2023 is 47.10% within 60 seconds
The average call answering performance across 22/23 was 50.39%
This follows the national trend of underperformance in 111 providers.



Calls abandoned as a % of all calls: Target 5%

The call abandonment rate for March 2023 is 14.83%
Average abandonment rate across 22/23 was 12.%

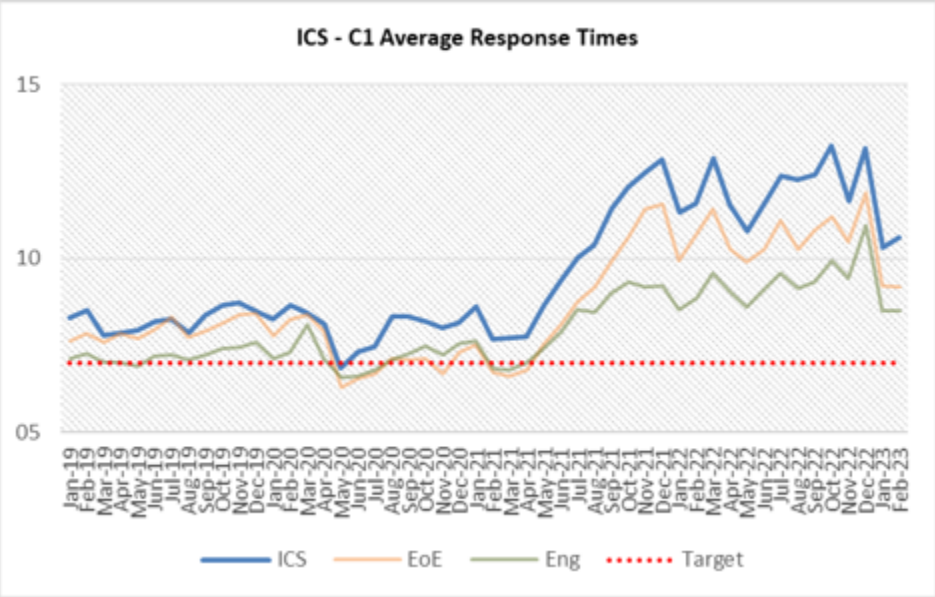
Parker, Rachael
16/05/2023 11:51:12

Action taken:

- IC24 planning a significant recruitment and training drive over spring and summer to boost staff numbers which is supported by the ICB
- IC24 have been nationally selected to continue use of remote working software which will aid retention and widen recruitment pool
- National changes are in development to change and simplify the training pathway which will position 111 as a more attractive employment option
- Weekly operational meetings in place with UEC and quality teams to review performance and plans

Access standards – Ambulance Response Times

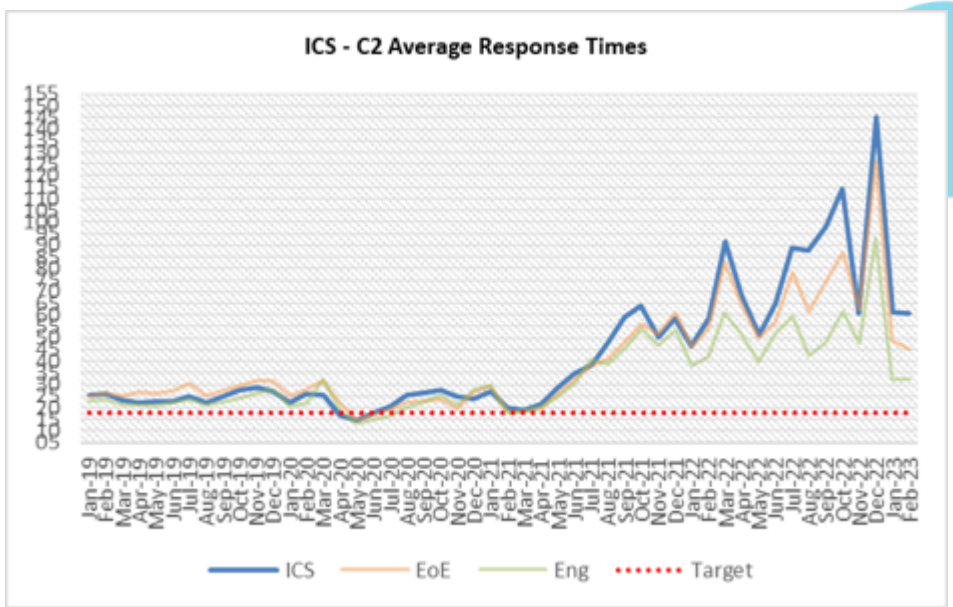
Board Assurance Framework - risk & mitigations (BAF02)



Category 1 response times: Target <7 mins

C1 mean response time for Norfolk and Waveney for March 2023 is 10 mins 43 seconds.
C1 Mean response time for Norfolk and Waveney April 2022 – March 2023 is 11 mins 48 seconds. This compares to EEAST regional mean C1 response time across 22/23 of 10 mins 27 seconds

C1 90th centile response time for Norfolk and Waveney for March is 20 mins 38 seconds (<15 min target)



Category 2 response times: Target <18 mins

C2 mean response time for Norfolk and Waveney for March 2023 is 66 minutes 16 seconds
C2 Mean response time for Norfolk and Waveney April 2022 – March 2023 is 79 mins 40 seconds. This compares to EEAST regional mean C2 response time across 22/23 of 66 minutes 55 seconds

C2 90th centile response time for Norfolk and Waveney for March is 152 mins 19 seconds (<40 min target)

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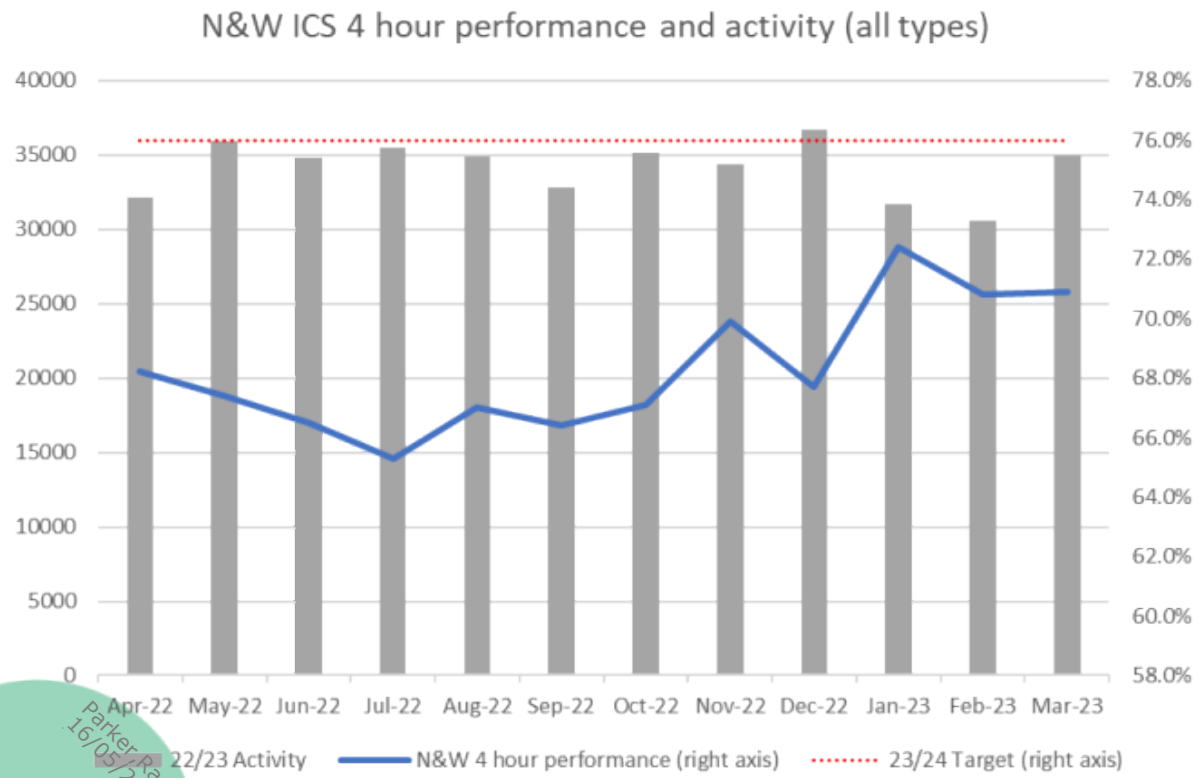
Access standards - Emergency Dept (ED)
4 hour performance



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4 hour performance (all types): Target 76%

The number of patients admitted, discharged or transferred within 4 hours was 70.9% for Norfolk and Waveney ICS, all types.
The national Delivery Plan for the Recovery of Urgent and Emergency Care Services and the 23/24 planning round sets the target of achieving at a minimum 76% for all A&E types.

March 2023

Provider	Performance
NHS England Average	71.5%
N&W ICS	70.9%
JPUH	66.6%
NNUH	76.0%
QEH	62.4%

Areas of improvement

- **999 dispatches and conveyances have reduced**

We have seen consistent reduction in the number of ambulances dispatched. FYE there were 28,460 fewer ambulance dispatches in 22/23 compared to 19/20 and over 22,000 fewer conveyances. Our work programmes across 22/23 have focussed on developing alternatives to ED (SDEC, UCR, UTCs/Streaming and CAS) and better using system capacity to provide alternative responses such as 2 hour UCR and the CAS to direct lower acuity patients to other parts of the system.

Ambulance Dispatches	Ambulance Conveyances
19/20: 162,544	19/20: 101,879
21/22: 155,709	21/22: 95,891
22/23: 134,084	22/23: 79,636

- **Emergency Admissions have reduced**

YTD (Apr – Feb) we have had 8614 fewer non-elective admissions than in 19/20 and 3555 fewer than in 21/22. While over the winter period admissions were slightly higher than in 21/22, this is to be expected as normal circulation of seasonal illness returned in the first winter post pandemic with no social isolation or infection prevention & control measures in place. Admissions over winter remained lower than 19/20.

- **Norfolk and Waveney UEC Plan on a Page**

In response to our successes, risks and the things we know we need to deliver as part of the national Delivery Plan for UEC Recovery we have develop a Norfolk and Waveney system plan on a page with three UEC priorities for delivery

Paper Michael
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Norfolk and Waveney Urgent and Emergency Care Priorities 2023/24

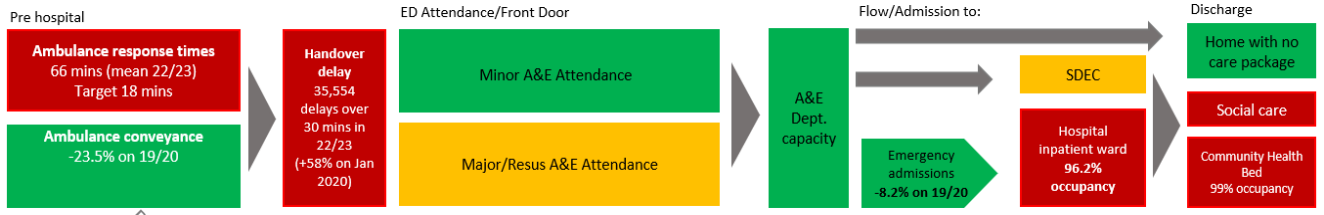
Why must we change

We want people requiring Urgent and Emergency Care to receive **the right care, in the right place, at the right time**. Everyone should receive the best care for their individual needs, whether the care system is accessed via 111, 999, a GP or by walking into an Emergency Department. Our UEC 'system' should assess and triage patients to the service best placed to managing their needs, rather than provide treatment in the setting the patient has accessed which can often be multiple settings due to hand-offs. This means we need to change where urgent care responses are provided and transfer patients between services where a health and care assessment determines another part of the system may be best placed to respond to that need. We need to do more to change where activity is seen, how teams integrate and increase capacity in the community to support patients and to give the patient an outcome to avoid them telling their story more than once.

This is set out in the national NHS England Delivery plan for recovering urgent and emergency care services. The targets and patient commitments set out in this plan are built into our Norfolk and Waveney Urgent and Emergency Care Priorities for 2023/24.

Where we are now

How and where in the health and care system urgent activity presents is slowly changing, however the system remains congested with the worst ambulance C2 performance to date, rising length of stay and long delays in ambulance handovers. Delays in transfers of care at the point of discharge causes bottlenecks in hospitals resulting in congested EDs which in turn traps ambulance crews in queues for handover reducing the capacity the ambulance service has to reach the most critically unwell patients in the community.



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Measurements

The 23/24 Planning Priorities and UEC Recovery Plan set out four targets to achieve in 23/24 to begin recovery of UEC services and improve patient outcomes.

- 76% 4 hour ED performance
- 92% (or lower) Occupancy
- 80 % Virtual Ward utilisation (occupancy)
- 30-minute Mean response time for C2 ambulances

Challenges and Opportunities

- Culture & behaviours – Working collaboratively / 'trusted assessor' model
- Workforce – Building capacity and capability
- Structure – "Place" is underdeveloped
- Duplication – Triage/patient handoffs
- Finance – Finance to follow patients

What we will change

In 23/24 we have three urgent and emergency care priorities which align with the national UEC Recovery Plan targets and transformation priorities and build on the progress we have made in 22/23:

Reduce Length of Stay across all settings

Reduce length of stay across all inpatient settings to improve flow

Metric: 92% occupancy by April 2024, 76% 4 hour ED performance by April 2024

How we will deliver: We will improve and expedite discharge across all in-patient units by

- Expanding Virtual Ward step down pathways and capacity
- Implement the national 100 day discharge challenge
- Continue to develop our Home First Hub capacity and capability
- Review capacity purchased through winter capacity funding and determine how we can create a stable and sustainable D2A offer
- Complete demand and capacity analysis

Improve ambulance C2 response time

Increase the number of patients transferred from 999 services to community services

Metric: 30 minute Mean C2 response time by April 2024

How we will deliver: Building on Access to Stack and Open Room, using the national HARIS Framework we will work with the ambulance service to develop a framework of alternatives to ambulance dispatch, alternatives to conveyance and access to advice for crews on scene brought together in an "urgent care hub"

Suitable C2, C3, C4 & C5 calls will be transferred to community services for response, including 2 hour urgent community response services. We will work with "Place" to design how responses will be coordinated / deployed in each locality.

Expand Virtual Ward

Expand step down virtual ward capacity and develop new step up provision

Metric: Increase to 80% utilisation by Sept 2023

How we will deliver: We will continue to work with the provider collaborative to expand capacity and utilisation of step down virtual wards in the agreed pathways, reducing length of stay and releasing physical bed capacity to in-patient wards.

By summer 2023/24 we will launch step up virtual wards hubs to provide alternatives to emergency admission. We will develop links between UCR, SDEC, ED and the ambulance service to refer patients who will receive senior clinical oversight and remote monitoring at home instead of an admission to hospital.

How we will change

We will work at both place and system level to bring together the right partner organisations to build on work started in 22/23. "Place" will be the forum to design and plan the majority of the work, utilising the "Place" UEC Steering Groups/SORTs which report into the system UEC Board. The ICB UEC Team will provide a level of consistency for equitable patient outcomes across Norfolk and Waveney while "Place" teams ensure services are designed to meet local needs.

Enabling work will cut across a number of functions, creating a need to have a programme board as well as project delivery groups. The programme board will have Digital, Workforce, Finance and Contracting workstreams and will need to have a strong relationship with regional teams who will be leading on a portfolio of 999 and discharge work.

Risks and challenges

- **Ambulance Handover Delays**
- **Category 2 Response Times**
- **Length of Stay**
- **Performance**

Parker Rachael
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Norfolk and Waveney Integrated Care System

Working with People & Communities in Norfolk and Waveney

Patients and Communities Committee Update
22 May 2023

Parker Rachael
16/05/2023 10:51:02

Guidance for People & Communities – reminder slide

Original ICS guidance asked local systems to agree on ways to **'listen consistently'** and **'act collectively'** regarding the experience and aspirations of local people and communities

Our aspiration using a spectrum of opportunities across the system:

"People and communities tell their story of lived experience once and its heard by everyone"

All feedback has value

Vision of Norfolk and Waveney's approach submitted to NHS England May 2022**.**

Positive feedback from NHS England and highlighted as regional exemplar – **Inclusion health groups** and **Community Voices pilot**

High level patient and public engagement 6 June – 18 July – **Feedback** available

An updated working draft version 10 now available on the **People and Communities hub** reflecting feedback and other changes in the system

New national guidance issued July 2022 - **Working in partnership with people and communities: statutory guidance**

Parker, Rachael
16/07/2022 10:51:2

Promoting Co-production - Update

Development of Co-production Hub – to launch 3rd July in Co-production week

To offer a systemwide place to showcase examples of local co-production from all system partners, and signpost to further information and mutual support.

Celebration of co-production event – 3rd and 5th July for Health and Social Care staff

An event is being held by the Making it Real Board at County Hall on 2 days in co-production week. It aims to raise awareness, and encourage staff to complete the new co-production training

NHS Norfolk and Waveney ICB Volunteer Expenses and Co-production Payments Policy:

Awaiting final details around HMRC arrangements so to encourage and enable people in receipt of benefits to apply.

We will be going to people and to ICB and provider staff across Norfolk and Waveney to get their views on the policy.

Parker, Rachael
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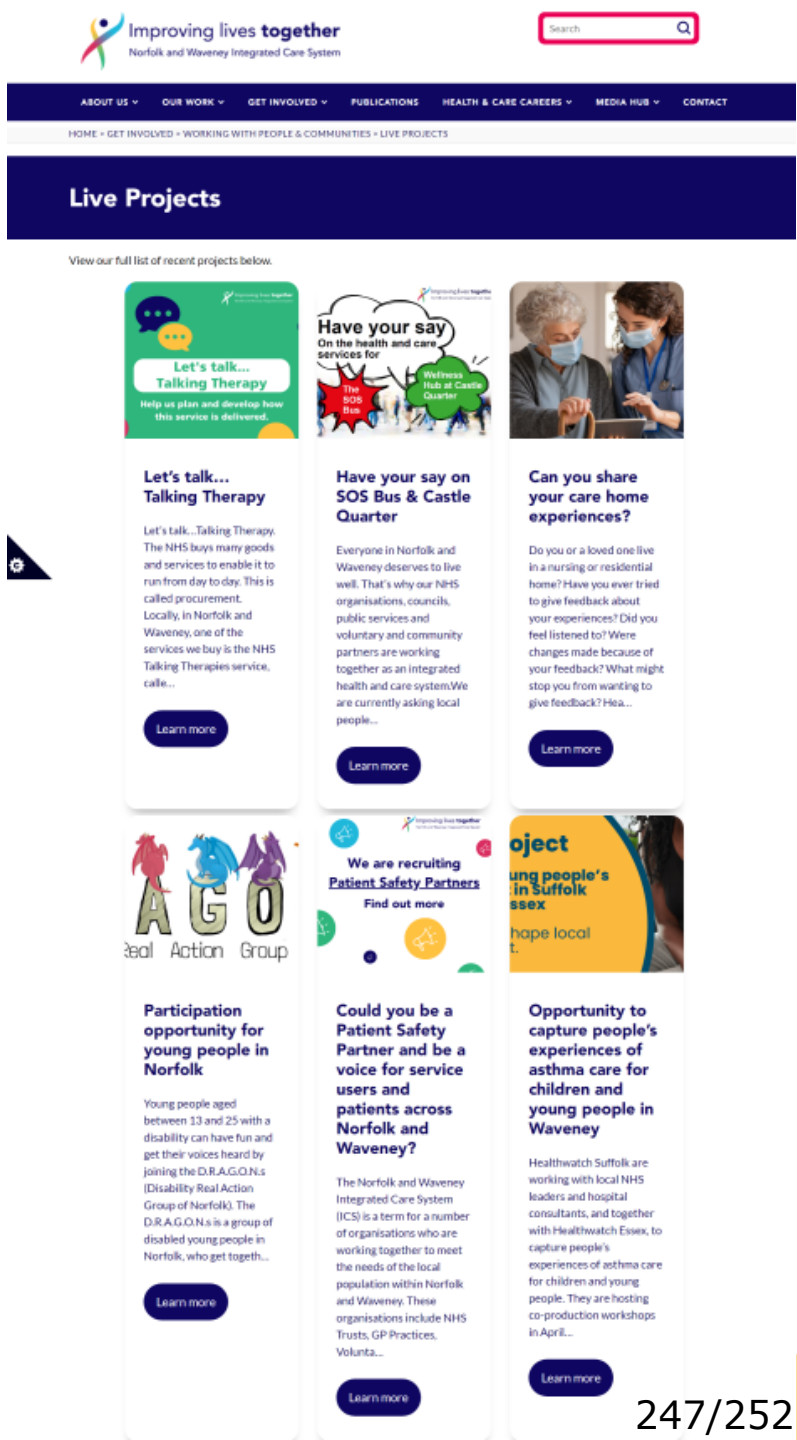
Reminder: The term co-production is generally used to mean an **end-to-end process** where people with **lived experience** work at the **earliest possible stage** with those who **design services** and projects in an **equal partnership**, **sharing power** and often involving a **significant commitment** and where involvement **fees** or other forms of **reciprocity** are offered alongside expenses.

ICB Engagement Projects

As well as supporting the development of strategic co-production, NHS Norfolk & Waveney ICB also undertakes engagement and participation around programmes of work. All live projects offered by the ICB as well as opportunities offered by system partners are available to see on the Live Projects page of our People and Communities Hub: **https://improvinglivesnw.org.uk/get-involved/working-with-people-communities/live-projects/**

- **Talking Therapies -** The current contract for Talking Therapy ends in the autumn of 2024. Before we talk to providers about a new contract we want to talk to local people and communities – those who have used talking therapies and those who haven't - to plan and develop how this service is delivered. **Goes live June 12th.**
- **SOS Bus and Castle Quarter** – We are keen to hear from anyone who has used our new Wellness Hub at Castle Quarter (offering COVID-19 vaccinations and NHS health checks) and/or the SOS Bus service that provides a support and first aid to people who are in Norwich City Centre on Friday and Saturday nights. **Live until June 11th.**



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Walk-in Centre (WiC) engagement update

- Early engagement 8 June – 26 June 2022 to gain patient and public views into the role and use of the Walk-in
- 9-week consultation 24 January – 26 March 2023
  - 3,043 survey responses were received online and in writing.
  - 14 qualitative 1:1 feedback opportunities with organisations and charities supporting vulnerable adults, at-risk adults, adults with additional needs, and children and young people.
  - Independent communications were also received from 9 organisations during the consultation period, including local councils and healthcare providers.
  - An online petition
- Recommendation WiC stays open going to Board 30 May 2023

Parker Rachel 16/05/2023 10:51

the engaging people company

NHS Norfolk and Waveney

Providing general practice services in Norwich

Norwich Walk-in Centre, Vulnerable Adults Service – Inclusion Health Hub, and GP Practice on Rouen Road

Consultation Findings Report
Published May 2023

1

NHSE Annual Assessments

NHS England has a statutory duty to conduct a performance assessment of each integrated care board (ICB) with respect to each financial year and publish a summary of these assessments.

The 2022/23 process will be delayed until the second quarter of 2023/24 to provide an opportunity to reflect on the findings of the Hewitt Report and engage further with ICB leaders on the assessment. Further guidance on the 2022/23 ICB assessment process is expected in May.

This will include how we manage our duty around working with people and communities. The assessment will be done using all relevant publicly available information. Work is underway to review the people and communities hub to make sure we are telling our story in the most positive way.

Parker Rachael
16/05/2023 10:51:02

Thanks for listening

Any questions?

Parker Rachael
16/05/2023 10:51:02

Rebecca Champion rebecca.champion@nhs.net

Population Health & Inequalities (PH&I) Board - Points of Assurance / Escalation [18/04/2023]

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Item No.	Meeting Name	Date of meeting where item was raised	Details of Item for Escalation	Requested Outcome/Support	Financial Implication (if any)	Is item recorded on Risk Register	"EXAMPLE" Board Decision	Fed back to Meeting Group Date
1.	PH&I Board	18/04/2023	PH&I / PHMOG / HIOG Terms of Reference (TOR)	TOR Approved – to be reviewed again at PH&I Board on 15/08/2023	N/A	N/A	For assurance – Decision 1 – PH&I Board	
2.	PH&I Board	18/04/2023	The statutory duties of ICSs to use PHM	For the committee to note the statutory requirement for ICS to PHM to address inequalities to improve health	N/A	No	For assurance	
3.	PH&I Board	18/04/2023	The scale of challenge if we do not prioritise prevention as per the JSNA	For the committee to note the projected scale of increase in demand unless actions are taken now to improve prevention, address avoidable adverse health factors and address inequalities as well as the scale of opportunity if this is prioritized	N/A	No	For escalation	
4.	PH&I Board	18/04/2023	Proposed framework to prioritise work plans	To note that we have defined a rationale and framework to identify which areas of work to prioritise. PHM and HI strategies are being developed to formalize this	N/A	No	For assurance	
5.	PH&I Board	18/04/2023	Co-ordination required to prevent duplication between multiple strands of work	The board will map and coordinate overlapping work across HITG, Health Protection Assurance Board and other groups to prevent duplicaiton	N/A	No	For assurance	
6.	PH&I Board	18/04/2023	The need for a broad linked data set across the ICS and partners	BI team is working in collaboration with PSL to address this, and may require additional support in data gathering process	N/A	Yes	For escalation	

Parker Rachael 16/05/2023 10:51:02

PH&I Board - New Risks [18/04/2023]

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Programme New Risks as of 18/04/2023 – PH&I Board	Mitigation	Lead	RAG
No new risks were raised at the PH&I Board on 18/04/2023			
			RED
			AMBER
			GREEN

Parker Rachael
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