Norfolk Health & Wellbeing Board

Date: **Wednesday 05 March 2025**
Time: **09:30 - 12:30**
Venue: **Council Chamber, County Hall, Martineau Lane, Norwich**

Representing	Membership	Substitute
Borough Council of King's Lynn & West Norfolk	Cllr Jo Rust	Cllr Bal Anota
Breckland District Council	Cllr Tristan Ashby	Cllr Sam Chapman-Allen
Broadland District Council	Cllr Natasha Harpley	Cllr Eleanor Laming
Cambridgeshire Community Services NHS Trust	Anna Gill	Steve Bush
East Coast Community Healthcare CIC	Ian Hutchison	Andy Wood
East of England Ambulance Trust	Jason Gillingham	Nicolas Smith
East Suffolk Council	Cllr David Beavan	Cllr Jan Candy
Great Yarmouth Borough Council	Cllr Emma Flaxman-Taylor	Cllr Donna Hammond
Healthwatch Norfolk	Patrick Peal	Alex Stewart
James Paget University Hospital NHS Trust	Mark Friend	Joanne Segasby
Norfolk Care Association	Christine Futter	
Norfolk Community Health & Care NHS Trust	Lynda Thomas	Laura Clear
Norfolk Constabulary	ACC Chris Balmer	DCS David Freeman
Norfolk County Council, Cabinet member for Adult Social Services	Cllr Alison Thomas	Cllr Shelagh Gurney
Norfolk County Council, Cabinet member for Children's Services	Cllr Penny Carpenter	
Norfolk County Council, Cabinet member for Public Health and Wellbeing	Cllr Fran Whymark	
Norfolk County Council, Executive Director Adult Social Services	Ian Wake	Nicholas Clinch
Norfolk County Council, Executive Director Children's Services	Sara Tough	Sarah Jones
Norfolk County Council, Director of Public Health	Stuart Lines	Suzanne Meredith
Norfolk & Norwich University Hospital NHS Trust	Tom Spink	Rachael Cocker
Norfolk & Suffolk NHS Foundation Trust	Zoe Billingham	Tricia Fuller
NHS Norfolk and Waveney Integrated Care Board (Chair)	Rt Hon Patricia Hewitt	
NHS Norfolk and Waveney Integrated Care Board (Chief Executive)	Tracey Bleakley	Andrew Palmer
North Norfolk District Council	Cllr Liz Withington	Cllr Wendy Fredericks
Norwich City Council	Cllr Adam Giles	Cllr Claire Kidman
Place Board Chair Great Yarmouth & Waveney	Jonathan Barber	Sheila Oxtoby
Place Board Chair Norwich	Tracy Williams	
Place Board Chair North Norfolk	Dr James Gair	Heather Farley
Place Board Chair South Norfolk	Allan Petchey	Karen Bradley
Place Board Chair West Norfolk	Carly West-Burnham	Oliver Judges
Police and Crime Commissioner	Sarah Taylor	Dr Gavin Thompson
Queen Elizabeth Hospital NHS Trust	Andy Wood	Alice Webster
South Norfolk District Council	Cllr Kim Carsok	Cllr Andy Evans
Voluntary Sector Representative	Tim Gardiner	
Voluntary Sector Representative	Dan Mobbs	
Voluntary Sector Representative	Daniel Childerhouse	

Additional members (non-voting)

Norfolk Health Overview and Scrutiny Committee (Chair)	Cllr Brenda Jones
Suffolk County Council, Cabinet Member for Adult Care	Cllr Beccy Hopensperger
Suffolk County Council Representative	Nicholas Pryke
University of East Anglia Representative	Prof Nicole Horwood

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

Norfolk and Waveney Integrated Care Partnership

Date: **Wednesday 05 March 2025**
Time: **on rise of the Health and Wellbeing Board**
Venue: **Council Chamber, County Hall, Martineau Lane, Norwich**

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

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

Norfolk Health & Wellbeing Board and Norfolk and Waveney Integrated Care Partnership

Wednesday 05 March 2025
Agenda
Time: 09:30 - 12:30

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

Advice for members of the public:

This meeting will be held in public and in person.

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

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

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

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

1.	Apologies	Committee Officer	
2.	Chair's opening remarks	Chair	
	Norfolk Health and Wellbeing Board (HWB)		
3.	HWB Minutes	Chair	(Page 5)
4.	Actions arising	Chair	
5.	Declarations of interests	Chair	
6.	Public Questions (How to submit a question: HWB) Deadline for questions: **5pm, Thursday 27 February 2025**	Chair	
7.	Urgent arising matters	Chair	
8.	Better Care Fund 2024/25: Q3 report request for sign off and Better Care Fund 2025/26: proposed Plans update	Ian Wake / Edward Fraser / Tracey Bleakley / Karin Bryant	(Page 16)
9.	Norfolk and Waveney Joint Forward Plan update	Tracey Bleakley / Liz Joyce	(Page 51)

	Norfolk and Waveney Integrated Care Partnership (ICP)		
1.	Election of Chair	Committee Officer	
2.	Nominations to the Integrated Care Board	Chair	
3.	ICP Minutes	Chair	(Page 5)
4.	Actions arising	Chair	
5.	Declarations of Interest	Chair	
6.	Public Questions (How to submit a question: ICP) Deadline for questions: **5pm, Thursday 27 February 2025**	Chair	
7.	Driving Integration through Digital, Data and Technology	Ian Wake / Geoff Connell Tracey Bleakley / Ian Riley	(Page 53)
8.	Norfolk and Waveney Health and Wellbeing Partnership Event	Stuart Lines / Nichola Coburn / Jamie Sutterby	(Page 58)
9.	Norfolk and Waveney Place Board Update	Tracey Bleakley / Mark Burgis	(Page 63)
10.	Section 75 contract for Integrated Community Health and Social Care	Ian Wake / Nicholas Clinch Lynda Thomas / Robert Mack	(Page 74)
11.	Health Inequalities Update	Stuart Lines / Tracy Williams	(Page 77)

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

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

Health and Wellbeing Board and Integrated Care Partnership
Minutes of the meeting held on 04 December 2024 at
in the Council Chamber, County Hall.

Present:	**Representing:**
Cllr Jo Rust	Borough Council of King's Lynn & West Norfolk
Cllr Tristan Ashby	Breckland District Council
Cllr Natasha Harpley	Broadland District Council
Anna Gill	Cambridgeshire Community Services NHS Trust
Ian Hutchison	East Coast Community Healthcare CIC
David Allen	East of England Ambulance Trust
Cllr David Beavan	East Suffolk Council
Alex Stewart	Healthwatch Norfolk
Mark Friend	James Paget University Hospital NHS Trust
Christine Futter	Norfolk Care Association
ACC Chris Balmer	Norfolk Constabulary
Cllr Shelagh Gurney	Norfolk County Council, Cabinet member for Adult Social Services
Cllr Fran Whymark	Norfolk County Council, Cabinet member for Children's Services
Cllr Bill Borrett	Norfolk County Council, Cabinet member for Public Health and Wellbeing, Leader (nominee)
Ian Wake	Norfolk County Council, Executive Director Adult Social Services
Stuart Lines	Norfolk County Council, Director of Public Health
Kim Goodby	Norfolk & Norwich University Hospital NHS Trust
Kate McCandlish	Norfolk & Suffolk NHS Foundation Trust
Tracey Bleakley	NHS Norfolk and Waveney Integrated Care Board (Chief Executive)
Cllr Liz Withington	North Norfolk District Council
Cllr Adam Giles	Norwich City Council
Jonathan Barber	Place Board Chair Great Yarmouth & Waveney
Tracy Williams	Place Board Chair Norwich
Heather Farley	Place Board Chair North Norfolk
Carly West-Burnham	Place Board Chair West Norfolk
Sarah Taylor	Police and Crime Commissioner
Cllr Kim Carsok	South Norfolk District Council
Tim Gardiner	Voluntary Sector Representative
Dan Mobbs	Voluntary Sector Representative
Daniel Childerhouse	Voluntary Sector Representative

Additional members present (non-voting):

Cllr Brenda Jones	Norfolk Health Overview and Scrutiny Committee (Chair)
Cllr Beccy Hopensperger	Suffolk County Council, Cabinet Member for Adult Care
Prof Joanna Semlyen	University of East Anglia Representative
Nicholas Pryke	Suffolk County Council Representative

Officers Present:

Stephanie Butcher	Policy Manager Health and Wellbeing Board
Stephanie Guy	Advanced Public Health Officer
Maisie Coldman	Committee Officer

Speakers:

Diane Steiner	Deputy Director of Public Health, NCC
Mark Whitmore	Assistant Director – Health, Wellbeing & Public Protection, Borough Council of Kings Lynn and West Norfolk
Ciceley Scarborough	Consultant in Public Health, NCC
Nicholas Clinch	Director of Communities, Prevention and Partnerships, Adult Social Services, NCC
Stuart Lines	Director of Public Health, NCC
Paul Wardle	Strategic Human Resource Business Partner - Adults

Sharon Crowle	Head of Professional Education, Training and Development, Norfolk and Waveney Integrated Care Board (ICB)
Marcus Bailey	System Resilience Director, ICB
Andrew O'Connell	Senior Nurse, LeDeR, ICB
Tracy Williams	Clinical Lead for Health Inequalities & Inclusion Health, ICB
Geoff Connell	Director of Digital Services, NCC
Anne Heath	Associate Director of Digital, ICB
Ian Riley	Executive Director of Digital & Data, ICB
Sharon Brooks	Chief Officer, Carers Voice Norfolk and Waveney
Bethany Small	Commissioning Manager, ICB
Edward Fraser	Assistant Director Communities and Integration, Adult Social Services, NCC

Norfolk Health and Wellbeing Board (HWB)

1. Apologies

1.1 Apologies were received from Cllr Thomas (substituted by Cllr Gurney), Angela Steggles (substituted by Christie Futter), Patrick Peal (substituted by Alex Stewart), Tom Spink, (substituted by Kim Goodby), Cllr Carpenter (substituted by Cllr Whymark), Lynda Thomas and their substitute, Nicole Horwood (substituted by Professor Joanna Semlyen), Zoe Billingham (substituted by Kate McCandlish), Dr Gair (substituted by Heather Farley), Cllr Flaxman Taylor, Chris Lawrence and his substitute and Patricia Hewitt. Sara Tough and Allan Petchey were also absent.

2. Chair's Opening Remarks

2.1 The Chair welcomed Ian Wake, ACC Chris Balmer, Tim Gardiner and Nicholas Pryke as new members to the committee. He reminded members that an attendance sheet would be appended to the minutes (Appendix A).

3. Minutes

3.1 The HWB minutes of the meeting held on 4 September 2024 were **agreed** as an accurate record and signed by the Chair.

4. Actions arising

4.1 None.

5. Declarations of Interests

5.1 None.

6. Public Questions

6.1 None.

7. Urgent Matters Arising

7.1 None.

8. Norfolk Drugs and Alcohol Partnership (NDAP) Annual Report

8.1 Stuart Lines, Director of Public Health, NCC introduced the appended (8) report which updated the Board on priorities, progress, and work underway by NDAP.

8.2 Diane Steiner, Deputy Director of Public Health, NCC provided a summary of the report in which she shared that the work of the NDAP was highlighted in a report from the Local Government Association on progress against the national drug strategy. Work had been undertaken to explore the impacts of ketamine misuse in the county and pathways had been established. Additionally, work was happening

with the Office for Health Improvements and Disparities, and progress was reflected in the data. Training of the workforce, harm reduction messaging in police custody, and pathways for people with dual diagnosis were also occurring. The Board heard that a real-time surveillance system, that was linked to data on suspected suicides, was now up and running. There was uncertainty around some funding elements, but it was hoped that the majority would continue.

8.3 The following points and comments were discussed:

- Norfolk had previously had a high rate of alcohol and drug-related deaths; this had improved but was beginning to increase again. Members heard that the Drug and Alcohol Panel identified physical ill health as a link to the increase. People were accessing support later when they already had physical ill health.

- The only change to the funding was the supplementary funding; drug and alcohol funding would remain as it was. Alternative options have been discussed with services if the supplementary funding was not available.

- Following a member's question, it was shared that the voluntary sector input was important and that additional information would be shared with members on the voluntary sector members of the NDAP.

- There was a ketamine clinic at the Norfolk and Norwich University Hospital Trust that had seen over 100 people. The provision was increased to include children under 16 and people who fall into other catchment areas.

- A member questioned if an assessment had been done about whether the proposed reduction in the housing support funding from NCC would impact the people who receive housing support. This question would be responded to outside of the meeting.

8.4 The HWB **RESOLVED** to:

a) Provide executive support to the work that HWB Board members' teams are engaged in, for example senior leaders of commissioners and providers of mental health and drug and alcohol services helping to accelerate the work on dual diagnosis that continues within the context of structural re-organisation.
b) Continue to support their organisations to identify drug and alcohol users in their care and support them to engage with drug and alcohol treatment to reduce the risk of drug and alcohol related deaths.
c) Continue to support relevant staff to take up drug and alcohol and mental health training coordinated by the partnership.
d) Acknowledge the progress of the current workstreams and endorse the work of the partnership.
e) Ensure HWB Board member organisations are appropriately engaged with NDAP.
f) Acknowledge that other partnerships – e.g. some Health and Wellbeing Partnerships – may also contribute to this agenda, e.g. through Community Alcohol Partnerships.

9. Better Care Fund 2024-2025 Quarterly Reports (Q1, Q2)

9.1 The Chair introduced the appended (9) report which provided details on the BCF quarter 1 and 2 report for sign-off. Members would receive detailed information of quarter 3 at the next meeting.

9.2 The HWB **RESOLVED** to:

a. Agree and sign-off the BCF Q1 and Q2 reports.
b. Support a presentation of the Q3 report at the next meeting of the Health and Wellbeing Board.

10. Becoming a 'Marmot Place': West Norfolk's work with the Institute of Health Equity

10.1 Jo Rust, Cabinet Member for People & Communities, Borough Council of King's Lynn and West Norfolk introduced the appended (10) report, noting that she was proud that King's Lynn and West Norfolk had

become a Marmot Place.

10.2 Mark Whitmore, Assistant Director – Health, Wellbeing & Public Protection, Borough Council of Kings Lynn and West Norfolk shared that there were four areas of work to be completed over two years with the support of the University College of London Institute of Health Equity (IHE) led by Professor Sir Michael Marmot. This work would launch on 12 March 2025. Governance would consist of an advisory board of senior leaders from relevant partners; requests to be part of this group would be sent out shortly. The opportunity to become a Marmot Place was seen as a positive opportunity to put inequality at the centre of decision-making, to have a critical friend, and to recognise the work already happening across the area.

10.3 The following points and comments were discussed:

- A member shared their experience of being part of Marmot Place, noting the difference that it made and the value that came out of the deep dive.
- It was requested that the ask to join the advisory board was sent to the Norfolk Care Association, the governors of the QEH, and the youth council that had recently launched.
- Learning from the programme would be brought to the Health and Wellbeing Partnerships, Place Boards and would be shared with the community more generally. Part of the commitment to the programme was to share what had been learned.
- Members expressed their support towards Kings Lynn and West Norfolk becoming a Marmot Place.
- The ICB, NCC Public Health, and the Borough Council of Kings Lynn and West Norfolk were working in partnership to carry out this work.
- East Suffolk Council was expected to become a Marmot Place next year.
- Volunteer sector members would likely be drawn from the Health and Wellbeing Partnership, and involvement in the advisory board was welcomed from across the system.
- The Chair summarised, noting the influence of the Place Board, Health and Wellbeing Partnerships, and District Councils. He reminded members that they all influence to help drive the agenda.

10.4 The HWB **RESOLVED** to:

a) Note the work of the West Norfolk Marmot team.
b) Advocate with system partners to ensure the advisory board and steering group are appropriately supported.

The Health and Wellbeing board closed at 10:05

Integrated Care Partnership

1. Integrated Care Partnership Minutes

1.1 The minutes of the Integrated Care Partnership (ICP) meeting held on 4 September 2024 were **agreed** as an accurate record and signed by the Chair.

2. Actions arising

2.1 None.

3. Declarations of Interest

3.1 None.

4. Public Questions

4.1 None.

5. Launching the Norfolk & Waveney Health Inequalities Commitment

5.1 Tracey Bleakley, Chief Executive, ICB introduced the appended (5) report and highlighted that Norfolk does have wide inequalities but that there was a strong partnership across the system to address this. She thanked those involved for their work.

5.2 Stuart Lines, Director of Public Health, NCC shared with the partnership that system coordination was the biggest challenge to a system-wide approach to addressing health inequalities. A system approach would allow for different perspectives to be brought together. There were four key actions that organisations were being asked to commit to: Identifying a Health Inequalities Lead in members organisations, connecting with communities and listening to seldom heard voices, undertaking a self-assessment, and, embedding addressing health inequalities into organisational approach. There were 10 key actions for the first year of the strategy.

5.3 Tracy Williams, Clinical Lead for Health Inequalities & Inclusion Health, ICB added that progress was being made against all of the 10 key actions. Members of the ICP are asked to express their commitment to addressing Health Inequalities and participate in the self-assessment process. At the Integrated Care System Conference in October 2024, members received a QR code that would allow them to complete the baseline assessment surety of their organisation. Health Inequalities leads within organisations could access support to do this if needed.

5.4 The following points and comments were discussed:

- Members generally endorsed the Norfolk & Waveney Health Inequalities Commitment.
- It was confirmed that being health literacy-friendly would mean that all services were accessible to all members of the community. The strategic steering group and a coordination group made up of partners, were supporting the development of tools and techniques to make services more accessible. This work was occurring nationally; there was a focus on the inequality of agency and the need to develop and enable people to engage effectively.
- A member suggested that the members needed early engagement with the development of the monitoring framework so they could see headlines and how this could be shaped.
- Metrics were being established, as was a dashboard, to keep track of changes.
- The partnership heard that the shift of resources to prevention was a challenge for the system. System working provided opportunities for a system overview to be taken. It was acknowledged that some people needed more and different resources.
- The ICS Health Inequalities Steering Group, via its Coordination Group, would develop tools and resources to support this work, which would include support to Health Inequalities Leads.
- The importance of collaborative working and making the most of resources was highlighted by a member.
- Following a member's question regarding the expectations from organisations in the social care sector with respect to self-assessment and the Health Inequalities Lead, officers agreed to take this question away and members would be updated.
- The Chair summarised the discussion and took the opportunity to congratulate those involved in the Integrated Care System Conference and to highlight the success of the Health and

Wellbeing Partnership conference. Place-based focus was at the heart of dealing with Health Inequalities.

5.5 The ICP **RESOLVED** to:

a) Support the Health Inequalities Commitments.
b) Members are asked to take the Health Inequalities Commitment back to their respective organisations and pledge to support the proposed actions.
c) Oversee uptake of the Norfolk & Waveney Health Inequalities Commitment.
d) Support the development of a system improvement plan based on the consolidated results of the organisational self-assessments.

Brenda Jones left the meeting at 10:30

6. Update on driving integration through system wide training opportunities

6.1 Tracey Bleakley, Chief Executive, ICB, introduced the appended report (6) on the update on driving integration through system-wide training opportunities noting that this was suggested by members and would be a standing item to keep the partnership informed.

6.2 Paul Wardle, Strategic Human Resource Business Partner – Adult Social Care, NCC, and Sharon Crowle, Head of Professional Education, Training and Development, ICB provided the partnership with an overview of the report. Communication was occurring to align the ICP recommendation on system leadership with the Adult Education Budget; members would be kept updated on this work. Members also heard updates on the digital skills passport, Volunteering for Health Programme, Social Care Institute for Practice Excellence Board, Digital Placement System, and Norfolk Initiative for Coastal and Rural Health Equalities (NICHE).

6.3 The following points and comments were discussed:

- An update would be provided to the ICP on joint learning opportunities and development following the Social Care Institute for Practice Excellence Board meeting. This was scheduled for October 2024 but had been delayed.

- Following a member's question, it was shared that officers were not aware of a link between the NICHE and the Marmot Place project. Officers would take this away to explore links. Alex Stewart, Chief Executive of Healthwatch Norfolk, and Chair of NICHE, shared that they would be looking into the Marmot Place project.

- Some members felt that councillor training should also be included in the training opportunities available.

- A member highlighted the Talk Centre training provided by the VCSE with the support of the ICB.

- Understanding the existing provision to prevent duplication was noted as an area to be further explored. Currently, there was not a single leadership forum that looks at training providers and training provision.

- A member shared concerns regarding the system's reliance on the VCSE and the composition of charity trustees. Particularly highlighting how risk was managed in a VCSE. Not all members shared this view.

- The Chair concluded discussions and noted the importance of this work, signposting, and free-flowing information.

6.4 The ICP **RESOLVED** to:

a) Consider the update on ongoing activities taking place across the ICS in respect of system

leadership, educational and training opportunities.

7. Driving Integration through Digital, Data and Technology including Digital Inclusion

7.1 Ian Wake introduced the appended report (7) sharing that he was pleased with the progress. Integration through digital, data, and technology systems has the capacity to transform how care is planned and delivered, to enable a holistic view of the system, to be able to use predictive analytics to prevent risk and use commissioning intelligence to understand how people move through the system and to plan care in response to this.

7.2 Tracey Bleakley, Chief Executive, ICB, added that this was a topic that members were interested in hearing more about and understanding how data could be used to solve issues. Concerning the Share Care Record (ShCR), it was noted that Norfolk performed well nationally for accessing the ShCR.

7.3 Anne Heath Associate Director of Digital, ICB, provided the partnership with an update on the digital overview which included cloud telephony installation in GP practices, ICS-wide intranet, NHS app uptake, ongoing work with care homes, and the SCR.

7.4 The following points and comments were discussed:

- The ICS intranet had been launched in primary care and care homes to ensure access to information, enabling them to self-serve and provide support.
- A member asked how predictive analytics would be used in the future. It was shared in response that Artificial Intelligence and predictive analytics would be explored at the next meeting. The partnership heard that the team had recently won a National Award for their work in artificial Intelligence and predictive analytics.
- It was noted that the team worked with the digital inclusion team and Healthwatch Norfolk to ensure that the NHS app was accessible and useable for the public. This was important as it was the ambition for the NHS app to be the front door to the NHS.
- The parts of the VCSE sector that were commissioned to provide social prescribing would be given access to the ShCR in the next phase. Standards had to be met before access to the ShCR was granted. A member requested that District Councils Housing Teams be considered to have access.
- A member suggested creating a heat map of all the projects to identify gaps and take up provisions.
- A member noted that it would be helpful to see details of a project's timeline, including evaluation so that future projects could be aligned with financial planning at District Councils.
- The partnership heard that ShCR had made a difference to front-line workers and their assessment of risk.
- Following a comment about the virtual ward provision in care homes, it was noted by another member that there was a programme of work associated with virtual wards and care homes.
- The Chair concluded discussions, highlighting the exciting work that was happening.

7.5 The ICP **RESOLVED** to:

a) Note the updates on the progress taken around the collaboration as a system and raise any potential gaps or priorities to further inform the plan.
b) Review, comment, and advise on the progress taken with the Shared Care Record.
c) Review, comment and advise on the proposed items to be discussed at future meetings.

8. Preparing for Seasonal Pressures: ICS Framework for 2024/25

8.1 Ian Wake introduced the appended report (8) which provided an overview of preparing for seasonal pressures. It was noted that this year was particularly difficult as there was reduced winter planning funding.

8.2 Tracey Bleakley, Chief Executive, ICB noted that the reason it was being referred to as seasonal pressures was because it was not just Winter that caused impact. Planning and working together across the system were important.

8.3 Nicholas Clinch, Director of Communities, Prevention and Partnerships, NCC provided the partnership with an overview of the report and the actions being taken to manage seasonal pressures, including details of winter planning and delivery. The publication of national expectations on social care during winter, by the Department of Health and Social Care has been received which laid out a home first approach, high-quality care, supporting people to stay well, and involvement with people receiving care, their families and carers. This guidance aligned with other national guidance from the Association of Directors of Adult Social Services and NHS England. There were three key areas in Adult Social Services outlined in the paper: meeting people's needs, resilient communities, and supporting our workforce.

8.4 Marcus Bailey, System Resilience Director, ICB, added that ongoing resilience was important for continuous improvement and for transformation items to have an impact. Ongoing resilience and development were looked at concerning the annual operating plans. Focus on unplanned and emergency care activity and to equalise where possible with planned care. The Emergency and Urgent Recovery Plan was also an area of focus; the partnership heard that there had been improvements to the category 2 ambulance response times and through emergency department performance. These improvements reflect collaborative working. There was a recognition that whilst there was work that needed to be done, communication was key.

8.5 The following points and comments were discussed:

- Following a member's question, it was noted that vaccinations remained a key part of the winter planning programme, and the Health Protection Assurance Board looked at vaccination uptake rates.

- A member shared that areas across the system were already feeling pressurised and highlighted the importance of implementing plans before the winter peak.

- A member asked if Norfolk Care Association could be involved in communication and engagement with the decisions made in acute hospitals. In response, it was noted there was a commitment to make sure there was engagement at a variety of levels.

- Resilience of services was important but raising awareness of likely events was also useful to reduce the pressure on the system.

- The Chair noted the importance of this work and how it had developed over the years. This year would be especially challenging as there was no winter funding.

8.6 The ICP **RESOLVED** to:

a) Comment on the draft Winter Framework for 2024/25, including the assurance it provides on preparedness for seasonal pressures.
b) Endorse the draft Winter Framework for 2024/25.

Alex Stewart left the meeting at 11:50

9. 2023/2024 Learning from Lives and Deaths: People with a Learning Disability and Autistic People (LeDeR) Annual Report

9.1 Tracey Bleakley, Chief Executive, ICB introduced the appended annual report (9) and highlighted to the partnership that people with learning disabilities and autistic people on average live 20 years less than the other people within the population. She expressed the importance of learning and implementing change.

9.2 Andrew O'Connell Senior Nurse, LeDeR, ICB, provided the partnership with an overview of the report which outlined the health inequalities experienced by people with learning disabilities and autistic people. The partnership heard that the main cause of death continued to be aspiration pneumonia and other respiratory conditions; prevention of respiratory ill health was key. Members also heard that there were efforts to catch up with reviews for autistic people. There was work occurring to increase vaccination, bowel and cervical screening, and to support people to live healthier lives. Additionally, work was occurring to encourage people to use ReSPECT and to ensure that the Mental Capacity Act was used to protect people.

9.3 The following points and comments were discussed:

- A member raised engagement in services and how we could be supported collectively. It was confirmed that the services that people were involved with, and/or had accessed were looked at but this was not tracked post review. It was noted that this could be an area of work that could be explored further in the future.

- A member asked how the review that fell short of good practice informed actions. It was noted in response, the partnership heard that these reviews would feed into the learning from action work. There was a robust process and collaboration to ensure that issues are dealt with as they are identified in the review. It was acknowledged that general quality issues could be more difficult to resolve.

- The Health Inequalities Team had a process to support primary care to maintain learning disability registers. The team supports the decision around the Mental Capacity Act and training primary care and care providers to inform and educate on what a good quality health check looks like. The partnership heard that a nurse within the team had recently won an award for their work in addressing health inequalities for people with learning disabilities and autistic people.

- Concerning cervical screening and the lessons learned from reduced uptake, it was noted that work was being done to improve the uptake of cervical screening. Communication was occurring with primary care and care providers to remind them of the importance of the checks as part of the health check. There were attempts to mitigate the barriers that may prevent someone from attending.

- It was confirmed that reporting structures were strong, and that learning was fed into the Learning from Deaths Forum and End of Life Board regarding deaths in acute environments. The partnership heard that end of life was sometimes not identified early enough and thus, not planned for. However, more people were being supported to die at home.

- A member shared that it would be important to ensure that people with a learning disability and autistic people were reflected in the Marmot Place programme.

9.4 The ICP **RESOLVED** to:

a) Agree and approve the recommendations from the LeDeR annual report and system learning.
b) Champion advocacy and inclusion for people with a learning disability and autistic people in any discussion and/or decision that may impact their health and wellbeing.

10. All Age Carers Strategy for Norfolk and Waveney 2024 – 2029

10.1 Ian Wake introduced the appended report (10), highlighting the vital function that unpaid carers offer

that contributes to £162 billion in savings. The Strategy demonstrated partnership working.

10.2 Edward Fraser, Assistant Director Communities and Integration, Adult Social Services, NCC, noted that this was the first All Age Carers Strategy for Norfolk and Waveney developed in collaboration with carers of all ages, including Young Carers and Parent Carers. Key actions were co-produced and it was the ambition that these would be implemented within a reasonable timescale. The strategy demonstrated the views of carers and reassured them that their views had been listened to.

Sharon Brooks, Chief Officer of Carers Voice Norfolk and Waveney thanked the carers that had been involved in the production of the strategy. She provided an overview of the report to the partnership, highlighting the carer's statements and the seven strategy areas identified.

10.3 The following points and comments were discussed:

- Members acknowledge the work that had gone into producing the All Age Carers Strategy for Norfolk and Waveney 2024 – 2029.

- A member shared that there seemed to be no communication with District Councils, in particular East Suffolk District Council and the East Suffolk partnership.

10.4 The ICP **RESOLVED** to:

a) Endorse and promote the first co-produced All Age Carers Strategy for Norfolk and Waveney 2024 – 2029.
b) Commit to supporting the All Age Carers Strategy for Norfolk by sending representatives from all partner member organisations to be part of the Monitoring Group as appropriate.
c) Ensure all partners commit to developing Action Plans based on the Focus Areas and Recommended Actions within the Strategy document.

Meeting concluded at 12:26

Bill Borrett

Chair Health and Wellbeing Board and Integrated Care Partnership

Appendix A

Health and Wellbeing Board and Integrated Care Partnership Attendance Record
(From the last 3 meetings)

Member Organisation Represented	Named Member	12 Jun 2024	04 Sept 2024	04 Dec 2024
Borough Council of King's Lynn & West Norfolk	**Cllr Jo Rust**	X	X	X
Breckland District Council	**Cllr Tristan Ashby**	X		X
Broadland District Council	**Cllr Natasha Harpley**	X	X*	X
Cambridgeshire Community Services NHS Trust	**Anna Gill**	X	X	X
East Coast Community Healthcare CIC	**Ian Hutchison**	X	X*	X
East of England Ambulance Trust	**David Allen**	X		X
East Suffolk Council	**Cllr David Beavan**	X	X	X
Great Yarmouth Borough Council	**Cllr Emma Flaxman-Taylor**		X	
Healthwatch Norfolk	**Patrick Peal**	X	X	X*
James Paget University Hospital NHS Trust	**Mark Friend**	X*	X	X
Norfolk Care Association	**Angela Steggles**			X*
Norfolk Community Health & Care NHS Trust	**Lynda Thomas**		X	
Norfolk Constabulary	ACC Nick Davison **ACC Chris Balmer**	X	X*	 X
NCC, Cabinet member for Adult Social Services	**Cllr Alison Thomas**	X	X	X*
NCC, Cabinet member for Childrens Services	**Cllr Penny Carpenter**	X	X	X*
NCC, Cabinet member for Public Health and Wellbeing	**Cllr Bill Borrett**	X	X	X
NCC, Interim Executive Director Adult Social Services	Debbie Bartlett **Ian Wake**	X	X	 X
NCC, Executive Director Children's Services	**Sara Tough**	X	X	
NCC, Director of Public Health	**Stuart Lines**	X*	X	X
Norfolk & Norwich University Hospital NHS Trust	**Tom Spink**	X	X	X*
Norfolk & Suffolk NHS Foundation Trust	**Zoe Billingham**			X*
NHS Norfolk and Waveney Integrated Care Board (Chair)	**Rt Hon Patricia Hewitt**	X	X	
NHS Norfolk and Waveney Integrated Care Board (Chief Executive)	**Tracey Bleakley**	X*	X	X
North Norfolk District Council	**Cllr Liz Withington**		X	X
Norwich City Council	Cllr Claire Kidman **Cllr Adam Giles**	X	 X	 X
Place Board Chair (Great Yarmouth & Waveney)	**Jonathan Barber**		X	X
Place Board Chair (Norwich)	**Tracy Williams**	X	X	X
Place Board Chair (North Norfolk)	**Dr James Gair**	X*	X*	X*
Place Board Chair (West)	**Carly West-Burnham**	X*	X	X
Place Board Chair (South Norfolk)	**Allan Petchey**	X		
Police and Crime Commissioner	**Sarah Taylor**			X
Queen Elizabeth Hospital NHS Trust	**Chris Lawrence**			
South Norfolk District Council	**Cllr Kim Carsok**	X	X	X
Voluntary Sector Representative	*Emma Ratzer* **Tim Gardiner**	X*	X	 X
Voluntary Sector Representative	**Dan Mobbs**	X	X	X
Voluntary Sector Representative	**Daniel Childerhouse**			X
Norfolk Health Overview and Scrutiny Committee (Chair)	**Cllr Brenda Jones**	X	X	X
Suffolk County Council, Cabinet member for Adult Care (Guest)	***Cllr Beccy Hopfensperger***	X	X	X
Suffolk County Council Representative (ICP)	*Nicola roper* **Nicholas Pryke**	X*		 X
University of East Anglia Representative (Guest)	Prof Nicole Horwood	X	X	X*

*X member attended, * Indicates Substitute attended*

Norfolk Health and Wellbeing Board

Item No: 8

Report title: Better Care Fund 2024/25: Q3 report request for sign off
Better Care Fund 2025/26: Proposed plans update

Date of meeting: 05 March 2025

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

Reason for the Report

Norfolk Health and Wellbeing Board (HWB) holds the responsibility for overseeing and agreeing the Better Care Fund (BCF) plans each year and for agreeing the quarterly reports requested by the national Better Care Fund Team (NHS England). This paper provides an overview of the Quarter 3 (Q3) BCF report as well as an update regarding proposed plans for the BCF in 2025/26.

Report summary

The Norfolk BCF project team welcomes the opportunity to share an update on the BCF with the Board. We are pleased to share that schemes within the BCF continue to deliver against key national and local metrics and priorities. The Q3 report is attached as an Appendix for sign-off by the Board. This report focusses on our metrics, activity and spend cumulatively from April 2024 to December 2024. An update is also provided regarding BCF planning for 2025/26, particularly proposed changes to the Norfolk BCF plan following the joint review that was completed last year and endorsed by the Board in June 2024.

Recommendations

The HWB is asked to:

a) Agree and sign-off the BCF Quarter 3 report.
b) Note the proposed changes to the BCF plan for 2025/26 arising from the joint BCF review, ahead of formal approval at the next Health and Wellbeing Board in June 2025.
c) Agree to a presentation of the 2024/25 End of Year report at the Health and Wellbeing Board in September 2025.

1. Background

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

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

The BCF for 2024/25 is made up of a number of elements:

- NHS Minimum Contribution (“Core BCF”)
- Improved BCF (iBCF)
- Disabled Facilities Grant (DFG)
- Additional Discharge Fund (ADF) – split into Integrated Care Board (ICB) and Local Authority (LA) allocations

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

1.4 The ICB and LA work together to agree the allocation of the minimum NHS contribution and to develop an annual joint BCF plan. The HWB is responsible for signing off the annual plans and quarterly reports. The 2024/25 plan was signed off by HWB at the September 2024 meeting and HWB approved the Quarter 1 and Quarter 2 reports in December.

1.5 This paper includes the Quarter 3 report, for approval by the HWB. An update is also provided regarding BCF planning for 2025/26, particularly proposed changes to the Norfolk BCF plan following the joint review that was completed last year and endorsed by the Board in July 2024.

2. Better Care Fund 2024/25 Quarter 3 Return

2.1 The Quarter 3 report (see **Appendix 1**) looks at the National Conditions, our Capacity and Demand figures, our performance against metrics and our spend and output activity across all four income elements of the BCF. The report confirms that we are meeting our National Conditions, and that our outputs and spend are on track.

2.2 The report is formed of six tabs:

- **1. Guidance:** This tab offers guidance on completing the report.
- **2. Cover:** This tab shows who is submitting the report, when it is going to Health and Wellbeing Board, and has validation boxes, which are green when the report is completed.
- **3. National Conditions:** This tab asks us to verify that we have met the BCF National Conditions, which we confirm.
- **4. Metrics:** This tab looks at the four national metrics, and our performance against them.
- **5.1 C&D Guidance and Assumptions:** This tab offers guidance on completing the next tab.
- **5.2 C&D Actual Activity:** This tab looks at our actual Capacity and Demand activity for across intermediate care services, both for hospital discharge and step up from the community.
- **6a Expenditure Guidance:** This tab offers guidance on completing the next tab.
- **6b Expenditure:** This tab looks at all of our BCF spend. It asks for the actual expenditure to date, the outputs delivered to date where required, and whether there have been any implementation issues.

2.3 Activity and expenditure profiles are in line with original profiles submitted in the 2024/25 planning return that was approved by HWB in June 2024.

3. The BCF Review

3.1 **Introduction:** In June 2023, the HWB requested a review of the Norfolk BCF to cover the core BCF, which includes 58 schemes totalling £81,533,291 funding (2024/25 values). The key purpose was to ensure that the BCF schemes are aligned to current system priorities, local BCF priorities and the national BCF metrics.

3.2 To remind members, the BCF forms part of core organisational funding and is not an additional funding stream.

3.3 The review was completed by the joint BCF project team working across Norfolk County Council and Norfolk and Waveney NHS Integrated Care Board. In June 2024, the HWB received a paper summarising the key findings from the review. This paper is included as **Appendix 2**.

3.4 The review resulted in a series of recommendations, including revised local priorities for BCF investment in Norfolk, which were approved by the HWB in June 2024. One of the agreed next steps was to optimise the BCF by implementing a new 'future state' model as follows:

- Refresh Norfolk's local BCF priorities to ensure they are in line with Norfolk and Waveney Integrated Care System ambitions. Strategic alignment of BCF schemes with the following categories:
    1. Place based initiatives
    2. Prevention & Community Support
    3. Admission Avoidance
    4. Discharge & Recovery
    5. Enablers for integration
    6. Mental Health, LD and Autism
- Focus the BCF on core integrated services operating at scale within a strategic framework, and requiring joint commissioning and oversight.
- As a consequence of the above, schemes that do not operate at scale were reviewed to identify:
    1. If there are equivalent schemes being delivered elsewhere in the system that are not on the current BCF Plan, that could be onboarded so that the totality of the scheme type is in the BCF Plan.
    2. If no equivalent schemes are being delivered elsewhere in the system, then the scheme will be offboarded from the BCF. Move towards no part-funded schemes. This may mean evidencing more funding in the BCF than the nationally required NHS minimum, but it would be existing services already funded (and not previously identified as BCF-eligible).
- All schemes funded through the BCF must have suitable governance and performance management arrangements so as to tangibly evidence the impact of the scheme on local and national priorities/metrics.

3.5 The BCF project team have now completed this process, which has resulted in proposed changes to the Norfolk BCF Plan for 2025/26. The next section summarises these changes, ahead of formal approval for the Norfolk BCF Plan for 2025/26 which will be sought from the HWB in June 2025.

3.6 **Summary of changes:** The BCF project team has undertaken a line-by-line detailed assessment of each scheme within the core BCF. Building on the agreed approach outlined above, schemes have been reviewed against the following criteria, using an assessment form to document decision making:

- Does this scheme support one or more of the national BCF metrics?
- Does this scheme support one or more of the local priorities?
- Does this scheme enable integrated outcomes?
- Delivering at scale as part of strategic framework? Yes or Potentially?

3.7 If the answer to any question was 'No' then it was recommended that the scheme is no longer eligible for BCF funding.

3.8 Following the review, it was recommended that 39 schemes remain eligible for BCF funding. 19 schemes have been identified as no longer eligible. These schemes are listed in **Appendix 3**.

3.9 The results of the review were endorsed through the ICB and NCC's joint governance group, the Joint Social Care & Health Assurance Board, in October 2024, and supported by the ICB Executive Management Team on 2nd December 2024. Schemes that have been found to be ineligible will be offboarded from the BCF plan for 2025/26.

3.10 The 19 schemes to be offboarded come to a value of circa £3.5 million. The core BCF requires a minimum contribution, which for 2024/25 was set at £81,533,291 for Norfolk. So as not to present a cost pressure, existing services totalling circa £3.5 million will need to be brought into the BCF plan to offset the value of the schemes that have been offboarded.

3.11 As per the recommendations agreed by HWB in June, the approach taken to identify schemes that should be onboarded onto the BCF has been to prioritise (eligible) schemes within the current BCF plan that have equivalent services that are *not* drawing down BCF funding and to bring the funding for these services into the BCF so that the totality of that scheme "type" is included. The details about specific services to be brought into the BCF are being confirmed, but the focus is likely to be on the following areas:

3.11.1 **Prevention and Proactive Intervention** – NCC, working closely with District Councils, wider ICS partners and private technology enterprise, is developing and delivering a nationally innovative approach to how we move from a reactive to proactive approach to preventing, reducing and delaying health and care demand. Mobilising from July 2025, our "Proactive Intervention" programme will transform the way in which we engage with local people, moving at scale from reactive, formal support to proactive, targeted and preventative support. We are planning to bring the totality of the funding for this programme into the BCF, thereby enabling shared oversight over a critical priority and building on the HWB ambition to increase the focus on prevention within BCF planning.

3.11.2 **Urgent and Emergency Care** (UEC) – some of our key system UEC services are funded through the BCF (and the aligned BCF Additional Discharge Fund). However, there are instances of some UEC services within the BCF that are also partly funded from other budgets. To meet our ambition to fully fund key integrated services within the BCF, the ICB is proposing to onboard further contributions to the UEC response for 2025/26 This is with a view to developing a systemwide "UEC budget" containing all relevant expenditure within the BCF plan (including core, ADF and iBCF) for 2026-27.

3.12 To confirm, no new cost pressures will be introduced through this process. Rather, this is about removing services that are not eligible from the BCF and replacing them with services that are already funded (outside of the BCF) and are better aligned to local and national BCF priorities.

3.13 It is important to note that the remit of the BCF review has focused on whether schemes are eligible for BCF funding and should continue to form part of the Norfolk BCF plan in 2025.

3.14 No de-commissioning decisions have been made as part of the BCF review process. Where schemes have been found to be ineligible the lead commissioning organisation, i.e. Norfolk County Council or the ICB, is responsible for identifying an appropriate funding stream. The removal of BCF funding from a scheme does not in and of itself result in a cost pressure; rather it is a re-classification of how local services are funded across funding streams as described earlier.

3.15 **National BCF planning framework 2025/26:** The national BCF policy and planning guidance for 2025/26 was released 30th January 2025. The framework sets out a reasonably light-touch, 12-month funding agreement for 2025/26 and highlights the aspiration to move towards a multi-year settlement from 2027/28 that aligns to the forthcoming NHS 10 Year Plan. There are minor changes to the national conditions and metrics for 2025/26.

3.16 The four national conditions for 2025/26 are:

1. Jointly agreeing a plan; Local authorities and ICBs must agree a joint plan, signed off by the HWB, to support the policy objectives of the BCF for 2025 to 2026.
2. Implementing the objectives of the BCF; HWBs, through their joint plans, should deliver health and social care services that support improved outcomes against the fund's 2 principal policy objectives:
   - To support the shift from sickness to prevention.
   - To support people living independently and the shift from hospital to home.
3. Complying with grant conditions and BCF funding conditions – including maintaining the NHS minimum contribution to adult social care (see below)
4. Complying with oversight and support processes.

3.17 There are three headline metrics for 2025/26, which are:

1. Emergency admissions to hospital for people aged 65+ per 100,000 population. *This metric broadens the metric used for 2024/25 that focused on emergency admissions for ambulatory sensitive chronic conditions.*
2. Average length of discharge delay for all acute adult patients. *This is a new metric that will be derived from a combination of: proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD) for those adult patients not discharged on DRD, average number of days from DRD to discharge.*
3. Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population. *This is a continuation of a metric for 2024/25.*

3.18 Funding streams have also been consolidated for 2025/26. Specifically, the ADF, which was previously limited to supporting discharge schemes, has been un-ringfenced, although local areas are still expected to ensure a continued focus on UEC as part of their BCF planning.

3.19 The funding streams within the BCF for 2025/26 are as follows:

- Local Authority Better Care Grant – combining what used to be the iBCF and the Local Authority ADF allocation.
- NHS Minimum Contribution – now also including the ICB ADF Allocation.
- DFG – uplifted by **c24%** as against 2024/25 levels.

3.20 At a national level, overall allocations to the Better Care Fund NHS contribution have increased by £85m (**c1.7%**). Following a decision by the Secretary of State, NHS England have stated that this value should be used in full to increase the NHS minimum contribution to Adult Social Care. National guidance advises this amounts to an uplift of **c3.93%** for Adult Social Care against the 2024/25 values.

3.21 As part of planning for 2024/25, the increased pressure on NCC and the ICB led to challenging discussions in terms of how best to utilise the national uplift to the BCF. Specifically, the ICB identified an ambition to deliver £1.9m through re-allocation of funding within the BCF. Over the last 12 months, great progress has been made to reach a more collaborative approach, which has led to the ICB agreeing to draw a line under this ambition and instead focus on opportunities for the BCF to underpin transformation to improve outcomes for local people and communities whilst contributing to efficiencies for both partners. Given the clear guidance on use of the uplift in 2025/26, as outlined in paragraph 3.20, we do not anticipate any disagreements on this matter for 2025/26.

3.22 Further changes to the BCF will be confirmed as part of joint planning work with a view to submitting the final plan to HWB members for approval in June 2025.

Officer Contact

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

Name: Edward Fraser Tel: 01603 223122 Email: edward.fraser@norfolk.gov.uk

Better Care Fund 2024-25 Q3 Reporting Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE). Please also refer to the Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements which was published in April 2024. Links to all policy and planning documents can be found on the bottom of this guidance page.

As outlined within the BCF Addendum, quarterly BCF reporting will continue in 2024 to 2025, with areas required to set out progress on delivering their plans. This will include the collection of spend and activity data, including for the Discharge Fund, which will be reviewed alongside other local performance data.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund, including the Discharge Fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

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

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off by HWBs, or through a formal delegation to officials, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Please submit this template by 14 February 2025

Note on entering information into this template

Please do not copy and paste into the template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

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

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

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2024-25 will pre-populate in the relevant worksheets.

2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.

3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.

https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, an outline of the challenge and mitigating actions to support recovery should be outlined. It is recommended that the HWB also discussed this with their Regional Better Care Manager.

In summary, the four National conditions are as below:

National condition 1: Plans to be jointly agreed

National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer

National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time

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

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process outlined within 24/25 planning submissions.

This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.

Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2024-25 has been pre-populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at local authority level.

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

- On track to meet the ambition
- Not on track to meet the ambition
- Data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements. Please note columns M and N only apply where 'not on track' is selected.

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

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

5. Capacity & Demand Actual Activity

Please note this section asks for C&D and actual activity for total intermediate care and not just capacity funded by the BCF.

Activity
For reporting across 24/25 we are asking HWBs to complete their actual activity for the previous quarter. Actual activity is defined as capacity delivered.
For hospital discharge and community, this is found on sheet "5.2 C&D H1 Actual Activity".

5.1 C&D Guidance & Assumptions

Contains guidance notes as well as 4 questions seeking to address the assumptions used in the calculations, changes in the quarter, and any support needs particularly for managing winter demand and ongoing data issues.

5.2 C&D H1 Actual Activity

Please provide actual activity figures for this quarter, these include reporting on your spot purchased activity and also actuals on time to treat for each service/pathway within Hospital Discharge. Actual activity for community referrals are required in the table below.
Actual activity is defined as delivered capacity or demand that is met by available capacity. Please note that this applies to all commissioned services not just those funded by the BCF.

Expenditure

Please use this section to complete a summary of expenditure which includes all previous entered schemes from the plan.

The reporting template has been updated to allow for tracking spend over time, providing a summary of expenditure from all 3 quarters to date alongside percentage spend of total allocation.
Overspend - Where there is an indicated overspend please ensure that you have reviewed expenditure and ensured that a) spend is in line with grant conditions b) where funding source is grant funding that spend cannot go beyond spending 100% of the total allocation.
Underspend - Where grant funding is a source and scheme spend continues you will need to create a new line and allocate this to the appropriate funding line within your wider BCF allocation.
Please also note that Discharge Fund grant funding conditions do not allow for underspend and this will need to be fully accounted for within 24/25 financial year.

For guidance on completing the expenditure section on 23-25 revised scheme type please refer to the expenditure guidance on 6a.

Please use the Discontinue column to indicate if scheme is no longer being carried out in 24-25, i.e. no money has been spent and will be spent.

If you would like to amend a scheme, you can first 'discontinue' said scheme, then re-enter the scheme new data into the 'add new schemes' section.

Useful Links and Resources

Planning requirements
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

Policy Framework
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/2023-to-2025-better-care-fund-policy-framework

Addendum
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/addendum-to-the-2023-to-2025-better-care-fund-policy-framework-and-planning-requirements

Better Care Exchange
https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2Fbettercareexchange%2FgroupHome

Data pack
https://future.nhs.uk/bettercareexchange/view?objectId=116035109

Metrics dashboard
https://future.nhs.uk/bettercareexchange/view?objectId=51608880

HM Government

NHS England

Better Care Fund 2024-25 Q3 Reporting Template

2. Cover

Version 1.0

Please Note:

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

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

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

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

			Checklist Complete:
Health and Wellbeing Board:	Norfolk		Yes
Completed by:	Edward Fraser		Yes
E-mail:	edward.fraser@norfolk.gov.uk		Yes
Contact number:	01603 223122		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no, please indicate when the report is expected to be signed off:	Wed 05/03/2025	<< Please enter using the format, DD/MM/YYYY	Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.

Complete		
	Complete:	
2. Cover	Yes	For further guidance on requirements please refer back to guidance sheet - tab 1.
3. National Conditions	Yes	
4. Metrics	Yes	
5.1 C&D Guidance & Assumptions	Yes	
5.2 C&D H1 Actual Activity	Yes	
6b. Expenditure	Yes	

<< Link to the Guidance sheet

Better Care Fund 2024-25 Q3 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Norfolk

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	No	Yes
If it has not been signed off, please provide the date section 75 agreement expected to be signed off	28/02/2024	Yes
If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.	Norfolk County Council Cabinet approval given on 02/12/2024. Awaiting signatures and NCC official seal on document.	Yes

Confirmation of Nation Conditions

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

Better Care Fund 2024-25 Q3 Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Norfolk

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

Metric	Definition	For information - Your planned performance as reported in 2024-25 planning Q1	Q2	Q3	Q4	For information - actual performance for Q2 (For Q3 data,please refer to data pack on BCX)	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs *Please:* *- describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans* ***- ensure that if you have selected data not available to assess progress that this is addressed in this section of your plan***	Achievements - including where BCF funding is supporting improvements. *Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics*	Variance from plan *Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan*	Mitigation for recovery *Please ensure that this section is completed where a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan*	Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	186.5	168.5	195.8	189.0	148.3	On track to meet target	Urgent and emergency care pressures remain high in Norfolk and Waveney. The UCCH is already having a positive impact on improving the capacity of services across the system and will be monitored going into winter pressures.	UCCH enables ambulance and Urgent Care Response (UCR) resources to discuss cases on the stack as a multi-disciplinary team (MDT), and agree a timely plan to support the person using local UCR resources to address the crisis/avoid an admission. All UCR cases receive a follow-up welfare call and can be referred to other relevant support services. Focus is on winter preparation for care home residents and also on integrating Virtual Ward & UCCH including development of an overnight offer with the staff/teams already working overnight by co-locating and coordinating responses.	N/A - on track to meet target	NA - on track to meet target	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	93.3%	93.3%	93.3%	93.3%	93.4%	On track to meet target	Ensuring the care market is able to respond promptly to support hospital discharge has alway been a challenge, however we have addressed this through our NFS offer, and additional capacity available through our Caring for Better Outcomes (CfBO) service, who have supported over 465 people so far in 2024/25.	The Norfolk & Waveney Community Support Service offers short-term, temporary practical support for individuals and aims to link clients with services, groups and support networks in their community. Support can be for 2-12 weeks depending on the complexity needs. The service can support individuals with underlying needs (e.g. multiple health issues, cognitive concerns, poor mobility) and/or help them to adjust and adapt to alterations in their life - such as illness, injury, long term health conditions and issues that affect their mental, social, physical and emotional health and wellbeing. Community healthcare providers and therapy outreach teams from the acute support individuals discharged with healthcare needs to enable their rehabilitation. Individuals with longer term needs beyond the up to 6-week discharge pathway will be assessed under the Care Act and suitable ongoing support will be arranged e.g. a package of care. Where appropriate for the complexity of the individual's needs (e.g. someone living with dementia) and under the NCC Caring for	N/A - on track to meet target	NA - on track to meet target	Yes

Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	1,495.1	382.9	On track to meet target	There is a considerable focus on falls prevention and response across the system. There is work underway to ensure that the falls prevention and response pathways are aligned, robust and coherent and offer equity of outcome across the system. As the UCCH and the Virtual Ward models mature, and with support from ECIST (Emergency Care Improvement Support Team), it is hoped that the opportunities to improve the falls-response pathways will be identified - this may include the introduction of a single long-lie falls pathway and a pathway for fallers that have sustained a head injury whilst on blood thinners.	The ICS approach to falls prevention and reduction is now part of the Ageing Well Programme Prevention workstream. Proactive support being provided to care homes with a view to reducing falls / conveyance to hospital. NCC Public Health are finalising the Joint Strategic Needs Assessment for falls prevention – this will be an important evidential document to inform future commissioning and delivery. The report will be considered by the Ageing Well Programme Board with recommendations for future N&W approaches to Falls Prevention The Active NoW falls pathway continues to embed well in our commissioned offer.	N/A - on track to meet target	NA - on track to meet target	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	531	not applicable	Not on track to meet target	There have been significant numbers of transitions from short term bed use, especially related to hospital discharge, which are converting to long term placement. Our growing elderly population, combined with increasing complexity of need, remains a challenge despite the focus and initiatives aimed at supporting people in their own homes.	The BCF includes some of our system's key Promoting Independence services, aiming to enable people to live safe and well in their own homes. This includes, for example, our Integrated Community Equipment Service (ICES), which was re-commissioned in 2023 and has seen increased volumes of people supported over 2023-24 and 2024-25.	New permanent residential placements in the 9 months to Dec 24, multiplied up to 12 months with population estimates applied shows an annual figure of 616. Variance from plan is largely attributed to a high conversion from short term bed usage into long term residential placements during the year.	We note that there are national challenges with this metric. At a local level, using BCF and ADF funding we have piloted a number of successful service innovations this year. This includes, for example, embedding additional OT resource within our health and social care pathways to maximise the use of equipment and adaptations to enable people to live independently at home. Our BCF plan for 2025-26 will support these intiatives to be scaled up further, which we believe will have a positive impact on the rate of permanent admissions to residential care in Norfolk.	Yes

Better Care Fund 2024-25 Q3 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Norfolk

5.1 Assumptions

	Checklist
1. How have your estimates for capacity and demand changed since the last reporting period? Please describe how you are building on your learning across the year where any changes were needed.	
Actual activity levels remain slightly higher than originally profiled. The surge in winter pressures was experienced earlier than usual this year but the plans we described in our previous submission have resulted in additional capacity to meet this demand. This has included, for example, expansion of our Caring for Better Outcomes model by 25-50%, through which home support providers are providing dedicated reablement capacity alongside our in house reablement service.	Yes
2. Do you have any capacity concerns for Q4? Please consider both your community capacity and hospital discharge capacity.	
Generally speaking, we feel we have sufficient capacity in place across various services to meet demand. However, we recognise further work is required to reduce LOS within our local hospitals by ensuring available capacity is easily accessible and suited to meet the specific needs of local people. Operational work programmes to maximise the effectiveness of existing resources through changes to policy/process will continue to form the basis of our strategic priorities for 2025-26.	Yes
3. Where actual demand exceeds capacity, what is your approach to ensuring that people are supported to avoid admission or to enable discharge? Please describe how this improves on your approach for the last reporting period.	
Arrangements are in place to access care and support on a spot basis, where demand exceeds capacity. However, we recognise this is not ideal in most cases. Enabled by ADF funding, our strategic focus is to scale up commissioned intermediate care capacity, which has led to a reduction in the use of spot purchasing over the year to date. For example, through expansion of reablement we have reduced the % of spot placements used for Pathway 1 discharges from 8.8% in April to 4.8% in December. We have experienced some delays in bringing online newly commissioned Pathway 2 provision, which explains ongoing usage of spot arrangements in these cases. However, plans are in place for this capacity to come online over Q4.	Yes
4. Do you have any specific support needs to raise for Q4? Please consider any priorities for planning readiness for 25/26.	
Demand and capacity modelling for 2025-26 is now in progress, using learning from the process completed in 2024-25. This will be completed alongside and in tandem with the NHS operational planning returns. As part of this process, specific challenges and opportunities will be identified for progression through our three local Urgent and Emergency Care Systems aligned to the three acute hospitals. As part of this we will be renewing our focus on pathways to support admission avoidance and community step up.	Yes

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

5.1 Guidance

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

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

- Actual demand in the first 9 months of the year
- Modelling and agreed changes to services as part of Winter planning
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

Hospital Discharge

This section collects actual activity of services to support people being discharged from acute hospital. You should input the actual activity to support discharge across these different service types and this applies to all commissioned services not just those from the BCF.

- Reablement & Rehabilitation at home (pathway 1)

- Short term domiciliary care (pathway 1)

- Reablement & Rehabilitation in a bedded setting (pathway 2)

- Other short term bedded care (pathway 2)

- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

Community

This section collects actual activity for community services. You should input the actual activity across health and social care for different service types. This should cover all intermediate care services to support recovery, including Urgent Community Response and VCS support and this applies to all commissioned services not just those from the BCF. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Better Care Fund 2024-25 Q3 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Norfolk

Actual activity - Hospital Discharge		Prepopulated demand from 2024-25 plan			Actual activity (not including spot purchased capacity)			Actual activity through only spot purchasing (doesn't apply to time to service)			Checklist Complete:
Service Area	**Metric**	**Oct-24**	**Nov-24**	**Dec-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Oct-24**	**Nov-24**	**Dec-24**	
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	570	640	623	639	691	636	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	3	3	3	3	3	3				Yes
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	0	0	0	0	0	0	32	37	32	Yes
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	7	7	7	7	7	7				Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	233	250	238	231	217	231	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	15	15	15	15	15	15				Yes
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	0	0	0	0	0	0	43	34	20	Yes
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	15	15	15	15	15	15				Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	101	110	102	0	0	0	101	119	109	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	15	15	15	15	15	15				Yes

Actual activity - Community		Prepopulated demand from 2024-25 plan			Actual activity:			
Service Area	**Metric**	**Oct-24**	**Nov-24**	**Dec-24**	**Oct-24**	**Nov-24**	**Dec-24**	
Social support (including VCS)	Monthly activity. Number of new clients.	103	103	103	216	220	192	Yes
Urgent Community Response	Monthly activity. Number of new clients.	3074	3119	3107	3244	2878	2998	Yes
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	1317	1405	1368	439	409	348	Yes
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	9	9	20	9	9	20	Yes
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	0	0	0	Yes

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The ten changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.

15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care or Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed based intermediate Care Services	Number of placements
Home-based intermediate care services	Packages
Residential Placements	Number of beds
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2024-25 Q3 Reporting Template

To Add New Schemes

6. Expenditure

Selected Health and Wellbeing Board: Norfolk

	2024-25			
Running Balances	Income	Expenditure to date	Percentage spent	Balance
DFG	£9,988,855	£9,988,855	100.00%	£0
Minimum NHS Contribution	£81,533,291	£61,334,508	75.23%	£20,198,783
iBCF	£39,618,564	£29,713,923	75.00%	£9,904,641
Additional LA Contribution	£0	£0		£0
Additional NHS Contribution	£0	£0		£0
Local Authority Discharge Funding	£9,257,435	£6,814,512	73.61%	£2,442,923
ICB Discharge Funding	£8,340,076	£6,102,057	73.17%	£2,238,019
Total	**£148,738,221**	**£113,953,855**	**76.61%**	**£34,784,366**

Comments if income changed

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2024-25		
	Minimum Required Spend	Expenditure to date	Balance
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£23,124,650	£29,325,882	£0
Adult Social Care services spend from the minimum ICB allocations	£40,243,713	£41,254,641	£0

Checklist Column complete: Yes Yes

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Planned Outputs for 2024-25**	Outputs delivered to date (Number or NA if no plan)	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Previously entered Expenditure for 2024-25 (£)	Expenditure to date (£)	Discontinue (if scheme is no longer being carried out in 24-25, i.e. no money has been spent and will be spent)	Comments
1	Norfolk Advice Network and Advocacy	Provider: Age UK, Equal Lives. To provide a single point of contact for	Integrated Care Planning and Navigation	Care navigation and planning			NA		Social Care	0	Joint	0.12	0.88	Charity / Voluntary Sector	Minimum NHS Contribution	£ 262,571	£185,639		
2	A Social Impact Bond for Carers	Provider: Carers Matter Norfolk To support carers to	Carers Services	Carer advice and support related to Care Act duties		2244	2372	Beneficiaries	Social Care	0	Joint	0.12	0.88	Private Sector	Minimum NHS Contribution	£ 1,496,906	£1,389,209		
76	DOLS	Deprivation of Living Safeguards	Care Act Implementation Related Duties	Other	Deprivation of Living Safeguards		NA		Social Care	0	lA			Local Authority	iBCF	£ 248,000	£186,000		
9	ICES (Integrated Community Equipment	Provider: Medequip Provides equipment to aid independence at home.	Assistive Technologies and Equipment	Community based equipment		39322	32478	Number of beneficiaries	Social Care	0	Joint	0.92	0.08	Private Sector	Minimum NHS Contribution	£ 7,777,996	£6,418,368		
10	Integrated Care Coordinators	Provider: Norfolk County Council. ICC roles work with health and social care	Integrated Care Planning and Navigation	Care navigation and planning			NA		Primary Care	0	Joint	0.89	0.11	Local Authority	Minimum NHS Contribution	£ 656,367	£486,834		
20	Norfolk First Response	Provider: Norfolk County Council. Reablement Services offering six weeks	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		6827	6567	Packages	Social Care	0	Joint	0.122	0.878	Local Authority	Minimum NHS Contribution	£ 10,821,868	£8,044,846		
21	Rapid Response (part of Swifts and Nightowls)	Provider: Norfolk County Council rapid response service for people with short	Urgent Community Response				NA		Social Care	0	Joint	0.25	0.75	Local Authority	Minimum NHS Contribution	£ 1,700,598	£1,084,590		
56	District Direct	Provider: District and Borough Councils. Ensures District Council	High Impact Change Model for Managing Transfer of Care	Housing and related services			NA		Acute	0	Joint	0.00305	0.99695	Local Authority	Minimum NHS Contribution	£ 162,400	£117,780		
60	Out of hosptial / Short Term offer	Bed based short term offer and hospital social work teams	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as			NA		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 8,197,927	£6,148,445		
61	Brokerage	Brokerage Team Staff - increased capacity to support placements out of	Enablers for Integration	Joint commissioning infrastructure			NA		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 34,826	£26,120		
62	Social Care and Health Partnership	Joint Commissioning Team across NCC and the ICB	Enablers for Integration	Joint commissioning infrastructure			NA		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 261,192	£195,894		
63	Integrated Quality Team	Joint Quality Team across NCC and the ICB	Enablers for Integration	Joint commissioning infrastructure			NA		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 272,075	£204,056		
64	LD, MH and Autism Packages of Care	Care services for people with LD, MH and Autism	Home Care or Domiciliary Care	Domiciliary care packages		138610	103491	Hours of care (Unless short-term in which case it is packages)	Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 3,532,499	£2,649,374		
65	BCF Health and Wellbeing Partnership Funds	Provider: Norfolk's Health and Wellbeing Partnerships. To support place based	Enablers for Integration	Joint commissioning infrastructure			NA		Social Care	0	LA			Private Sector	Minimum NHS Contribution	£ 643,248	£482,436		

67	Disabled Facilities Grant	Spend on DFG's by our district and borough councils	DFG Related Schemes	Adaptations, including statutory DFG grants		1500	1125	Number of adaptations funded/people supported	Social Care	0	LA			Local Authority	DFG	£ 9,988,855	£9,988,855		
70	ASC Core Care Services (underlying spend	Covering market pressures	Home Care or Domiciliary Care	Domiciliary care packages		602155	451616	Hours of care (Unless short-term in which case it is packages)	Social Care	0	LA			Private Sector	iBCF	£ 14,524,000	£10,893,000		
77	Enhancement to Social Care Capacity 2018	Additional Social Work Capacity	Care Act Implementation Related Duties	Other	Additional Social Work		NA		Social Care	0	LA			Local Authority	iBCF	£ 2,640,000	£1,980,000		
81	The Old Maltings service provision	Housing with Care service	Housing Related Schemes				NA		Social Care	0	IA			Private Sector	iBCF	£ 179,000	£134,250		
82	Practice Educator Lead	Practice Educator Lead to support good practice.	Enablers for Integration	Workforce development			NA		Social Care	0	IA			Local Authority	iBCF	£ 54,000	£40,500		
84	Technology for agile working	Support agile working for SW Teams	Enablers for Integration	Workforce development			NA		Social Care	0	IA			Local Authority	iBCF	£ 34,000	£25,500		
85	Winter Pressures Project Support	Coordinating Winter Planning for ASC	Enablers for Integration	Programme management			NA		Social Care	0	IA			Local Authority	iBCF	£ 51,000	£38,250		
38	Eating Matters	Eating Matters provides counselling in the community for people	Prevention / Early Intervention	Risk Stratification			NA		Community Health	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 161,288	£115,173		
40	West Norfolk Carers Project	Independent charity supporting unpaid family carers and providing a	Carers Services	Other	Information, advice and guidance	164	155	Beneficiaries	Social Care	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 20,334	£23,520		
43	Wellfamily Services (West Norfolk)	Well Family is a one-stop health and wellbeing service comprising a suite of health-	Prevention / Early Intervention	Risk Stratification			NA		Community Health	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 84,693	£58,830		
44	St. Martin's Hub	Provides emergency accommodation and support for rough sleepers in	Housing Related Schemes				NA		Mental Health	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 69,298	£49,043		
45	West Norfolk Disability Information	Provides a range of information and support to individuals with disabilities,	Integrated Care Planning and Navigation	Care navigation and planning			NA		Social Care	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 14,698	£9,935		
46	GP / Medical cover - Int Care Beds (West	GP medical cover to bed-based intermediate care services to help people	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as	Medical cover for IC beds		NA		Primary Care	0	NHS			Private Sector	Minimum NHS Contribution	£ 21,306	£45,330		
48	Transport Plus	Provides transport to enable access to health, social care and wellbeing services using	Community Based Schemes	Other	Transport		NA		Other	0	NHS			Local Authority	Minimum NHS Contribution	£ 41,383	£29,375		
49	West Norfolk Community Action Norfolk	CAN is the leading organisation for engagement with the voluntary,	Enablers for Integration	Voluntary Sector Business Development			NA		Primary Care	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 44,377	£31,091		
50	West Norfolk Community Transport	Provides day to day management of a bank of drivers, including	Community Based Schemes	Other	Transport		NA		Other	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 28,861	£19,743		
79	MH Capacity (evolve and practitioners)	MH Capacity	Care Act Implementation Related Duties	Other	MH Capacity		NA		Social Care	0	LA			Local Authority	iBCF	£ 235,000	£176,250		
82	Home Support Enhanced Discharge	Increased rate for Home Care Providers and additional reabling home	Home Care or Domiciliary Care	Short term domiciliary care (without reablement input)		380	502	Hours of care (Unless short-term in which case it is packages)	Social Care	0	LA			Private Sector	Local Authority Discharge	£ 1,988,000	£2,007,315		
83	Evolve - Discharge Supported Living Scheme	Mental Health - 6 units for discharge	Housing Related Schemes				NA		Social Care	0	LA			Private Sector	Local Authority Discharge	£ 114,423	£85,817		
84	Provider: CAB and Carers Matters Norfolk: Carers	Advice and support services for carers	Carers Services	Carer advice and support related to Care Act duties		520	433	Beneficiaries	Social Care	0	LA			Charity / Voluntary Sector	Local Authority Discharge	£ 35,000	£0		
86	Provider NCC: staffing costs to administer ADF	Costs associated with distributing / reporting on the funding (1%)	Enablers for Integration	Programme management			NA		Social Care	0	LA			Local Authority	Local Authority Discharge	£ 34,822	£26,117		
87	Discharge Hubs	To facilitate the Discharge Process	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge			NA		Social Care	0	LA			Local Authority	Local Authority Discharge	£ 1,200,000	£900,000		
4	Dementia / Alzheimer's Support Service	DSS is a three tier step-up / down system providing: Information, Advice &	Integrated Care Planning and Navigation	Care navigation and planning		0	NA		Mental Health	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 1,317,116	£943,977		
7	HomeWard (Norwich)	HomeWard provides urgent short term care, nursing and therapy support. The MDT	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		24	18	Packages	Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	£ 1,679,786	£1,285,974		
90	Independent Mental Health Advocacy and	Independent Mental Health Advocacy and Independent Mental Capacity Advocate	Integrated Care Planning and Navigation	Care navigation and planning			NA		Social Care	0	LA			Charity / Voluntary Sector	Minimum NHS Contribution	£ 907,662	£680,747		
37	Social Prescribing	A community wellbeing service that focus' on improving wellbeing. A free	Prevention / Early Intervention	Social Prescribing			NA		Social Care	0	NHS			Private Sector	Minimum NHS Contribution	£ 2,321,816	£1,638,617		
11	Intermediate Spot Purchase Beds	Accomodation based commissioning.	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		306	234	Number of placements	Community Health	0	NHS			Private Sector	Minimum NHS Contribution	£ 1,940,830	£1,194,669		
13	Community Access Team (CAT)	CAT manages transfers of care into NCHC's intermediate care units for	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge			NA		Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	£ 1,121,191	£858,337		
14	Medical Loans Service	Provider: British Red Cross. Short term loans of equipment to aid	Assistive Technologies and Equipment	Community based equipment		4861	3663	Number of beneficiaries	Community Health	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 144,791	£108,561		

16	Norfolk Medicines Support Service (NMSS)	NMSS supports vulnerable individuals with practical, user-friendly solutions to	Personalised Care at Home	Physical health/wellbeing			NA		Community Health	0	NHS			Local Authority	Minimum NHS Contribution	£ 326,035	£249,942		
17	Equal Lives	A disability rights organisation supporting people to empower	Integrated Care Planning and Navigation	Care navigation and planning			NA		Social Care	0	NHS			Local Authority	Minimum NHS Contribution	£ 160,520	£113,941		
51	Learning Disability Beds	Accomodation-based CHC commissioning. Difficult to calculate give the varied	Residential Placements	Learning Disability		0	0	Number of beds	Community Health	0	NHS			Private Sector	Minimum NHS Contribution	£ 626,209	£472,057		
52	Q1 beds	Intermediate pathway beds with various private providers during the spring	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		52	414	Number of placements	Community Health	0	NHS			Private Sector	ICB Discharge Funding	£ 2,968,775	£3,494,872		The ICB is spending further in Norfolk and Waveney for P2 beds and MDT support which explains why the cost is higher than
53	Home First Hubs	Locality Priority Schemes with NCH&C & NCC	High Impact Change Model for Managing Transfer of Care	Other	Hub staffing	0	NA		Community Health	0	NHS			Local Authority	ICB Discharge Funding	£ 3,588,659	£2,025,020		Central locality expenditure phasing is expected to increase during the winter period
54	Bridging the Gap	Reablement in a Person's Own Home. Service models are being developed and	Home Care or Domiciliary Care	Domiciliary care packages		0	NA	Hours of care (Unless short-term in which case it is packages)	Community Health	0	NHS			NHS	ICB Discharge Funding	£ 1,782,642	£582,165		This scheme is forecasted to be underspent, ICB to invest more into P2 beds. Please see BCF scheme 52.
26	Neuro Cardiac & Pulmonary Support Services	Specialist community nurses providing neurological, cardiac & pulmonary support	Personalised Care at Home	Physical health/wellbeing			NA		Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	£ 547,766	£419,347		
27	Specialist Nursing Teams	Specialist Nursing Teams to support people in the community	Personalised Care at Home	Physical health/wellbeing			NA		Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	£ 552,592	£423,041		
29	Norfolk and Norwich SEND (Special	The Special Educational Needs and Disabilities (SEND) Support scheme	Prevention / Early Intervention	Risk Stratification			NA		Community Health	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 17,539	£12,278		
30	Norfolk Deaf Association	Norfolk Deaf Association (NDA) delivers community-based support to individuals	Prevention / Early Intervention	Risk Stratification			NA		Community Health	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 275,760	£270,689		
31	Community Stroke Support (West)	Provides a range of community stroke support services in the West:	Prevention / Early Intervention	Risk Stratification			NA		Community Health	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 132,041	£91,878		
32	Together	Service for people with serious mental health problems provided by	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as			NA		Mental Health	0	NHS			Local Authority	Minimum NHS Contribution	£ 422,177	£296,139		
34	Discharge Practitioner Services	Funding of practitioners to support multi-agency discharge teams.	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge			NA		Social Care	0	NHS			Local Authority	Minimum NHS Contribution	£ 135,555	£55,039		
1901	Norfolk Hospice Tapping House (NHTH) - West	Specialist palliative and end of life care provider for people living with life-	Community Based Schemes	Other	Hospice care, community outreach and	0	NA		Other	0	NHS	0		Charity / Voluntary Sector	Minimum NHS Contribution	£ 788,985	£507,540		
1902	Swaffham & Litcham Home Hospice (social	Swaffham & Litcham Home Hospice is a non-medical organisation giving free	Community Based Schemes	Other	Palliative and end of life wellbeing and	0	NA		Other	0	NHS	0		Charity / Voluntary Sector	Minimum NHS Contribution	£ 86,024	£40,997		
39	Acute Psychiatric Liaison QEH and JPUH - East	The Acute Psychiatric Liaison service works with individuals with mental	Prevention / Early Intervention	Risk Stratification	0	0	NA		Mental Health	0	NHS	0		Charity / Voluntary Sector	Minimum NHS Contribution	£ 155,770	£116,651		
4201	Nursing support for Glaven Day Centre	This scheme provides funds for a nurse on site at Glaven Day Centre (North Norfolk)	Prevention / Early Intervention	Risk Stratification	0	0	NA		Community Health	0	NHS	0		Private Sector	Minimum NHS Contribution	£ 64,921	£8,237		Planned spend swapped with 4202 - should be £11,803
4202	Complex Community Support Outreach	Community outreach service for individuals living with complex health/social care	Community Based Schemes	Other	Outreach support for individuals with	0	NA		Other	0	NHS	0		Charity / Voluntary Sector	Minimum NHS Contribution	£ 11,803	45583		Planned spend swapped with 4201 - should be £64,921
4701	ASD / ADHD / Asperger's Pre-Diagnostic	The ASD & ADHD pre-diagnostic support service offers assistance for the	Prevention / Early Intervention	Risk Stratification	0	0	NA		Other	0	NHS	0		Charity / Voluntary Sector	Minimum NHS Contribution	£ 215,257	£147,270		
4702	Autism Service (Norfolk)	The Autism Service in Norfolk provides pre-assessment support,	Prevention / Early Intervention	Risk Stratification	0	0	NA		Community Health	0	NHS	0		NHS Community Provider	Minimum NHS Contribution	£ 109,391	£78,114		
301	Community Nursing and Therapy (CN&T) -	Community nurses, therapists and clinical support staff provide	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as	0	0	NA		Community Health	0	NHS	0		NHS Community Provider	Minimum NHS Contribution	£ 8,686,818	£6,650,266		
302	Community Nursing and Therapy (CN&T) -	Community nurses, therapists and clinical support staff provide	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as	0	0	NA		Community Health	0	NHS	0		NHS Community Provider	Minimum NHS Contribution	£ 2,838,976	£2,161,165		
3601	SOS Bus - Kings Lynn	The SOS bus is a first point of contact, support and first aid for people experiencing	Prevention / Early Intervention	Risk Stratification	0	0	NA		Other	0	NHS	0		Charity / Voluntary Sector	Minimum NHS Contribution	£ 41,577	£28,107		
3602	Late Night Safe Space - Norwich	The Norwich SOS Bus provides a safe space for people socialising in Norwich	Prevention / Early Intervention	Risk Stratification	0	0	NA		Other	0	NHS	0		Charity / Voluntary Sector	Minimum NHS Contribution	£ 89,675	£51,705		
8	West Norfolk Rapid Assessment and Frailty Team	The Rapid Assessment and Frailty Team (RAFT) at the Queen Elizabeth hospital	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	NA		Community Health	0	NHS	0		NHS Community Provider	Minimum NHS Contribution	£ 2,133,629	£1,633,418		
35	Social care and ICC support to 3x mid Norfolk GP	The provision of social care and ICC resources to support mid Norfolk 3x GP Practices	Prevention / Early Intervention	Risk Stratification	0	0	NA		Primary Care	0	NHS	0		Local Authority	Minimum NHS Contribution	£ 147,122	£118,700		
24	Weight Management Scheme - Tier 3	Tier 3 Weight Management scheme to support people at risk of further health	Prevention / Early Intervention	Risk Stratification	0	0	NA		Community Health	0	NHS	0		NHS	Minimum NHS Contribution	£ 531,874	£439,824		
33	Central Norfolk NEAT	Central Norfolk NEAT is a multi-agency, multi-disciplinary single point of	Integrated Care Planning and Navigation	Assessment teams/joint assessment	0	0	NA		Other	0	NHS	0		NHS Community Provider	Minimum NHS Contribution	£ 682,367	£517,785		
91	Norfolk & Waveney Community	The scheme offers short term support for people on leaving hospital or in the	Community Based Schemes	Other	Simple discharge and community support to avoid	0	NA		Social Care	0	Joint	0.83	0.17	Charity / Voluntary Sector	Minimum NHS Contribution	£ 494,460	£265,567		

5	Great Yarmouth Community Hub	The community Hub supports a multi-agency approach with 20+ system	Integrated Care Planning and Navigation	Care navigation and planning	0	0	NA		Social Care	0	NHS	0		Local Authority	Minimum NHS Contribution	£ 13,313	£9,375		
92	Caring for Better Outcomes	NCC Home support framework, aims to increase reablement capacity to	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess	0	380	465	Hours of care (Unless short-term in which case it is packages)	Social Care	0	LA	0		Local Authority	Minimum NHS Contribution	£ 1,293,278	£969,959		
6401	LD, MH & Autism Packages of care	Care services for people with LD, MH & Autism. Number of placements dependent on	Residential Placements	Other	MH, LD & Autism residential care	14728 bed weeks	9078	Number of beds	Social Care	0	LA	0		Private Sector	Minimum NHS Contribution	£ 14,211,952	£10,658,964		
8901	Community Based Support	Community and VCSE support for Hospital Discharge and Admission	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess	0	0	NA		Social Care	0	LA	0		Charity / Voluntary Sector	Local Authority Discharge	£ 497,755	£293,613		
8902	Expanded Reablement Capacity	Additional reablement capacity to support people with complex needs,	Home-based intermediate care services	Reablement at home (to support discharge)	0	400	300	Packages	Social Care	0	LA	0		Local Authority	Local Authority Discharge	£ 1,829,000	£938,971		
8701	Social Care Worker Resource	Additional social worker resource to support D2A process including within	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning	0	0	NA		Social Care	0	LA	0		Local Authority	Local Authority Discharge	£ 1,032,000	£668,179		
88	Workforce retention	Home Care rate increase to support providers in their retention work	Workforce recruitment and retention	Improve retention of existing workforce	0	0	NA	WTE's gained	Social Care	0	LA	0		Local Authority	Local Authority Discharge	£ 2,376,435	£1,782,000		
7001	ASC Core Care Services (underlying spend	Covering market pressures	Residential Placements	Other	Covering Market Pressures	245	245	Number of beds	Social Care	0	LA	0		Private Sector	iBCF	£ 21,586,564	£16,189,923		The number of beds have not increased through the year. The funding is for the same 245 beds for the second half of the
7901	Autism Diagnostic Service	Contribution to service which assess for autism and its short term support	Care Act Implementation Related Duties	Other	Autism support	0	NA		Social Care	0	LA	0		Local Authority	iBCF	£ 67,000	£50,250		
9101	Norfolk & Waveney Community	The scheme offers short term support for people on leaving hospital or in the	Community Based Schemes	Other	Simple discharge and community support to avoid	0	NA		Social Care	0	LA	0		Charity / Voluntary Sector	Local Authority Discharge	£ 150,000	£112,500		

Norfolk Health and Wellbeing Board

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

Date of meeting: 12 June 2024

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

Reason for the Report

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

Report summary

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

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

The following key findings emerged from the review:

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

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

Recommendations

The HWB is asked to:

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

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

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

1. Background

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

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

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

2. Findings from the Review

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Next steps

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

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

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

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

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

Officer Contact

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

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Summary of schemes recommended as no longer eligible

Appendix 3

Improving lives together
Norfolk and Waveney Integrated Care System

BCF Scheme ID / Eligibility Criteria	5	24	30	31	35	37	40	43	44	45	48	49	50	62	63	3601	3602	4201	4202
Q1) Supporting national BCF metrics?	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	Yes	Yes	Yes	Yes
Q2) Supporting local priorities?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Q3) Enabling integrated outcomes?	Yes	No	Yes	Yes	Yes	No*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Q4) Delivering at scale as part of strategic framework? a) Currently b) Potentially	No	Yes b)	Yes b)	No	No	Yes a)	No	No	No	No	Yes a)	No	Yes b)	Yes a)	Yes a)	No	No	No	No
ELIGIBILITY	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Contract Expiring	No	No	Q4 2425	Q4 2425	No	No	Q4 2425	Q4 2425	No	Q4 2425	No	Q4 2425	Q4 2425	No	No	Q4 2425	Q4 2425	Q4 2425	Q4 2425

BCF Scheme Names

5 – Community Hub	40 – Carers service	62 – Social Care and Health Partnership Commissioning
24 –Weight Management	43 – Well Family Service	63 – Integrated Quality Team
30 – Hearing Support	44 – Complex Mental Health	3601 – Nighttime Safe Space
31 – Stroke Recovery	45 – Disability Info Service	3602 – Nighttime Safe Space
35 – Community and Primary Care	48 – Community Transport	4201 – Complex Outreach
37 – Social Prescribing	49 - Community Action	4202 – Day Centre
	50 – Community Transport	

Decision Criteria

Yes – BCF eligible	If Q1) to 3) = "Yes"; Q4) = "Yes a) Currently" or "Yes b) Potentially"
No	If any of Q1) to 4) = "No"

***Note:** Whilst social prescribers do contribute to integrated outcomes, roles are aligned directly to PCNs as part of the ARS initiative. In this way, the recommendation is to remove from the BCF because it is difficult to set KPIs and there is limited scope for joint strategic oversight.

Norfolk Health and Wellbeing Board

Item No: 9

Report title: Norfolk and Waveney Joint Forward Plan update

Date of meeting: 05 March 2025

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

Reason for the Report

This report sets out the proposed approach to the 2025/26 limited refresh of the Norfolk & Waveney Joint Forward Plan (JFP). The JFP is a rolling five-year plan and must describe how the Integrated Care Board (ICB) proposes to implement relevant joint local health and wellbeing strategies. Go to www.improvinglivesnw.org.uk to view the current Norfolk and Waveney 5 year JFP.

The Norfolk Health and Wellbeing Board (HWB) has provided a published opinion in the previous two JFP's, and this should be repeated each time the JFP is refreshed. The Guidance for 2025/26 sets an expectation that ICB's and Trusts perform a limited refresh of existing plans before April 2025 (not June as in previous years), given the anticipated publication of the 10-year health plan in the spring of 2025. After that, there will be a more extensive revision of JFP's aligned to wider reform of nationally co-ordinated NHS planning resources. Go to www.england.nhs.uk to read the current JFP Guidance from NHS England.

Report summary

This report briefly sets out the approach being taken to refresh the 2025/26 JFP and requests an opinion from the Norfolk Health and Wellbeing Board. The equivalent report is being taken to the Suffolk HWB on 6 March 2025 as a joint report with Suffolk & North-East Essex ICB for the Waveney component of the JFP. The timelines for producing the report to this Board are in advance of when the final JFP is available so it is acknowledged that the opinion will be based on the refresh approach outlined in this paper.

Recommendations

The HWB is asked to:

a) Consider the approach being taken to refresh the 2025/26 – 2029/30 JFP for Norfolk & Waveney and whether it takes proper account of the Integrated Care Strategy for Norfolk and Waveney / Joint Health and Wellbeing Strategy for Norfolk.
b) To agree a statement of opinion on behalf of the Norfolk Health and Wellbeing Board for inclusion in the 2025/26 – 2029/30 JFP.

1. Background

1.1 The HWB received a report on 12 June 2024 in relation to the 2024/25 – 2028/29 JFP which was a combined report describing the good progress made against the Norfolk and Waveney Integrated Care Strategy.

1.2 The 2025/26 year within the refreshed JFP must be consistent with the Operational Planning requirements for the same year, where the expectations are set out for achieving standards in relation to the main health care requirements, productivity improvement and financial balance. Go to www.england.nhs.uk to read the current operational planning guidance for 2025/2026.

1.3 The new 10-Year Health Plan for the NHS is expected to be published during spring 2025 following a period of national public engagement. ICB's have therefore been advised to undertake a limited refresh only of their JFP and acknowledge the three shifts being socialised by the government: From hospital to community, b) From analogue to digital, c) From sickness to prevention.

2. 2025/26 – 2029/30 JFP refresh approach

2.1 Within the context set out above, the system has set out to undertake a limited refresh of the JFP as follows:

2.2 Retain the Part 1 and Part 2 format. Part 1 contains the detail on Why, When and How, Part 2 covers the ICB's Legal Duties.

2.3 Retain the same 8 Ambitions, which as a reminder are:

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

2.4 Review the 21 Objectives underneath the eight Ambitions and if possible, bring out a clearer focus on health inequalities, research, innovation and the productivity challenge.

2.5 Build on progress made in the two previous years, go to www.improvinglivesnw.org.uk to read the progress reports for year one and for year two.

2.6 Introduce the three shifts referred to in 1.3 and reinforce the role of ICS Strategies as enablers, which includes both the Norfolk and the Suffolk Health and Wellbeing Strategy(s).

2.7 Refer to the New Hospital Programme and the two new hospitals being built at two of our NHS Trusts: James Paget University Hospitals NHS Foundation Trust and the Queen Elizabeth Hospital NHS Foundation Trust in King's Lynn, and collaboration more broadly with all our system partners.

2.8 Include the additional services delegated to the ICB by NHS England in 2024/25 and 2025/26.

2.9 Showcase our system work through some refreshed Case Studies.

2.10 Update Part 2 ICB Legal Duties to reflect statutory changes during 2024/25.

Officer Contact
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Name: Liz Joyce Tel: 07866 063026 Email: liz.joyce2@nhs.net

Report title: Driving Integration Through Digital, Data and Technology

Date of meeting: 05 March 2025

Sponsor (ICP member): Ian Wake, Executive Director of Adult Social Services, Norfolk County Council
Tracey Bleakley, Chief Executive, Norfolk and Waveney Integrated Care Board

Reason for the Report

This paper is to provide an update on how we continue to work collaboratively as a system and some of the progress that has been made since our last update in December. It also includes a deeper dive into our approach to using Artificial Intelligence.

Report summary

This report provides an update on the digital overview across the system, how we are progressing Artificial Intelligence together and the proposed area that we will cover in June.

Recommendations

The ICP is asked to:

a) Note the updates on the progress taken around the collaboration as a system and raise any potential gaps or priorities to further inform the plan.
b) Review, comment, and advise on our approach to Artificial Intelligence.
c) Review, comment and advise on the proposed forward plan.

1. Background

1.1 This paper is brought to the ICP to update on how we are working collaboratively as a system to enable data sharing and what we are doing to drive integration through our digital, data and technology systems (DDaT). The report provides a detailed update on the Norfolk and Waveney Shared Care Record and suggestions we can cover at future meetings.

2. Update on the Digital Overview

2.1 The final phase of the cloud telephony project for GP Practices will complete in January 2025 and this will see the technology live in all practices, 86 of these have been funded by the NHS England programme.

2.2 Cloud telephony has been installed in the majority of GP Practices in Norfolk & Waveney, giving the opportunity for patients to opt for a call back from the practice rather than waiting in a queue. Practices have more lines and more reporting via dashboards, so they can see call volumes, numbers waiting and other information that allows them to manage their staff resources.

2.3 Wi-Fi is now switched on in 37 practices as at mid-January 2025, with roll out to a further 10 practices planned each week. This is having a positive impact straight away, with visiting clinicians such as Paramedics and Mental Health workers connecting automatically using Govroam.

2.4 The first stage of the ICS wide intranet, Connect Now, went live as planned and is now available to GP Practices, Pharmacies, Optometrists and Dentists, and in Care Homes. Pages and information available on the intranet is growing and plans are in place to roll it out to further partners to support the Shared Care Record and Joy deployments as well as some digital workstreams.

2.5 The first go live of Joy, the social prescribing platform, is on track for 5th February 2025. This will not deliver access to the Shared Care Record straight away but will improve communication between the provider and the GP Practice, with more information being available to each side and the exchange handled securely.

2.6 In the last 4 weeks of 2024, the Shared Care Record was accessed 7,483 times, for the records of 44,415 patients. A social media campaign at the beginning of December was very successful and increased engagement. Progress is being made with bringing Radiology data into the record. Progress is also being made with bringing community services data in, although the interfaces continue to be challenging.

2.7 NHS App uptake is 56% across Norfolk and Waveney. An additional 4,000 people joined the App in December 2024. Throughout that month, there were just under 800,000 logins to the NHS App by Norfolk & Waveney residents. Messaging via the NHS App accounts for only 3% of all messages sent by GP Practices, as the main clinical systems in use in practices still link only to the text gateway. Our Tech Skills for Life Coaches are supporting residents who struggle with digital technology.

2.8 2.8 The Robotic Process Automation for prescriptions has now processed 88,000 repeat requests in 18 GP Practice sites. Time saved is the equivalent of 100 working days. The bot is trained to follow the protocols devised by the Medicines Management Team in the processing of repeat prescription requests and will manage all compliant requests, leaving more complicated requests for controlled drugs or patients requiring review to the practice staff. Technical infrastructure is being put in place to allow for the development of further robotic processes.

2.9 The EPR programme is progressing well. The software has been made available to the hospital team and work on configuring it for local use is underway. The programme team is not yet fully staffed and further recruitment is currently in progress.

2.10 The Digital Team for Care Homes is shortly to commence a range of pilot projects, funded by the Digitising Social Care programme and the Health Tech Adoption and Acceleration programme. These projects will evaluate various Falls Prevention digital tools for effectiveness.

2.11 Digital Teams in the ICB and NCC are working together to put on an event. Digital Connect will take place on 7th May 2025 and is aimed at anyone in the ICP with an interest in Digital. There will be exhibitors and breakout sessions, seminars and masterclasses in a wide range of topics, delivered by local and national experts and enthusiasts.

3. Deep Dive into our approach to Artificial Intelligence (AI)

3.1 AI is one of the most talked about technologies since the internet and the iPhone. It is the fastest adopted business technology of all time. It has the potential to radically improve health and care productivity, but it is not a silver bullet, nor a quick fix to our demand and resource challenges. Exploiting the benefits of AI requires business transformation capacity, including training, support, process redesign, policy, culture and technological change.

3.2 Let's start by defining what we mean by AI as there are different forms of AI with varying levels of applicability for the work that we do. Machine learning is the more established form of AI that we have been exploiting in Norfolk Health & Care. We use machine learning predominantly to create predictive models for population health management. A recent and exceptional example of this approach is in the NCC managed Falls project where AI is used to read all the free text case notes in the Social Care system and use this information in combination with other data sets to predict Norfolk residents who are at risk of falling in the near future. A description of this work is described more fully below. The more recently mainstreamed form of AI is called generative AI. Generative AI came into public consciousness a couple of years ago with ChatGPT and there are now numerous vendors selling similar services, most notably in our context, Microsoft's Copilot. Essentially this is a form of AI that can consume speech or text and generate new speech, text or image outputs based upon the prompts or instructions that we provide. Examples of how this has been used in NCC are provided from section 3.5.

3.3 Adult Social Services (ASSD), in partnership with wider Norfolk County Council (NCC) teams and delivery partners in District Councils and the Integrated Care System (ICS), is developing and delivering a nationally innovative approach 'Proactive Intervention' approach to how we move from a reactive to proactive approach to preventing, reducing and delaying demand for care. The 'Proactive Intervention' pilots have tested with 1250 residents how we can identify people at risk of escalating need using Artificial Intelligence technology, through people at risk of a fall on ASSD and District Council records.

3.4 Interventions have been provided to residents to reduce that risk, and produce an evidence base for the impact on their long term outcomes and social care demand. The pilots have evidenced proactively intervening (both with residents already known to ASSD, and those not yet in contact with us) delivers a reduction in falls including associated fractures, improved wellbeing outcomes, and lower social care cost.

3.5 With our partners, we are now mobilising to proactively engage c.12,000 residents at risk and develop the approach and services we mobilise to also be available for a wider future prevention and demand management approach in Adult Social Services and our ICS. This programme is at the cutting edge of prevention models using technology, and the evidence base we have been developing is also being used nationally as good practice (ADASS Future of Prevention) and part of Department of Health and Social Care (DHSC) policy development.

3.6 Generative AI tools, most notably Microsoft's Copilot has been deployed to around three hundred NCC staff and they have been given support to use it effectively. We learnt from this work that depending on the nature of the person's role, the amount of support they are given and the time they invest in learning, the return on investment ranges from minimal to dramatic increases in productivity levels. Following the initial organisation wide trials, further service specific trials and rollouts are now underway in areas of Adults and Childrens Social Care which have shown the greatest potential. It should be noted that the benefits are rarely directly cashable, they are usually staff time savings and so it is important to establish how these savings should be realised, for example clearing backlogs, enabling earlier intervention, handling increased caseloads or improving service quality.

3.7 One example of the use of generative AI that has been seen in both health and care contexts is where the AI is used to listen, record and transcribe the conversation between a healthcare professional and a patient/client and write it up at the end. This allows the professional to focus fully on the conversation rather than stopping periodically to take notes, which saves time, then generate the notes much faster afterwards. It can also add value for example by adding a glossary of medical terms used in the meeting and then

further automation can be used to upload the case notes or letter generated into the case management system.

3.7.1 To bring this functionality to life, here is a recent example of this approach being used in NCC Adult Social Care (anonymised). Adult Social Care worker Fiona met with her client Robert for a mental health assessment meeting. Because Fiona was using the new AI technology, she was able to focus completely on the conversation with Robert rather than being slowed down and distracted by the process of note taking. As a result, the meeting was quicker and more natural, the electronic notes were generated by the AI more quickly than usual and were more personalised, having picked up on exact phrases used in the conversation.

3.7.2 After the meeting was finished, Fiona just had to review and quality assure the notes then upload them into Liquid Logic (the council's case management system). The outcome was a higher quality more personal meeting which took less time and generated better quality notes faster, saving further time.

Feedback from Fiona and others trialling the approach includes the following:

- *Learning Disability Assistant Practitioner*
  "I think I love you! Copilot just wrote up a supervision for me in about 5 minutes to how I needed it once I got my prompts right and needed minimal editing. I am a convert!!!!! Can't wait to find out what else it can do!"

- *Learning Disability Practice Consultant*
  "It is making it more personal as it is taking the exact wording that the service user has said in the discussion and putting it in the assessment"

- SCCE Assistant Practitioner
  "*I feel like it has facilitated the conversations which I have are now far more person centred and allows me to focus on the individual rather than on note taking.* "

- SCCE Assistant Practitioner
  "I feel that it has provided a positive effect on the quality of my conversations/interactions that I am currently having with service users."

3.8 Other examples include sophisticated chatbots which can offer enhanced online self-service, or provide the contact centre agent with intelligent prompts to speed up the call and improve quality, then transcribe the call and save the notes to reduce wrap time. AI is also being built into automated workflows thereby expanding our existing Robotic Process Automation projects into what Gartner has termed hyper-automation.

3.9 The use of AI is not without risks however. It can make mistakes and so it is essential that AI generated outputs are quality assured and owned by the person who uses the AI. We insist that any AI supported decisions have a “human in the loop” and are not fully automated. AI can exhibit bias if is it acting upon data with includes bias, or just make bad decisions if using poor quality data. It can also be hacked or used by people with illegal or unethical intentions such as cyber criminals.

3.10 Good AI Governance is critical to ensure that any proposed uses of AI are considered in terms of ethical, legal, cultural and risk perspective. Our approach has been to test and learn with internal processes and systems before exposing the technology to residents. We must maintain public confidence in our services and minimise any risks of data loss. Both NCC and the ICB have put in place AI Governance Boards to drive AI benefits while minimising risks.

3.11 Prime Minister Sir Keir Starmer recently said*: "AI isn't something locked away behind the walls of blue-chip companies. It's a force for change that will transform the lives of working people for the better. "That's the irony of AI; it will make public services more human, reconnect staff with the reasons that they came to public service in the first place, a force that will turbocharge every single element of our Plan for Change, the defining opportunity of our generation."*

4. Forward plan for further discussion at the ICP

4.1 To ensure the partnership is aware of all of the digital activities being carried out across the ICS please find below the forward plan proposing the items to be covered over the remainder of the year:

Item topic to be discussed	**Meeting date**
Overall Digital Roadmap	included in all meetings/papers
Information Governance and sharing of data across the system	June 2025
Assistive Technology and Virtual Wards	September 2025
Data Hub and Population Health Management	December 2025

Officer Contact

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Item No: 8

Report title: Norfolk and Waveney Health and Wellbeing Partnership Event

Date of meeting: 05 March 2025

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

Reason for the Report

The Integrated Care Partnership (ICP) is asked to note the success of the event in recognising and developing place-based working and to agree to the three recommendations. Members of the eight Norfolk and Waveney Health and Wellbeing Partnerships (HWPs) attended an event on 26th November 2024 to celebrate the successes of the last two years since the HWPs launched, showcase key projects and explore ways in which they can work towards achieving the four Integrated Care System (ICS) priorities going forward. This paper details key actions taken from the event and the benefit of bringing Place partners together to drive integration and prioritise prevention.

Report summary

This report outlines the successes shared and actions taken forward from the HWP event held on the 26th November 2024. The event brought partners together to highlight the importance of community-based prevention by sharing projects and outcomes from each HWP across Norfolk and Waveney and explore how they can continue to drive progress towards the four ICS priorities. The ICP are encouraged to acknowledge the HWP model as an effective way of reducing health inequalities and focusing on prevention at a local level. The ICP are encouraged to utilise these knowledgeable local bodies to deliver longer-term locally tailored prevention through pooling resource strategically.

Recommendations

The ICP is asked to:

a) Acknowledge the HWPs role in bringing partners together as key and strategic anchors to the ICP's shared objectives of addressing health inequality and prioritising prevention based on data-led local priorities since their formation in 2022.
b) Support the HWPs to develop proposed actions from the HWP event to further strengthen their goals via a model of shared leadership and how resource can be distributed to support longer-term locally-tailored prevention initiatives.
c) Agree an annual HWP event to bring the HWP partners together to share learning and report progress to the ICP.

1. Background

1.1 The HWPs were established in 2022 with a primary focus on prevention, addressing health inequalities, and utilising partners' expertise in the wider determinants of health. Varying Place by Place, they include participation and commitment from local leaders from across the full spectrum of local public services and VCSE.

1.2 Norfolk County Council's Public Health and Adult Social Services supported the coordination of the event in order to invite all HWP members across Norfolk and Waveney to celebrate progress in each HWP. The development of the day was co-produced with nominated HWP representatives collaboratively.

1.3 The event shared learnings, best practice and looked to the future exploring how each HWP could drive forward each ICS priority (driving integration, addressing health inequalities, enabling resilient communities, and prioritising prevention).

2. Outcomes of the Health & Wellbeing Partnership Event

2.1 On 26th November 2024 all eight HWPs came together to celebrate their progress so far and discuss how to achieve the four ICS priorities.

2.2 Around 90 people attended representing around 32 different organisations (listed in Appendix 1). Each table had a variety of members from each HWP in order to facilitate integration and learning from each place throughout the day.

2.3 A networking space provided an opportunity for HWPs to showcase projects and discuss learning and outcomes from prevention based local activity.

2.4 Each HWP presented a key successful project which included videos from residents impacted and supported by the programmes. This included Breckland 'Community Health and Wellbeing Workers', Great Yarmouth 'Community Hub', King's Lynn and West Norfolk 'Food for Thought', Norwich 'Safe and Habitable Homes', North Norfolk 'PositiviTea', Broadland 'Co-production and engagement through World Cafés', South Norfolk 'Proactive Interventions', and Waveney 'Healthy Hearts' project (further information on example projects can be found in Appendix 2).

2.5 The second session explored how the HWPs could work to progress the four ICS priorities. Key discussion points raised by HWP members as follows:

2.5.1 **Driving Integration:**

- Take an Asset-Based Community Development approach to support communities to be the driving force in supporting each other.
- Utilise approaches such as the World Café model to support communities to be connected and integrated.
- Success measured on communities' feedback on integration being felt in addition to organisations and services.
- Audit to identify gaps and where Places and the system can be increasingly integrated.
- Single year funding can hinder integration. As a group of leaders, the HWPs will strive to do their own brave commissioning to combat this.

2.5.2 **Addressing Health Inequalities:**

- Continue to strengthen the data picture in each Place to ensure the system understands inequalities together and can target limited resources effectively.
- Improve sharing learning across all HWPs.
- Increase consistency and coordination of commissioning for longer term planning.
- HWPs will utilise their influence to inspire and show brave commissioning with support from partners to strengthen resource in order to develop successful projects.

2.5.3 **Enabling Resilient Communities:**

- Identify effective models of engagement with communities which prioritise two-way delivery and co-production built in from the start.
- Utilise Community Voices model within each HWP to enable communities to understand and act on their health and share their views.
- Develop a focus on children and young people in order to enable resilient communities in the long term.
- Focus on improving sustainability of volunteer network.

2.5.4 **Prioritising Prevention:**

- Ensure priorities and activity is data driven and utilised to identify need.
- Take whole family approach to prevention to reduce generational health inequalities.
- Utilise assets within communities such as well-connected community hubs for effective prevention from the ground up encouraging local ownership and buy-in.
- Develop coordinated communication. Recognising a diverse range of channels to engage communities.

2.6 Outcomes

2.6.1 **Raising the profile:** Following a communications release on the Norfolk County Council website on the day, (go to www.norfolk.gov.uk to read the communications release), Norwich HWP received a request from the BBC to have an item on Safe and Habitable Homes. The interview was broadcast on BBC Breakfast radio on 12th December 2024 go to bbc.co.uk to read the hoarding support service article.

2.6.2 **Constructive partnership building and collaboration:** After presenting their key projects in the event, HWP Coordinators reported increased interest from across the system in hearing their learnings and exploring delivery in other Places. Reducing competition by sharing learning will enhance the success and reach of these initiatives.

2.6.3 **Strong attendance and engagement:** The strong attendance and engagement at the event enabled partners to continue to strengthen their networks across Norfolk and Waveney. Their continued attendance and commitment to the HWPs demonstrates their potential to contribute to an affective Integrated Care System due to their long-term collaboration. The variety of organisations across a range of sectors that attended reinforces the collaborative efforts towards improving population's health and wellbeing.

2.6.4 **Post event survey feedback:**

- 92% rated the event as good or excellent, with 85% saying it fulfilled their expectations.
- Positive feedback regarding the opportunity to network and hear about other HWP projects and learning.
- Key actions attendees noted they will be taking back to their HWPs include:
    - Continue to drive collaboration and integrate multi-agency input into existing and prospective projects.
    - Ensure VCSE partners acknowledged for their contribution and incorporate their perspective and expertise into HWP development.
    - Develop and maintain relationships with HWPs to ensure greater sharing of learning on successful projects and best practice across HWPs to support wider rollout where applicable.
    - Strengthen HWP foundations by maximising data, collaboration, delivery models and community engagement.
    - Need for physical activity to gain a higher profile.

Officer Contact

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Appendix 1: Organisations represented at the Health & Wellbeing Partnership event

- Active Norfolk
- Age UK Norfolk
- Age UK Norwich
- Alive West Norfolk
- Borough Council of King's Lynn & West Norfolk
- Breckland District Council
- Broadland District Council
- Citizen's Advice Diss, Thetford and District
- Community Action Norfolk
- Cup O-T Wellness Therapy Services
- Department for Work and Pensions
- East Coast Community Health Care CIC
- East Suffolk Council
- Great Yarmouth Borough Council
- Great Yarmouth Refugee Outreach and Support
- Headway Norfolk and Waveney
- Mid-Norfolk Healthcare Limited
- Norfolk and Suffolk Foundation Trust
- Norfolk and Waveney Integrated Care Board
- Norfolk and Waveney Mind
- Norfolk Care Association
- Norfolk Citizen's Advice
- Norfolk Community Law Service
- Norfolk County Council (Adult Social Care and Public Health)
- North Norfolk District Council
- Norwich City Council
- Queen Elizabeth Hospital
- South Norfolk and Broadland Councils
- South Norfolk District Council
- Suffolk County Council
- The Matthew Project
- Together for Mental Wellbeing.

Appendix 2: Examples of Health and Wellbeing Partnership projects

Food For Thought

Food for Thought's mission is to create a sustainable change in people's perception and understanding of healthy eating and nutrition, particularly areas of highest deprivation, and where health inequalities are identified within King's Lynn and West Norfolk. The programme offers a series of free to attend live cooking demonstrations with a professional chef who teaches how to cook healthy, nutritious, low-cost meals from scratch. The interactive environment is designed to be accessible, safe, and friendly, helping to combat social isolation and loneliness. 85% of responders agree that the project has helped them to increase their knowledge and understanding of the importance of healthy eating and basic

nutrition. 50% report that Food for Thought has helped them to maintain or improve current health conditions.

Co-production and engagement

Broadland Health and Wellbeing Partnership organised World Cafes to address health inequalities in Reepham, identified as a priority area due to health and wellbeing outcomes and rurality. The events provided a welcoming space for community members to share ideas and develop solutions. The first World Café in September 2024 had 26 attendees, whose feedback was categorized into themes such as Community and Social Life, Facilities, Children and Young People, Transport, Challenges, and Rural Living. A follow-up event in November explored solutions based on these themes supported by a range of HWP stakeholders. 100% of responders felt better connected to the community, and 99% would attend another World Café.

Lowestoft Healthy Hearts

Healthy Hearts is a two-year partnership programme to address health inequalities in Lowestoft, focusing on hypertension, a key cardiovascular disease (CVD) risk factor. Face to face engagement with residents in community hubs across the town has been led by VCSE organisations to understand what is important to Lowestoft residents, gauge understanding of CVD and its risk factors. The insights will be utilised to inform the design of the Healthy Hearts programme and analysed against the COM-B Framework.

Safe & Habitable Homes

Data showed that self-neglect and hoarding was an unaddressed issue for Norwich which led the Norwich HWP to fund a person-centred, trauma-informed, tenure neutral self-neglect and hoarding service. A multi-agency, wrap-around service which includes St Martins, Norfolk County Council, Fire Service, Mind, Norfolk Integrated Housing and Community Support Service, and more. Since 2022, 138 referrals have been received with 87 referrals accepted, and currently actively working with 36 residents. 32 residents have already met all their goals. There is an 87% engagement rate for those residents offered direct support and ongoing advice, guidance and signposting supporting 51 residents.

Norfolk and Waveney Integrated Care Partnership

Item No: 9

Report title: Norfolk & Waveney Place Board update

Date of meeting: 05 March 2025

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

Reason for the Report

The Integrated Care Board (ICB) would like to update the Integrated Care Partnership (ICP) on the work that has been happening at Place and in Place Boards in the last year. In addition, the ICB seeks commitments from partners across the system to define and advance the role of Place and harness the potential of place-based working to helping the people of Norfolk and Waveney to live longer, healthier, and happier lives.

Report summary

Place is an organising concept within the Integrated Care System (ICS) that coordinates system partners to address the unique community needs of populations of around 240,000. It leverages local insights, expertise and resources to improve health and wellbeing outcomes, integrate services, and support the workforce. Each Place is distinct, shaped by its demographics, stakeholders, and priorities, and fosters collaboration to reduce health inequalities and deliver better outcomes tailored to local needs.

In Norfolk and Waveney, Place Boards work closely with the connected Health and Wellbeing Partnerships, sharing priorities, stakeholders and activity. While the Place Boards are forums to focus on integrating health and care services, ICB place teams act as essential facilitators in any place-based working, driving progress, bridging governance gaps and building relationships. Despite operating below full capacity, place teams enable proactive collaboration and contribute towards realising the potential of place-based working.

Place-based working thrives when vision and priorities are shared, there is the flexibility to decide on how resources are allocated locally, and partners collaborate on integrated projects. While there are examples of success, many projects are short-term funded, operational pressures impact engagement, and the absence of delegated authority limits the level of transformation that can be achieved. Fully realising the potential of Place requires systemic changes, including equitable funding mechanisms, prioritising prevention, establishing accountability, and empowering Places with authority to shift care closer to home in line with the requirements in the NHSE neighbourhood health guidelines 2025/26. This approach would create a more sustainable, and responsive health system, better equipped to manage current and future demand

Recommendations

The ICP is asked to;

a) Commit to defining and advancing the role of Place to have a clear strategy with shared coordinated outcomes that will support Place to implement objectives in the NHSE neighbourhood health guidelines 2025/26[1].
b) Establish shared accountability for resourcing integration and system transformation at all levels.

[1] NHSE, (2025) *Neighbourhood Health Guidelines 2025/26* https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/ (Accessed: 14/02/2025)

c) Establish a system-wide framework for investing in Place and neighbourhood health, ensuring resources are allocated equitably based on evidenced need to reduce inequalities and achieve the greatest impact.

1. Background

1.1 Place, rather than Place Boards, is the organising concept within the ICS that focuses on coordinating system partners for populations of around 240,000. It is a mechanism to address unique community needs by leveraging local insights, expertise and resources. Place shares the ICS goal of helping people live healthier lives, integrating services, and supporting the workforce. Each Place is distinct, shaped by its demography, assets, and stakeholders. The power of Place lies in building relationships and fostering collaboration between cross-sector partners to improve outcomes and experiences for the people and communities it serves.

2. Norfolk & Waveney Place Updates

2.1 **Understanding Place in the ICB: The role of Place Boards and Place teams in place-based working;** There are five Place Boards within Norfolk & Waveney, spanning the same geography as the eight Health and Wellbeing Partnerships and three acute provider footprints in the East, West, and Central localities. Each Place interfaces with the relevant Urgent & Emergency Care (UEC) Alliance which are aligned with those three acute hospital footprints. In addition to our Norfolk & Waveney structures, Places also work closely with partners in Suffolk County Council, West Suffolk Hospital, Cambridgeshire & Peterborough, Lincolnshire and Suffolk & Northeast Essex ICBs.

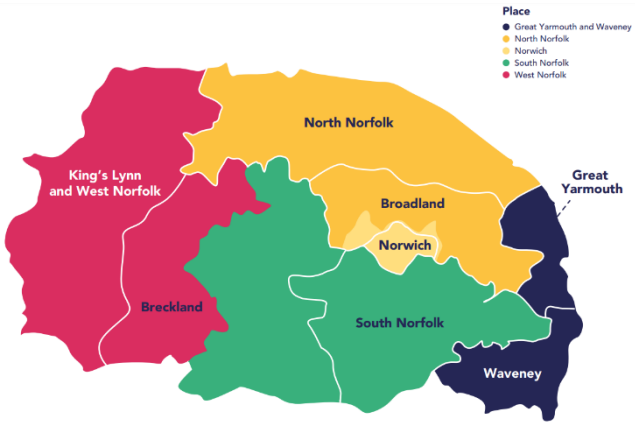

Figure 1: NHS Place boundaries and overlapping Health and Wellbeing Partnership boundaries.

2.2 Place Boards play a vital role in bringing partners together to align priorities and foster collaboration. They serve as forums where organisations can pool resources, share data and expertise, and collectively shape initiatives to improve health and wellbeing outcomes at the local level. They should be the linchpin of effective local health and care integration, yet their ability to deliver is constrained by systemic barriers that require urgent resolution. Their ability to drive meaningful change currently relies on goodwill, perseverance, and voluntary engagement, and is hindered by the fact that they operate without formal authority or dedicated resources. Instead, their capability and value lie in their ability to convene local stakeholders and progress alignment across different organisations where possible, building relationships and collaborating on common challenges. Currently, Place Boards have no formal commissioning powers or delegated budgets, and often representatives on the Board do not have the authority within their own organisations to make the necessary decisions about existing assets and services. Place Boards are forced to rely on goodwill rather than

any stronger accountability, hampering their ability to enact necessary change at the pace and scale required.

2.3 Alongside Place Boards, Health and Wellbeing Partnerships (HWPs) often share overlapping boundaries and priorities. Together, these structures aim to improve the health and wellbeing of their populations by creating a more integrated and efficient system of care and support. HWPs work to address the wider determinants of health and work across the prevention agenda. Place Boards look at integrating health and care services, aiming to improve care and optimise the use of resources. It is a closely connected relationship, where both agendas have complementary priorities, working with the same stakeholders, some of whom are members of both forums. Their shared purpose is to ensure that finite resources are used effectively and that efforts are coordinated to meet local needs. This is commonly evidenced through the shared programmes of work, described later in this paper.

2.4 Supporting all this activity from the ICB are the Place teams, a dedicated resource within the ICB to facilitate place-based working. These teams play an indispensable role, not just in convening partners, but also in actively driving initiatives forward. This has been happening against a backdrop of a wider ICB restructure, with ICB Place teams operating below full capacity since 2022. In addition to facilitating place working and convening partners around a common purpose, ICB Place teams also lead or contribute to delivery groups for Place Boards and HWPs, provide project support for place-based initiatives, and bridge gaps between governance structures. They are instrumental in overcoming challenges and ensuring progress. The ICB Place teams' in-depth understanding of local contexts and relationships enables them to identify opportunities and address issues proactively, helping to unlock the unique potential of place-based working.

2.5 What has been happening at Place?

2.5.1 Ultimately, place-based working is about more than Place Boards and governance—it is about people, relationships and partnerships. By bringing together organisations and individuals with a shared vision and using local data and insights, place-based working creates opportunities to design and deliver services tailored to effectively meet local population needs. This approach ensures that care is tailored to address the specific needs of each community, promoting fairness and reducing health inequalities, rather than applying a one-size-fits-all model that could inadvertently widen disparities. It has been shown to thrive, where expertise, resources, and priorities are aligned to achieve better outcomes for communities. However, it is impossible to implement without collaboration and trusted relationships, which take time to develop and could be further galvanised.

2.5.2 Each Place develops and delivers work according to the issues and challenges faced in each geography, each Board agreeing their own local priorities. The work of each Board also contributes to the wider system strategies for Norfolk and Waveney, including the Integrated Care and Joint Health and Wellbeing Strategy[2] and the Joint Forward Plan[3]. Transformation work delivered at Place achieves greatest impact where there are shared priorities and clear ownership between Place partners. Achievements exceed the sum of the individual efforts when all partners back an integrated project, populations are engaged, and resources are shared at a local level. Place-based working also delivers soft but powerful outcomes - empowering professionals through collaboration enhances job satisfaction, promoting staff retention and a more informed and motivated workforce. Additionally, sharing resources and expertise not only improves efficiency but also uncovers

[2] Norfolk & Waveney ICS, (2024) *Norfolk and Waveney Integrated Care Strategy and Norfolk Joint Health and Wellbeing Strategy* https://improvinglivesnw.org.uk/wp-content/uploads/2024/06/Integrated-Care-Strategy-2024-.pdf (Accessed: 31/01/25)
[3] Norfolk and Waveney Integrated Care System (2024), '*Norfolk and Waveney 5-year Joint Forward Plan* ', https://improvinglivesnw.org.uk/norfolk-and-waveney-5-year-joint-forward-plan/ (Accessed: 31/01/25)

new opportunities for innovation, strengthening service delivery and creating a more resilient, adaptable system.

2.5.3 Programmes and projects have developed in each Place, depending on local need and shared priorities, some examples of which can be seen in section 2.2.1. Across all five Places, there are common issues that can be identified. Key enablers, such as information governance, data sharing, business intelligence, finance, procurement, estates, and technology, are critical to supporting progress. However, they often present as challenges that require significant input to overcome. These enablers must be addressed at organisational and system levels to fully realise the potential of place-based initiatives and enable meaningful transformation.

2.5.4 There is also a sense that, while the creation of the ICB has improved system-wide integration and commissioning, the shift to system-level planning has inadvertently distanced decision-making from those who understand local needs best. Rebuilding local voice and influence is not just desirable, it is essential to delivering care closer to home that meets community needs. It is vital to a functioning system, where local ownership and engagement leads to improvements in the way people work and the services they deliver. This is supported in the recently published NHSE neighbourhood health guidance 2025/26[4], which emphasises the need an integrated response from all parts of the system to improve the experiences of people receiving care as well as the staff delivering it. Place-based working offers a solution by aligning strategic priorities with local implementation. Place must be empowered to shape the means by which outcomes, set at a system level, are achieved. This ensures alignment across Norfolk and Waveney while allowing frontline providers and local populations to tailor delivery models to their needs building on existing assets.

2.5.5 This also requires a sophisticated approach to resource allocation, both across and within each place. This means targeting investment where it is most needed and designing flexible, locally relevant services that all contribute to shared system outcomes. This must be supported by ICS members at all levels. Place can enable genuine transformation by removing barriers between organisations, services, and commissioning where it is empowered to do so. This ensures services are not only fair and accessible but also tailored to local needs, effective in delivery, and sustainable for the long term. A system that listens, adapts, and empowers local voice is one that will deliver better health and wellbeing for all.

2.5.6 Each Place has a range of different programmes and projects depending on local priorities and assets. These projects, when taken all together, contribute to the broader strategic priorities and ambitions for the whole system. We have selected a representative sample to highlight the breadth and impact of place-based work. This approach provides a balanced snapshot of key initiatives to showcase the variety of work happening across each Place, although it is by no means all of the work that is happening there. This work is closely linked with the four priorities in the Norfolk & Waveney Integrated Care and Joint Health and Wellbeing Strategy and the eight ambitions in the Norfolk & Waveney Joint Forward Plan.

[4] NHSE, (2025) *Neighbourhood Health Guidelines 2025/26* https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/ (Accessed: 14/02/2025)

2.6 A sample of Place projects

2.6.1 Great Yarmouth & Waveney

(1) Lowestoft Healthy Hearts Programme
Aimed at tackling cardiovascular health inequalities in Lowestoft, where emergency admissions and CVD-related premature deaths exceed national and local averages. It is led by a Place Partnership including colleagues from local government, Primary Care, ICB, Health Innovation East, and Public Health.

- Initial 6 month Norfolk and Waveney Community Voices engagement programme with VCSE partners to inform and shape the programme Key components of the programme are:
    - **Prevent**: Supported by a hypertension media campaign and recruitment of a dedicated 'Healthy Hearts' behaviour change advisors as part of the Feel Good Suffolk local team.
    - **Detect**: Supported by a Sisu Health check pod located in Lowestoft Library, from mid Sept '24. Over first 16 weeks completed 400 health checks. Participant average data was 42yrs, IMD 2 and 10% had high Blood Pressure, 64% were obese. 89 trigger to contact GP/Pharmacist for high BMI/Blood Pressure
    - **Protect**: Supported by Expertcare, who are proactively contacted 3500 Lowestoft residents identified via CVD Prevent data as benefiting from a hypertension case review. All practices in the PCN are involved and between Nov & Dec 2024, a 7% increase in Blood Pressure optimisation.

"Lowestoft Healthy Hearts has proved invaluable for the wider ICB plans regarding CVD Prevention. The work underway in Lowestoft has been functionally utilised to inform the approach the ICB is taking across Norfolk and Waveney with regards to case-finding and intervention, as well as the potential of the impact from lifestyle advice and change. The LHH approach is in effect being scaled-up and rolled out across the wider ICB"
Joseph Crowe, Clinical Programmes Senior Manager, N&W ICB.

"*This project has been a brilliant example of how successful a collaborative project can be, when involving multiple organisations and geographies coming together to prioritise the populations heart health. Starting with the N&W Community Voices work, followed by piecing together innovative interventions to improve the detection and management of hypertension has resulted in the project so far seeing positive outcomes. We are looking forward to seeing the project progress with more patients improving their cardiovascular health across the Lowestoft community, and working closely to support our incredible primary care workforce at the same time*".
Nick Pringle, Senior Advisor & CVD Programme Lead at Health Innovation East.

(2) Waveney Home Energy Efficiency Programme (Winter 24/25)

- Provides affordable warmth assistance through proactive outreach to clinically vulnerable patients living in energy-inefficient homes.
- This project builds on the GY&W Warm Homes Project (Winter 23/24), which focused on addressing fuel poverty and its impact on health by linking health directly with local authority data, for older adults and children with chronic respiratory conditions.
- By working collaboratively data on both low energy efficient households and occupants whose health conditions may be adversely affected by living in a cold home was shared with East Suffolk Council.
- Initial uptake of home upgrade grants, financial and social assistance has been high, with a 40% response rate. Without the targeted data led approach, the expected response rate is 1%.

(3) Health Connect Services
A collaborative post-hospital discharge support service aimed at reducing readmission risks and connecting residents to VCSE resources.

- Delivered by four trained "connectors" hosted by ECCH.
- 5,500 welfare calls made and 1,300 residents referred for tailored support.
- Expansion includes two new respiratory posts, one funded via Suffolk Public Health, and one via GY HWP and iBCF funding.

2.6.2 North Norfolk

(1) Frailty Programme
North Norfolk Place Board has prioritised tackling frailty, recognising its high proportion of older residents with complex needs.

- The project takes a targeted approach for patients aged 50+ who attend the Norfolk and Norwich University Hospital (NNUH) or Cromer with fall-related injuries but are not admitted. Using the Rockwood Scale, patients are identified for interventions ranging from support services to rehabilitation, focusing on Rockwood 1–6.
- This pathway includes collaborative input from district councils, who provide tailored support like housing adaptations, social prescribing, and access to community services.
- Where a health need is identified, this is passed to Integrated Care Coordinators who are able to add patients to Multidisciplinary Team meetings for wider discussion
- Proactive frailty initiatives include using population health data to identify frailty risks early, offering support like MOTs, carer assistance, and system-wide frailty training.
- Supporting the adoption of frailty scoring tools, working with the Norfolk Escalation Avoidance Team (NEAT), Virtual Ward services, NNUH and Primary Care.
- Early Outcomes include
- Between June and December 2024, 799 patients were identified through the frailty pathway and referred for tailored support. Following contact from the district council 248 people had onward referrals made Future plans include expanding eligibility criteria and shifting to anticipatory interventions.
- Multidisciplinary meetings (MDMs) across practices have been reviewed with shared templates developed fostering improved care planning and coordination.
- The frailty programme is undergoing evaluation, with a 12-month review planned to assess impact and scalability.

(2) Daffodil Standards – End of Life Care

- The Place team has supported practices in North Norfolk to implement the Daffodil Standards End of Life Care Programme which has been developed by the Royal Collage of General practice in partnership with Marie Curie.
- The aim is to encourage practices to develop best practice in palliative and end of life care which is a priority area for North Board.
- This will be an ongoing piece of work but was an initiative instigated during this year and supports both practice development and patient/ carer experience.

(3) VCSE Capacity Building

- Better understand the VCSE landscape in North Norfolk through a comprehensive survey and workshops and develop an action plan from the results of the survey, to support and strengthen the sector.
- Create a VCSE engagement group who will be a reference group for North Board and partners operating in North.
- This work has been developed during 2024 and is being delivered in the first few months of 2025.

2.6.3 Norwich

(1) Integrated Anticipatory Care Team (INTERACT) and Safe Habitable Homes

- Developed by the Local Delivery Group (the precursor to the Norwich Place Board) and hosted at City Hall, **INTERACT** is a multi-agency team providing holistic support for people whose housing or home environment has a negative impact on their health or wellbeing
- The integrated service involves Age UK Norwich, Norfolk Citizen's Advice, Norwich City Council and Norfolk County Council and has evolved to provide the mix of skills and organisational links to best support people with these issues. N&W MIND and Menscraft are now supporting operational delivery
- **INTERACT** delivers tailored interventions and practical support to help people achieve their housing-related goals such as home adaptations, moving to more suitable accommodation, financial support, and social connection opportunities to help individuals maintain their independence
- Since April 2022, **INTERACT** has received over 900 referrals, with approximately 80% of clients aged 50+, many of whom have complex medical and/or social care needs. Evidence demonstrates people's improved satisfaction with their housing, physical and mental health with an associated reduction in activity within statutory services
- **INTERACT** identified a gap around long-term support for individuals at risk due to self-neglect or hoarding leading to the Norwich Health & Wellbeing Partnership funding **Safe Habitable Homes**
- **Safe Habitable Homes** is delivered by St Martins, Norwich City Council and Norfolk County Council and provides trauma-informed, tenure-neutral support to stabilise at-risk individuals, helping them to maintain safe and healthy living conditions.
- The service has received 149 referrals in the last 2 years. 30 people have met all their goals. Of the 37 people currently being supported, 18 were initially assessed as high risk in line with NSAB guidance, but this figure has reduced to 7 due to the team's involvement. There are 11 people on the waiting list. All clients have physical and/or mental health needs, and a significant number have mobility issues, drug and alcohol use, severe depression and psychiatric disorders and have been supported to access help.

(2) CHESS – Complex Health & Enhanced Social Support

- The CHESS programme is delivered by Age UK Norwich and provides holistic, wrap-around support for frail/older people living with complex health or social needs to help them live as independently as possible for as long as possible, aiming to prevent health deterioration and reduce the demand for crisis interventions. It offers up to 12 weeks of personalised support, including regular welfare checks, structured physical activities, home assistance, and companionship to enhance social connections and overall well-being. Participants benefit from early identification of risks, with tailored interventions to support physical and emotional health, home safety, and access to financial assistance.
- As well as a 31% increase in client's self-reported health and wellbeing scores, **CHESS** has demonstrated its effectiveness in reducing demand for urgent and emergency care:
    - 87% avoided emergency GP appointments, reducing pressure on primary care.
    - 92% were not hospitalised in an emergency, reducing non-elective activity.
    - 86% did not require an increase in home care services, demonstrating improved independence.
    - 80% avoided falls or trips, reducing injury risks and associated complications.

(3) Tea@3 – Connecting for Healthier Communities

The Norwich Place team established this networking initiative in March 2023 to provide a supportive space to help rebuild working relationships impacted by the pandemic, remote working and high levels of demand. Hosted in local community spaces to foster deeper connections with the populations we serve, Tea @ 3 encourages cross-sector workforce integration, collaboration and supports staff development and morale. Taking a thematic

approach to ensure that community needs and challenges are addressed, the well-attended, bi-monthly sessions include:

- Service overviews to improve understanding of roles, remits and available resources
- Speed updates on key initiatives and partnership developments
- Informal networking opportunities to build effective relationships between frontline staff, identify opportunities to join the dots, enhance the local offer and share best practice

2.6.4 South Norfolk

(1) Joint Funded Roles for Health and Wellbeing

South Norfolk Place has used Community Transformation Funding to employ joint roles between the Integrated Care Board (ICB) and each of the district councils within South Norfolk Place.

- The purposed of these roles is to enhance collaboration on place-based health and wellbeing initiatives
- Different in each council, the roles include some operational and strategic leadership in managing projects such as the implementation of the Joy social prescribing system, the expansion of integrated care models, the alignment of district council and health services, and supporting the programme of work developed by each Health and Wellbeing Partnership
- The roles also ensure there is dedicated resource for developing and delivering place-based initiatives

(2) Community Health and Wellbeing Workers (CHWW) – Watton

South Norfolk Place Board has implemented a Community Health and Wellbeing Worker (CHWW) project to tackle health inequalities and improve access to health and care services in Watton.

- The project is a partnership between Breckland Council, NHS Norfolk and Waveney ICB, and Watton Medical Practice, aiming to proactively engage residents with unmet health and wellbeing needs.
- CHWWs work within the community, based in the council and GP practice.
- The CHWWs visit households to build relationships, provide health guidance, and connect individuals to local support services.
- The project is taken from a successful model in Brazil, which has shown positive outcomes in reducing health inequalities, improving access to primary care, and reducing avoidable hospital admissions.
- To date, over 240 households have been engaged, with residents receiving targeted support for long-term conditions, financial challenges, and social isolation. CHWWs have moved beyond the initial cohort to reach out to anyone registered at the Watton practice.
- The approach has improved self-management of health conditions and reduced reliance on urgent and emergency care services.

(3) Community Mental Health Caseload Review

- In response to increasing mental health referrals, a partnership between primary care, Norfolk and Suffolk NHS Foundation Trust (NSFT), and social prescribing teams was developed to review caseloads and improve access to appropriate community support.
- A triage system was introduced, allowing low-acuity patients on CMHT waiting lists to be redirected to social prescribing, reducing unnecessary demand on secondary mental health services.
- Over 40 cases were successfully redirected, providing patients with quicker and more effective community-based support.

2.6.5 West Norfolk

(1) West Norfolk – Marmot Place

King's Lynn and West Norfolk is Marmot Place, embedding a collective approach to tackling health inequalities, over the next two years. A Marmot Place focuses on addressing the wider determinants of health, such as employment, housing, and education, through a structured, system-wide approach.

- This initiative is jointly funded by King's Lynn and West Norfolk Borough Council, West Norfolk ICB, and Public Health Norfolk, with the Borough Council acting as the lead agency. The Institute of Health Equity (IHE) will work with partners over two years to provide an independent assessment of health inequalities and develop targeted recommendations to drive sustainable change.
- It is a collaborative approach, with Local Authority, ICB, and Public Health partners working together to create a shared vision for reducing health inequalities. The programme aligns with Core20PLUS5 priorities and local strategies across the system. By working with businesses, communities, and the voluntary sector, the partnership will develop and implement practical, place-based solutions. The framework will ensure mutual accountability across partners, strengthening governance and delivering measurable change.

(2) Falls Prevention Project

The West Norfolk Place Board has overseen a successful falls prevention project, delivered in partnership with the Borough Council, Breckland Council and Active Now, with input from a range of other system partners too.

- The project targets people aged 65+ at the early stages of frailty, offering free referrals to the Active Now exercise programme and home adaptations.
- As of Dec 2024, the project has seen:
  - 128 people have been referred to the handy person service for home adaptations.
  - 90 people referred to Active Now, mostly for 1:1 personal training at home.
  - 143 participants joined funded community classes, including two retirement homes.
  - Fitness tests show improvements in strength and mobility for all participants.
- Beyond physical benefits, the programme has boosted confidence, identified social isolation issues, and helped participants transition into ongoing community-based exercise. With additional funding, more local classes and personalised training options are now available, further reducing barriers to participation.
- The project has also shown the potential opportunities from sharing data between organisations. For instance, the QEH shared data, about patients awaiting treatment, with Council partners
- Go to www.youtube.com to view a video about the perspective of one of the exercise participants.

(3) Discharge to Assess:

The aim of this project is to establish a West Place Discharge to Assess model to:

- Improve the timeliness, volume and quality of discharge for patients on Pathway 1 and 2.
- Ensure that the limited resources available are used in the optimal way for the West system, improving efficiencies, and addressing the challenges and opportunities of the West.

How this is being achieved:

- Pathway 1 – Following an initial pilot, referrals for patients requiring this pathway are now being referred directly to NFS rather than via the Home First Hub to source packages of care.
- Pathway 2 – Establishment of an integrated team of Trusted Assessors (comprising of

registered nurses from Complex Discharge Team and Home First Hub) to establish a health-to-health transfer process removing the need for the completion on a Transfer of Care to support patient discharge into an intermediate care setting.

The Impact from these projects has been to reduce the number of patients with “no criteria to reside” and length of stay resulting in improved flow and a reduction in ambulance handover delays.

3. What is next for Place?

3.1 **The potential of place-based working:** Place-based working is impactful because of its adaptability. It is not confined to the structures of Place Boards or HWPs; rather, it happens wherever there is an evidenced need for it within local systems. Whether supporting Primary Care Networks, tackling health inequalities, or addressing urgent care challenges, place-based working ensures that the right partners are working together in the right way to deliver the right results for our local populations.

3.2 There is already significant progress to celebrate, and the successes achieved so far demonstrate the power of this approach to improve care for our population and support demand management. However, much of the potential of place-based working remains untapped. Reliance on goodwill from partners to participate, without authority or resources to attract other key stakeholders, limits Place’s ability to fully realise their ambitions. Additionally, external accountabilities, such as day-to-day operational pressures, or waiting list targets compete for attention and focus and detract from the integration agenda. NHSE planning guidance and neighbourhood health guidance is clear that ICBs must continue to focus on reducing demand by developing neighbourhood models and shifting towards secondary prevention to improve health and reduce demand in the medium term. [5,6] Place-based working has been shown to drive meaningful improvements in health outcomes and prevent/reduce/delay demand for statutory service provision. This is done by focusing on relationships, shared goals, and enabling difficult discussions about the use of resources across a shared area. Properly supported, we can make the system more equitable, sustainable, and responsive to the needs of the population.

3.3 Place is essential for implementing policy effectively, bridging the gap between system-wide strategy and frontline service delivery that brings in all partners. The Fuller Stocktake highlights Place’s role in integrating health, social care, and public health by supporting co-located neighbourhood teams.[7] Without Place, changes made across a larger footprint lose local nuance; on a smaller scale, transformation lacks the necessary impact. Place Boards are uniquely places to facilitate out-of-hospital care improvements, reducing hospital pressures through integrated neighbourhood teams, care home support, home visiting services, virtual wards, rapid response teams, and admission avoidance schemes. They enable collaboration across sectors, strengthening community mental health, respiratory, and palliative care while embedding prevention and VCSE partnerships.

3.4 Without meaningful system-wide changes, Place-based working will remain a patchwork of well-intentioned initiatives rather than the transformative force for population health that we need to see. It is not an optional extra but a critical imperative to the long-term sustainability of the system. In line with national direction, the left-shift of resources upstream of demand

[5] NHS England (2025) *2025/26 priorities and planning guidance* https://www.england.nhs.uk/wp-content/uploads/2025/01/PRN01625-25-26-priorities-and-operational-planning-guidance-january-2025.pdf (Accessed 31/01/25)
[6] NHSE, (2025) *Neighbourhood Health Guidelines 2025/26* https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/ (Accessed: 14/02/2025)
[7] NHSE (2022) *Next steps for integrating primary care: Fuller Stocktake report* https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf (Accessed 14/02/2025)

and closer to home must become a higher priority across the system as pressures on health and social services grow due to the impact of growing heath inequalities and an ageing population. NHSE Neighbourhood Health guidance emphasises the important of prioritising community-based care to reduce lengthy hospital stays and improve accessibility and efficiency for patients.[8] While Place, with strong partnerships and local knowledge, is well-positioned to lead this shift, achieving long-term impact depends on agreeing coordinated outcomes to aim for, accountability for delivering on them and resources to support them. Without these changes, there will be continued inefficiencies, fragmented care, and worsening health inequalities, and we will miss the opportunity to shift the dial from the treatment of illness to health improvement and creation.

4. Enabling Place to deliver on its potential

4.1 We ask the ICP to further commit to driving meaningful system-wide integration and transformation to avoid stagnation and ensure Place-based working reaches its full potential. This is both a commitment to a direction of travel and to enabling concrete actions that empower Places to deliver on their potential. The ICP is asked to commit to advancing system-wide integration and transformation through the following three key areas:

(1) Commit to defining and advancing the role of Place to have a clear strategy with shared coordinated outcomes that will support Place to implement objectives in the NHSE Neighbourhood Health Guidelines 2025/26[9]. The ICP must align Place with system-wide priorities, ensuring flexibility to tailor local delivery while maintaining a clear strategic direction. Place Boards need more clarity to drive integration, prioritising prevention and community-based care in line with national and local strategies.

(2) Establish shared accountability for resourcing integration and system transformation at all levels. Place-based working depends on true collaboration, yet voluntary engagement limits progress. The ICP must embed accountability at all levels, ensuring commissioning supports integration, reducing barriers, balancing influence and power between organisations and empowering Place Boards to lead decision-making. Without clearer accountability, fragmentation will persist, undermining system-wide transformation.

(3) Establish a system-wide framework for investing in Place and Neighbourhood Health, ensuring resources are allocated equitably based on evidenced need to reduce inequalities and achieve the greatest impact. Investment must be allocated equitably based on need, prioritising prevention and early intervention. The ICP should support flexible use of existing budgets, enabling Place to address inequalities and drive sustainable transformation. A long-term commitment is required to shift resources upstream, reducing reliance on reactive, crisis-driven care.

4.2 By committing to these actions, the ICP can unlock the full potential of Place-based working, enabling system partners to collaborate more effectively and deliver meaningful and sustainable improvements for the people of Norfolk and Waveney.

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[8] NHSE, (2025) *Neighbourhood Health Guidelines 2025/26* https://www.england.nhs.uk/long-read/neighb/ourhood-health-guidelines-2025-26/ (Accessed: 14/02/2025)

[9] NHSE, (2025) *Neighbourhood Health Guidelines 2025/26* https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/ (Accessed: 14/02/2025)

Norfolk and Waveney Integrated Care Partnership

Item No: 10

Report title: Section 75 contract for Integrated Community Health and Social Care

Date of meeting: 05 March 2025

Sponsor (ICP member): Ian Wake, Executive Director Adult Social Services, Norfolk County Council
Lyndia Thomas, Ian Wake, Executive Director Adult Social Services, Norfolk County Council

Reason for the Report

To provide an update on the continued contract between Norfolk County Council (NCC) and Norfolk Community Health & Care (NCHC) to deliver integrated community Health and Social Care. The Integrated Care Partnership (ICP), guided by the Integrated Care Strategy authored by NCC, focuses on collaboration to improve service delivery and patient outcomes, aiming to help people live healthier lives and make Norfolk and Waveney a great place to work in health and care. NCC aims to create a “golden thread” from the ICP to service delivery.

For most people, day-to-day care, and support alongside interactions with communities is expressed locally in the ‘Place’ where they live, not at an ‘ICS’ footprint. The Health and Care Act has been accompanied by a renewed policy emphasis nationally and locally on the role of ‘community’ in improving health and wellbeing outcomes. For social care the organisations Skills for Care have emphasised the increasing importance of social care providers working much more closely with other providers in the ICS, such as community health, to ensure that a ‘strong partnership working with community health’ is formed that will ultimately help meet the medical needs of their residents. In Norfolk, the integrated arrangement with NCHC could increasingly act as the foundations for this new type of approach.

Report summary

The renewal of the Section 75 agreement between NCC and NCHC for an initial term of 3 years, with the option to extend up to a maximum of 9 years. Integration is crucial for people in Norfolk because it ensures that community health and social care services work seamlessly together, providing more efficient and effective care. This collaboration helps address the complex needs of individuals, promoting independence and improving overall health and wellbeing. By integrating services, resources are better utilised, leading to enhanced service delivery and reduced duplication of efforts. Patients and service users benefit from a more cohesive and holistic approach to care, which is highly valued by both staff and the community. Additionally, integration fosters stronger partnerships and community engagement, ensuring that services are responsive to the needs of the population. The objective is to continue integrated care services, focusing on reablement therapy, falls prevention, and support for complex patients.

Recommendations

The ICP is asked to:

a) Receive an update on the plans to renew the section 75 contract for Integrated Community Health and Social Care contract and provide comment.

1. Background

1.1 The integration of community health and social care services is crucial for addressing the complex needs of the population, promoting independence, and improving overall health and

wellbeing.

1.2 NCC and NCHC have made significant strides in integrating care services over the past decade. The current agreement ends in March 2025, and it is planned to continue this collaboration with a renewed focus on helping people live independently and fully.

2. The Renewal of the section 75 Contract

2.1 The renewed contract will provide a clear framework for integration, outlining shared points of collaboration and defining the roles for portfolio leads. This approach ensures that services can operate both independently and in a coordinated manner, enhancing overall efficiency and effectiveness.

2.2 The renewed contractual arrangement will include built-in flexibility which allow us to explore wider collaborations with key stakeholders to support the delivery of the aims and ambitions to greater benefit people in the community; Promote independence, increase productivity, and allocate resource effectively.

2.3 **The aims and ambitions are:**

2.3.1 **To develop a single reablement therapy offer that is place-based:** Our aim is that each Place will have a clear prevention plan for reablement and therapy. Professionals from different fields should work together from the start, with a single point of contact via phone and digital solutions. Teams will develop reliable assessments and Reablement staff should be trained to support peoples needs across health and care. Occupational Therapists (OTs) in health and social care should be trained to assess each other's disciplines these will improve efficiency and eliminate duplication.

2.3.2 **Develop a trusted assessor model using technology:** We aim to have health and social care professionals including providers in Norfolk who can reliably assess and recommend technology-enabled care. This will help meet care needs and prevent or delay those needs from becoming more serious and to ensure technology is available quickly when identified and its able to help people when they want to remain independent.

2.3.3 **Create an integrated approach to falls risk management and Prevention:** We aim to proactively identify people earlier to support them before they reach crisis, helping them to stay independent in their homes for longer. We will do this by working with key partners to take a system approach to identifying and supporting people who are at risk of a fall, working to reduce their falls risk and providing other preventative support that they might benefit from. This will help to prevent, reduce, and delay people's need for more formal care and support.

2.3.4 **Develop a 24-Hour response to unplanned care needs:** We aim to offer expert rapid response teams of health and social care practitioners. They will be able to support older people in their community within 2 hours, with aim of them remaining at home and avoid a hospital or care admission.

2.3.5 **Jointly develop and shape the 'target operating model' and 'neighbourhood teams.'**: We aim to enhance the current operating model to support and complement Place (or locality) structures to improve outcomes, reducing health inequalities, and ensuring strong partnership within the wider Integrated Care System (ICS).

2.3.6 **Deliver improvements in integrated intermediate care offer** (after a stay in hospital or there is a risk of admission to hospital): We aim to redesign and integrate a consistent intermediate care offer, including Nursing, Physiotherapy, Social Care, and Occupational

Therapy, with comprehensive measures beyond hospital metrics, prioritising home-based care, reducing readmissions and length of stay, and enhancing patient outcomes through multidisciplinary collaboration and efficient resource use.

2.3.7 **Develop a targeted integrated care home support offer:** We aim to develop a consistent support model for care homes in Norfolk, this would include a joined-up offer of Multidisciplinary Teams (MDT are a group of different professionals collaborating to provide the best care for the person) which includes support from community health and social services, a flexible support system designed to address the changing needs of the person including the use of technology, quality improvements and commissioning

2.3.8 **Support for complex patients (e.g., people living with dementia or multiple health and care needs)**: We aim to create a better support system for complex patients and their carers at a local level. This will involve an integrated, multi-disciplinary forum that facilitates action planning and escalation for specific complex patients/individuals and ensures quick access to the appropriate support, service, or person in a timely manner aimed at achieving positive outcomes for the person.

3. The Impact and benefits

3.1 The benefits to people who receive Community Health and Social Care in Norfolk are significant and include an enhanced service delivery**.** By continuing the integration, decisions on care can be made collaboratively across community health and social care, ensuring that organisational self-interest does not hinder patient care. This leads to a more seamless and efficient service delivery. The integration allows for a better understanding and utilization of community resources, leading to more effective and efficient service provision.

3.2 Patients and service users will benefit from a more cohesive service where health and social care teams work closely together. This integration is valued by both staff and service users, as it provides a more holistic approach to care. Encouraging active participation and ensuring the voice of the service user/patient are heard. The proposal emphasises the importance of engaging with stakeholders such as Healthwatch Norfolk, Carers Matters, Age UK, and the Norfolk Older Peoples Forum. This ensures that services are user-centred and responsive to the needs of the community.

3.3 Successful services developed under the section 75 arrangements, such as Norfolk Emergency Assistance Teams (NEATs), Integrated Care Communities (ICCs), and Multi-Disciplinary Teams (MDTs), are now being implemented system-wide, enhancing overall service delivery. The integration improves the influence and understanding of social care considerations in primary care decision-making, leading to more informed and comprehensive care plans. Collaborating across organisations to pool resources and expertise for better outcomes.

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Item No: 11

Report title: Health Inequalities update

Date of meeting: 05 March 2025

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

Reason for the Report

To provide assurance on progress in relation the Integrated Care System (ICS) Health Inequalities Strategic Framework for Action, provide a progress update on the commitments made and propose recommendations for further progress.

Report summary

There has been significant progress in implementation of the Health Inequalities Strategic Framework for Action, but, recognising that this is a 10 year plan, there is much yet to be accomplished. This report summarises some of the work underway to address inequalities and proposes several recommendations for the Integrated Care Partnership (ICP) to take forward, via the leadership provided by the ICS Health Inequalities Steering Group.

Recommendations

The ICP is asked to:

a) Develop an ICS plan to scale up Community Voices across the ICS as a shared framework for engaging our communities.
b) Scope the potential for a Community Connection/Health Creation plan for Norfolk and Waveney.
c) Formally agree the role of the place-based structures in the implementation of the Health Inequalities Strategic Framework for Action and support delegation where appropriate to enable local action plans to be developed and delivered.
d) Partner organisations of the ICP are invited to provide progress updates in relation to their commitment to reducing inequalities to the Steering Group, to inform future reports, highlighting learning and good practice and mutual areas of opportunity, challenge and risk.
e) Further our system understanding of 'proportionate universalism*' and implement a framework for equitable investment policies.

1. Background

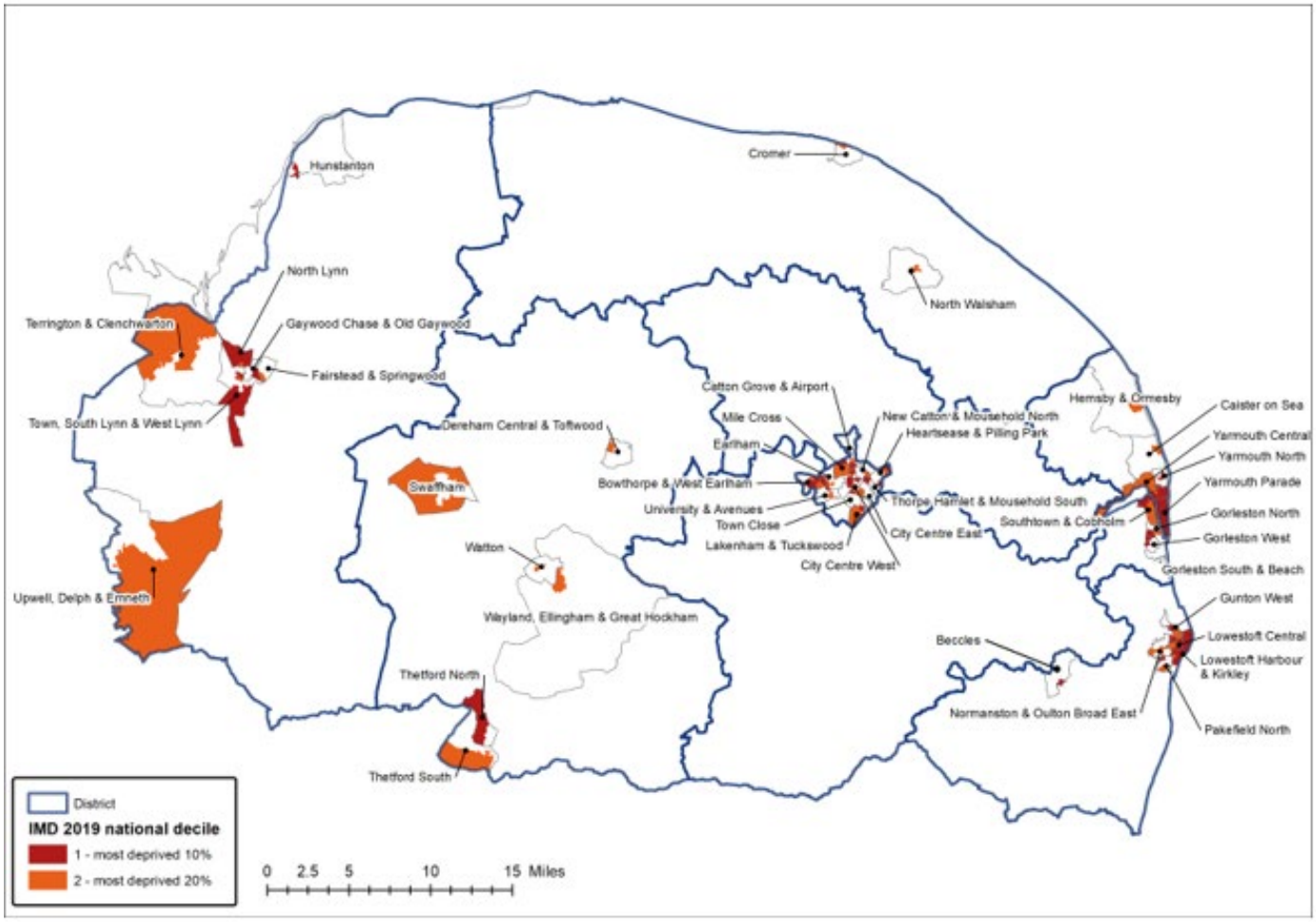
1.1 The Health Inequalities Strategic Framework for action was endorsed and agreed by the ICP in June 2024, with partners committing to supporting implementation of the Framework and the Partnership agreeing to provide oversight and receive quarterly progress reports.

1.2 The Health Inequalities Strategic Framework for Action set out 4 key areas of focus; Living and Working Conditions, Lifestyle Factors, Healthcare Inequalities and Creating the Conditions for Success.

**Proportionate universalism is a strategy for reducing social health inequalities. It refers to the resourcing and delivering of universal services and interventions at a scale and intensity proportionate to the degree of need of the target group. The Norfolk & Waveney ICS Health Inequalities Strategic Framework for action refers to this in the principle of 'everyone needs something, some people need more'.*

1.3 Ten key actions were committed to for the first 12 months of implementation and the Framework details a range of principles that should underpin this activity. In addition, the commitment to the different levels of action required for us to make a difference at system, organisational, place, community and individual levels.

1.4 The National Health Service (NHS) has identified the communities and groups we should focus on as the 'Core20plus' communities. These are the people living in the most deprived areas and vulnerable people in the local area, who are referred to as the 'plus groups'. Our most deprived 'Core20' communities are highlighted in the map below.



2. Health Inequalities Steering Group Report

2.1 Community and individual level action

2.1.1 The Health Inequalities Steering Group are pleased to report good progress against each of the 10 actions committed to for the first 12 months of implementation. Action is underway at all levels and this report summarises some of the key activity, planned actions and requests for support to ensure we effectively and successfully deliver against these commitments.

2.1.2 The health and care model needs a radical shift from the treatment of illness to focus on 'health creation' and communities are key to delivering this ambition. Looking through the 'community lens' rather than a 'service" or "provider" lens' and hearing from underserved communities will facilitate this transition.

2.1.3 The Health Creation Alliance recommends some key actions that can be taken by ICSs to support this 'left shift' from treatment into prevention and early intervention and there is much good practice in our Norfolk and Waveney system on which to build. This includes

investment in connection, investment in community connectors and leadership, building individual health literacy, ensuring community-informed decision making and measuring community connectedness, as well as shifting the balance of NHS investment and focus.

2.1.4 The Health Inequalities Strategic Framework for Action outlines an action to *'develop a common approach to engaging our communities that experience health inequalities to enable access to services and ensure voices are heard with equity'.*

2.1.5 The foundations are already in place. The Community Voices programme has developed as a collaborative, ICS-led programme of work that brings together the NHS, local government and the VCSE sector, which has been delivered since the pandemic.

2.1.6 Community Voices engages our 'Core20plus' communities via trusted communicators, usually within the VCSE sector, local government and organisations such as Healthwatch. It aims to build health literacy in communities, as well as gather qualitative insights that we analyse and use to inform planning and strategic decision making. It allows our most vulnerable people and communities to have a voice in our communities and be heard.

2.1.7 Working with Public Health, a training programme has been developed that includes "Making Every Contact Count" and ensures that our trusted communicators are equipped to have conversations about a range of topics which have included cancer screening, women's health, 'healthy hearts', smoking cessation and unemployment.

2.1.8 Trusted communicators feed their insights into a central 'insight bank', a valuable repository of information to inform commissioning, design and implementation of services as well as evidence need and inform investment cases.

2.1.9 The Voices programme brings together existing mechanisms for engaging communities and has worked closely with 50+ organisations, including district/borough 'community marshals and community connectors', social prescribers and VCSE organisations that have established trust with our seldom heard communities. It provides the infrastructure to harness the existing assets in our system and enhance them, rather than creating something new.

2.1.10 Partners feel that Community Voices has the potential to be scaled, via our place-based structures, to provide a 'common approach' to engage with our communities and could form part of a much-needed community connections or 'Health Creation Strategy'. Through the model, we can support the development of action plans for all three of the pillars in the Framework, with Voices having previously facilitated engagement around living and working conditions, lifestyle factors and healthcare and demonstrated good outcomes.

2.1.11 The Integrated Care Academy have offered support to Norfolk and Waveney to bring together existing expertise in the coproduction space and develop a common framework, through the lens of innovation. A series of workshops are planned for March 2025.

2.1.12 There are other pockets of great practice in the community connection space, but, as yet, no common approach or agreed strategy for how we deploy resources, how we equip our 'connectors' with training and digital resources and how we align with social prescribing and other advice and guidance approaches. This is a pivotal requirement for the future.

2.1.13 Go to www.thehealthcreationalliance,org for more information regarding the Health Creation approach.

2.2 Place level action

2.2.1 The evidence is clear that “place” is often the geographical footprint where system integration is best delivered and the greatest impact is possible in tackling inequalities, with more opportunities to deliver proactive, preventative care, develop a more ‘community first’ health service and make a positive contribution to social and economic outcomes and address the wider determinants of health.

2.2.2 Place Boards in West, Norwich and Great Yarmouth & Waveney have held workshops around their role in supporting the implementation of the Framework, with common agreement that they play a significant part in tackling *healthcare inequalities* and *creating the conditions for success.* Place Boards are developing action plans for healthcare inequalities, aligning with the Core20plus5 programme and the Health Inequalities Commitment.

2.2.3 Health and Wellbeing Partnerships are being supported by Advanced Public Health Officers (APHOs) to develop their future strategies. There is agreement to incorporate the health inequalities framework commitments within these strategies, with HWPs playing a key role in delivering primary prevention (lifestyle) and tackling the wider determinants of health (living and working conditions). This activity will be collated into a system view via the new Living and Conditions Group, for which TOR were agreed in March 2025.

2.2.4 As highlighted in the previous papers, the potential for place to contribute to the health inequalities agenda is significant, and a commitment to delegation, overcoming local challenges and breaking down organisational siloes at a local level could have significant impacts.

2.2.5 Formally agreeing the role of and the division of responsibilities between place-based structures to provide local leadership for the health inequalities agenda would facilitate the development of local action plans, aligning where appropriate to system activity. It is largely agreed that the Place Boards should provide the leadership around Healthcare Inequalities (coming together via the Healthcare Inequalities Oversight Group) and the HWPs for the lifestyle and living and working conditions (coming together via the Health Improvement Transformation Group and Living and Working Conditions Group).

2.3 Organisational level action

2.3.1 At the ICP conference in October 2024, the **Health Inequalities Commitment** was launched. This commitment asked organisations to undertake several actions to support the implementation of the Framework. These actions include:

a) Nominating/appointing a health inequalities lead.
b) Supporting the development of a Norfolk & Waveney Advocate Network through the identification of organisational advocates.
c) Undertaking a self-assessment to capture existing good practice and areas for improvement to inform an organisational improvement plan.

2.3.2 Early uptake of the Commitment has been relatively good, with the VCSE sector in particular pledging their commitment to the programme.

2.3.3 NHS England recently launched the 3rd cohort of the **Core20 Ambassador programme**, which brings individuals from across the country together and provides knowledge, learning and networking opportunities. Norfolk and Waveney had amongst the highest uptake of this cohort compared to other ICSs, with over 35 Ambassadors signed up to the cohort 3 programme.

2.3.4 In early 2025, the Ambassadors of cohort 3 and the previous cohorts will come together to discuss a Norfolk & Waveney advocate network to drive change in our local system.

2.3.5 A summary of the uptake of the commitment, self-assessment and Core20 Ambassador programme can be seen in Appendix 1.

2.3.6 In addition to the local commitments, NHS trusts and the ICB have undertaken a Health Inequalities Board Maturity Assessment, facilitated by NHS Providers. These assessments give valuable insights into the current ways of working, elements of good practice and areas of improvement and is being used to develop organisational improvement plans and contribute to an NHS Anchors system improvement plan that identifies and addresses common areas of action.

2.4 System level action

2.4.1 The Steering Group and Coordination Group have been driving implementation of the 10 actions. This includes the development of a Health Inequalities Commitment programme, which organisations from across the ICS have been invited to support.

2.4.2 The development of resources to support organisations to undertake the commitment have been, or are being, developed. These include:

- An ICS Health Inequalities Ambassadors Network.
- A self-assessment process that can support organisations to develop organisational improvement plans.
- A primary care Health Inequalities training pilot, launching in Feb 2025, that can be scaled across the system.
- The development of a toolkit that can support organisations and individuals to address inequalities (including Equality and Health Inequalities Assessment tools), which will be published in an accessible format A health inequalities dashboard which includes the key metrics for each of our ‘building blocks’ for success and will enable our governance structures and places to monitor impact.

2.4.3 Good progress has been made in the development of governance structures to oversee the action plans to support living and working conditions, lifestyle factors and healthcare access, experience and outcomes.

2.4.4 The **Healthcare Inequalities Oversight Group** is developing and implementing a programme to deliver the Core20plus5 health improvement frameworks for adults, children and young people, as well as creating an NHS Anchors group to drive improvements across our NHS providers and the ICB and maximise our opportunities to support wider social and economic outcomes.

2.4.5 The **Health Improvement Transformation Group** is developing and implementing an action plan focused on physical activity, smoking cessation, diet and behaviour change. A programme of behaviour change training is being rolled out across the ICS, the Active NoW programme has reached over 8000 people across Norfolk & Waveney and significant strides are being made to develop a more integrated approach to smoking cessation, which is aligning with place-based activity.

2.4.6 The **Living and Working Conditions Group** has been established with an agreed Terms of Reference and are currently developing the work programmes which focus on ‘a home, a house and a friend’.

2.4.7 Following a strategic review and the appointment of a new Chair, Tim Gardiner, the **VCSE Assembly** relaunched in January with a new Terms of Reference and is currently developing a communications plan to ensure a greater profile and improved engagement across the wider VCSE sector. Activity is underway to highlight the significant risk faced by the sector due to current financial challenges within the system, as well as the increase in demand on their services, and understand the impact.

2.4.8 In line with the commitment to map the flow of health inequalities resources & spend across ICS organisations, the Health Inequalities Steering Group is coordinating discussions around resourcing of priorities and how to maximise budgets moving forwards. Feedback from partners suggests that a system-wide commitment to 'proportionate universalism' (the principle of everyone needing something and some people needing more) is required. As a system, we need to commit to **equitable** rather than **equal** funding allocations or we will exacerbate rather than address existing health inequalities. It's not about creating a postcode post-code lottery; it's **warranted variation** to meet local needs and tackle the indefensible gap in life expectancy across Norfolk & Waveney.

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Uptake of Health Inequalities Commitment, Self-Assessment and Ambassador Programme **Appendix 1**

Health Inequalities Commitment Sign Ups ***(full or partial – where they are partial, I am working with the organisations to explore how they might sign up to all aspects)***

Sector	Count
VCSE	5
VCSE/Housing	1
Health	2
Local Authority	4
Total	**12**

Health Inequalities Self-Assessment (EQUIP)

Sector	Count
VCSE	6
Local Authority	2
Health	2
Total	**10**

Core20Plus Ambassadors ***(breakdown by sector across Norfolk and Waveney)***

Sector	Count (as per list provided by NHSE – in process of confirming)
VCSE	5
Health (ICB)	9
Health (Acute)	7
Health (Primary Care)	6
Health (Community)	1
Local Authority	6
Other	1
Total	**35 *(in process of confirming)**