Norfolk Health & Wellbeing Board

Date: **Wednesday 21 June 2023**
Time: **09:30 - 12:30**
Venue: **Old Canteen, County Hall, Martineau Lane, Norwich**

Representing	Membership	Substitute
Borough Council of King's Lynn & West Norfolk	Cllr Alexander Kemp	
Breckland District Council	Cllr Tristan Ashby	Cllr Sam Chapman-Allen
Broadland District Council	Cllr Natasha Harpley	
Cambridgeshire Community Services NHS Trust	Anna Gill	Steve Bush
East Coast Community Healthcare CIC	Ian Hutchison	Tony Osmanski
East of England Ambulance Trust	David Allen	
East Suffolk Council	Cllr Mike Ninnmey	
Great Yarmouth Borough Council	Cllr Emma Flaxman-Taylor	Cllr Donna Hammond
Healthwatch Norfolk	Patrick Peal	Alex Stewart
James Paget University Hospital NHS Trust	Joanne Segasby	Anna Davidson
Norfolk Care Association	Christine Futter	
Norfolk Community Health & Care NHS Trust	Lynda Thomas	Stephen Collman
Norfolk Constabulary	ACC Nick Davison	Supt Chris Balmer
Norfolk County Council, Cabinet member for Public Health and Wellbeing, Leader (nominee)	Cllr Bill Borrett	
Norfolk County Council, Cabinet member for Childrens Services and Education	Cllr Penny Carpenter	
Norfolk County Council, Director of Public Health	Stuart Lines	
Norfolk County Council, Interim Executive Director Adult Social Services	Debbie Bartlett	
Norfolk County Council, Executive Director Children's Services	Sara Tough	Sarah Jones
Norfolk County Council, Cabinet member for Adult Social Services	Cllr Alison Thomas	
Norfolk & Norwich University Hospital NHS Trust	Tom Spink	Sam Higginson
Norfolk & Suffolk NHS Foundation Trust	Stuart Richardson	
Norfolk and Waveney Integrated Care Board NHS	Tracy Williams	
Norfolk and Waveney Integrated Care Board NHS	Dr Satish Singh	
Norfolk and Waveney Health and Care Partnership (Chair) and NHS Norfolk and Waveney Integrated Care Board (Chair)	Rt Hon Patricia Hewitt	
Norfolk and Waveney Integrated Care Board (Chief Executive)	Tracey Bleakley	
North Norfolk District Council	Cllr Wendy Fredericks	Cllr Liz Withington
Norwich City Council	Cllr Cate Oliver	
Police and Crime Commissioner	Giles Orpen-Smellie	Dr Gavin Thompson
Queen Elizabeth Hospital NHS Trust	Chris Lawrence	Alice Webster
South Norfolk District Council	Cllr Kim Carsok	Cllr Andy Evans
Voluntary Sector Representative	Emma Ratzer	Pete Boczko
Voluntary Sector Representative	Dan Mobbs	
Voluntary Sector Representative	Alan Hopley	Daniel Childerhouse

Additional members invited as guests:

Suffolk Health and Wellbeing Board	Cllr Beccy Hopensperger

For further details and general enquiries about this Agenda please contact the Committee Officer: Jonathan Hall on 01603 679437 or email: committees@norfolk.gov.uk

Integrated Care Partnership

Date: **Wednesday 21 June 2023**
Time: **on rise of the Health and Wellbeing Board**
Venue: **Old Canteen, County Hall, Martineau Lane, Norwich**

Representing

Borough Council of King's Lynn & West Norfolk
Breckland District Council
Broadland District Council
Cambridgeshire Community Services NHS Trust
Chair of Voluntary Sector Assembly
East Coast Community Healthcare CIC
East of England Ambulance Trust
East Suffolk Council
Great Yarmouth Borough Council
Healthwatch
James Paget University Hospital NHS Trust
Norfolk Care Association
Norfolk Community Health & Care NHS Trust
Norfolk Constabulary
Norfolk County Council, Cabinet member for Adult Social Care, Public Health and Prevention
Norfolk County Council, Cabinet member for Childrens Services and Education
Norfolk County Council, Director of Public Health
Norfolk County Council, Executive Director Adult Social Services
Norfolk County Council, Executive Director Children's Services
Norfolk County Council, Leader (nominee)
Norfolk & Norwich University Hospital NHS Trust
Norfolk & Suffolk NHS Foundation Trust
Norfolk & Waveney Integrated Care Board (Chair)
Norfolk & Waveney Integrated Care Board (Chief Executive)
North Norfolk District Council
Norwich City Council
Police and Crime Commissioner
Place Board Chairs for each Place Board area
Primary Care Representatives (1)
Primary Care Representatives (2)
Primary Care Representatives (3)
Primary Care Representatives (4)
Primary Care Representatives (5)
Queen Elizabeth Hospital NHS Trust
South Norfolk District Council
Suffolk County Council, Cabinet Member for Adult Care
Suffolk County Council, Executive Director of People Services
Voluntary Sector Representative (1)
Voluntary Sector Representative (2)

For further details and general enquiries about this Agenda please contact the Committee Officer:

Jonathan Hall on 01603 679437 or email: committees@norfolk.gov.uk

Norfolk Health & Wellbeing Board and Integrated Care Partnership

Wednesday 21 June 2023
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 Kett Room near the Old Canteen at County Hall, Norfolk County Council.*

1.	Apologies	Committee Officer	
2.	Chair's opening remarks	Chair	
	Norfolk Health and Wellbeing Board		
3.	HWB Minutes	Chair	(Page 4)
4.	Actions arising	Chair	
5.	Declarations of interests	Chair	
6.	Public Questions (How to submit a question: HWB) Deadline for questions: **9am, Friday 16 June 2023**	Chair	
7.	Urgent arising matters	Chair	
8.	Five Year Joint Forward Plan (HWB)	Tracey Bleakley/ Andrew Palmer	(Page 13)
9.	Norfolk's Better Care Fund (BCF) End of Year Return (2022/23) and BCF 2023-25 Update (HWB)	Debbie Bartlett/ Bethany Small / Nicholas Clinch	(Page 64)
	Integrated Care Partnership		
1.	ICP Minutes	Chair	(Page 4)
2.	Actions arising	Chair	
3.	Declarations of Interest	Chair	
4.	Public Questions (How to submit a question: ICP) Deadline for questions: **9am, Friday 16 June 2023**	Chair	
5.	Our approach to improving pharmacy, Ophthalmology and dental services (ICP)	Tracey Bleakley/ Sadie Parker	(Page 92)
6.	Mental Health System Collaboratives (ICP)	Tracey Bleakley/ Adele Madin Debbie Bartlett/ Lorrayne Barrett Stuart Richardson/ Kathryn Ellis	(Page 97)
7.	Childrens Social Care reforms, SEND and Alternative Provision Improvement Plan (ICP)	Sara Tough	(Page 118)
8.	Public Health Prevention: Cardiovascular Disease (ICP)	Stuart Lines/ Dr Abhijit Bagade	(Page 124)
9.	CQC Local Authority and Integrated Care System Assessments (ICP)	Debbie Bartlett/ Lorrayne Barret	(Page 132)

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
Minutes of the meeting held on 8th March 2023 at 09:30am
in Council Chamber, County Hall Martineau Lane Norwich

Present:	**Representing:**
Cllr Alison Webb	Breckland District Council
Cllr Fran Whymark	Broadland District Council
Cllr Emma Flaxman Taylor	Great Yarmouth Borough Council
Judith Sharpe	Healthwatch Norfolk
Jonathan Barber	James Paget University Hospital NHS Trust
Rt Hon Patricia Hewitt	Norfolk & Waveney Health & Care Partnership (Chair) and NHS Norfolk & Waveney Integrated Care Board (Chair)
Tracey Bleakley	Norfolk and Waveney Integrated Care Board (Chief Executive)
Tracy Williams	Norfolk and Waveney Integrated Care Board
Christine Futter	Norfolk Care Association
Assistant Chief Constable Nick Davison	Norfolk Constabulary
Giles Ophen-Smellie	Norfolk Police and Crime Commissioner
Cllr Bill Borrett	Norfolk County Council, Cabinet member for Adult Social Care, Public Health and Prevention
Cllr John Fisher	Norfolk County Council, Cabinet member for Children's Services
Dr Louise Smith	Norfolk County Council Director of Public Health
James Bullion	Norfolk County Council Executive Director, Adult Social Services
Sara Tough	Norfolk County Council Executive Director, Children's Services
Sam Higginson (until 11.04am)	Norfolk & Norwich University Hospital NHS Trust
Kathryn Ellis	Norfolk & Suffolk Foundation NHS Trust
Tracy Williams	Norfolk & Waveney Integrated Care Board
Cllr Virginia Gay	North Norfolk District Council
Cllr Adam Giles	Norwich City Council
Dr Jeanine Smirl	Norwich Place Board
Cllr Alison Thomas	South Norfolk District Council
Dr Steven Bush (from 9.39am)	Cambridgeshire Community Services NHS Trust
Chris Lawrence	Queen Elizabeth Hospital NHS Trust
Alan Hopley	Voluntary Sector Representative
Dan Mobbs	Voluntary Sector Representative
Emma Ratzer	Voluntary Sector Representative
Guests Members	
Cllr Beccy Hopfensperger	Suffolk Health and Wellbeing Board
Bernadette Lawerence	Suffolk County Council
Officers Present:	
Stephanie Butcher	Policy Manager Health and Wellbeing Board
Rachael Grant	Policy Manager Public Health
Stephanie Guy	Advanced Public Health Officer
Jonathan Hall	Committee Officer

Speakers:

Marcus Bailey	Winter Director, Norfolk and Waveney Integrated Care Board
Steven Course	Director of Finance Norfolk and Waveney Integrated Care Board.
Alison Gurney	Programme Director – Lead for Place Partnerships & Health Protection
Gary Heathcote	Director of Commissioning – Adult Social Services
Rachael Peacock	Head of System Resilience – Norfolk and Waveney Integrated Care Board.
Bethany Small	Commissioning Manager, Social Care and Health Partnerships
Diane Steiner	Deputy Director of Public Health
Josh Robotham	Senior Epidemiologist Public Health

Norfolk Health and Wellbeing Board (HWB)

1. Apologies

1.1 Apologies were received from Anna Gill (Steven Bush substituting), Chris Lawrence, Tony Hutchison and his substitute Tony Osmanski, Cllr Mary Rudd, Lynda Thomas, Patrick Peal (Judith Sharpe Substituting), Stuart Richardson (Kathryn Ellis substituting) Cllr Lana Hempsall, Cllr Sam Sandell and Tom Spink (Sam Higginson substituting).

Absent: Dr Satish Singh, John Webster, Dr Ge Yu, Dr James Gair and David Allen.

2. Chair's opening remarks

2.1 The Chair welcomed all present and advised that the Integrated Care Partnership (ICP) meeting would follow directly after the meeting. In addition, he advised that the meeting would be the last attended by Dr Louise Smith, Director of Public Health (DPH) as she was to start a new role with the UK Health Security Agency (UKSA). The Chair thanked Dr Smith on behalf of the committee, for her excellent direction and guidance as the DPH for Norfolk was both a founder member of the HWB and the ICP. Dr Smith was a reassuring presence during the pandemic and was a key part of the County's efforts to help tackle the spread of Coronavirus and providing calm and effective support for communities. The Chair presented Dr Smith with a basket of flowers and wished her well in her new role.

3. HWB minutes

3.1 The minutes of the Health and Wellbeing Board meeting held on 9 November 2022 were agreed as an accurate record and signed by the Chair.

4. Actions arising

4.1 At the meeting of the Integrated Care Partnership on 9 November 2022, the transitional Integrated Care Strategy for Norfolk and Waveney was agreed. This strategy is combined with the Joint Health and Wellbeing Strategy for Norfolk. The committee agreed to ratify the strategy in the HWB meeting.

5. Declarations of interest

5.1 No interests were declared.

6. Public questions

6.1 None.

7. Urgent Matters Arising

7.1 None.

8. Better Care Fund – Adult Social Care Discharge Fund

8.1 The HWB received the report which advised that an additional £9.67m had been received in November 2022 for Adult Social Care Discharge Fund (ASC Discharge Fund) which had been split between NHS Norfolk and Waveney Integrated Care Board and Norfolk County Council. The Board were asked to ratify the jointly designed and agreed spending plans.

8.2 James Bullion, Executive Director of Adult Social Services, introduced the report and advised that the fund and additional funding received had been of prime importance in our system over the winter period and Norfolk had improved its relative position from 17% of beds occupied by a person who is deemed not to have a criteria to reside down to 13% and is one of the fastest improving areas in England,being below the average. Tributes were paid to Social Care, Community Health Staff and the Reablement Service for this position. However, it was recognised the limitations of a grant that is about discharge and not about admission avoidance.

8.3 Bethany Small, Commissioning Manager, Social Care & Health Partnerships and Marcus Bailey, Winter System Director NHS Norfolk & Waveney ICB presented the report. It was advised that some tabled information in appendix 2 was not showing due to a technical error and this would be recirculated to members shortly.

8.4 The following points and comments were discussed and noted:

- The funding for the Adult Social Care Discharge Fund was, for the first time, being extended to 2 years concurrently meaning that planning and implementation of plans could take place with some confidence and reassurance of service improvements.
- Partnership working across the system is really starting to make a difference
- Data was being collated for the current winter period and would be analysed to determine what had been successful in increasing discharges and what initiatives had worked well. A report detailing this data and evaluation findings would be presented to the HWB in due course.
- Evaluation of the initiatives will be good to enable understanding of the schemes that have worked well and those that could work better and be more sustainable. True effectiveness takes time and the recurrent funding would help with this as well as the ability to be agile enough across the system
- Wrap around support such as Occupational Therapy support is important around the beds, and for next year it is important to consider creating a critical mass around the urban areas so this support can be provided.
- It was felt that purchasing beds in advance with the Care Sector would have helped providers plan better in advance of winter pressures.

- It was acknowledged that weekend discharge was slower and that plans were in place to help resolve the issue. It was difficult sometimes to achieve as discharge needs could be complex.
- Whilst additional funding was welcomed it was hoped that better collaborative working within the partnerships would help the sector increase capacity to provide additional services and not just be utilised to purchase bed space.
- Workforce constraints would slow progress, however recuring funding would help secure positions and embed roles for the future. As plans develop and advance, partners would become reassured and have trust that funding channelled into areas where the data had shown had the greatest impact would benefit all in the sector.

8.4 The Health and Wellbeing Board **resolved to:**

- Receive and ratify the Adult Social Care Discharge Fund spend plans.

9. **Norfolk & Waveney Integrated Care Board Annual Report**

9.1 The HWB received the report. As part of the submission for the Annual report the HWB must be consulted on the narrative given by Integrated Care Board (ICB) on how it has met the priorities of their local Health & Wellbeing Boards.
The report was presented by Tracey Bleakley, Chief Executive, Norfolk and Waveney ICB, who advised that feedback from members could be received up until June 2023 when the report is due for submission. There was a large amount of governance and structural work that had been undertaken in the past 12 months which was reflected within the report, however it should also be noted that increased partnership working across the whole health care sector in Norfolk and Waveney and other stakeholders had been established and was having a greater impact.

9.2 The following points and comments were discussed:

- It was welcomed that the report not only aligned the priorities of both HWBs and Councils within the ICB region but acknowledged that evidence based priorities to address inequalities was key. Work undertaken by clinical staff and practitioners underpinned the strategy which helped identify the need to tackle issues in the most deprived areas within the ICB region.
- Members were pleased to note that the report concentrated on relationships between all partners and was not just about systems and processes. It was felt closer working was a key goal for future progress.

9.3 The Health and Wellbeing Board **resolved to:**

- Provide comment on the draft narrative and propose any amendments they would like made.

10 **Director of Public Health, Annual Report 2022 – How does health vary in Norfolk?**

10.1 The HWB received the report which highlighted the importance of place in addressing health needs and demonstrated how the new Office for National Statistics (ONS) Health Index can be used to understand the health needs of local areas.

10.2 The report was presented by Dr Louise Smith DPH, who highlighted the inequalities and vulnerable groups where the Health Care Sector needed to prioritise their actions. The

data reflected the 42 electoral wards within Norfolk that are the most deprived (which encompasses 140,000 residents). The data also reflected that Norfolk is significantly below average on mental health outcomes. In addition, other keys areas that required improvement were those with disabilities, deaths from cancer and cardio vascular diseases. Access to services was also a challenge, partly because of the wide geographical nature of Norfolk but also because of the current location of services which effected uptake, especially by those in the most deprived 42 electoral wards.

The DPH summed up by:

- Asking the question on how the top line strategy of the Health and Care System prioritises those 42 electoral wards in Norfolk which are the most deprived and how do we target those electoral wards and the investment required to help them level up.
- Thanking her team, Diane Stenier, Josh Robotham and Alison Gurney for their hard work in preparing the report.

10.2 The following points and comments were discussed:

- Although it was agreed that tackling smoking within those most deprived 42 electoral wards would help reduce cancer and heart disease, it was considered that for those residents it would be harder and more demanding to do so and perhaps does not recognise the overall wellbeing and deprivation experienced. The report had highlighted that in some of the areas smoking was as high as 35% of the adult population.
- The data would be taken to the Health and Wellbeing Partnerships and it was thought that the most effective solutions lie at a local Place level. The Place Boards should be encouraged to use the data as a driver for their actions so they understand who they should be targeting and what services they require.
- The pandemic had proved that local partnership working relationships in areas had been successful and that working with communities, finding out about their needs and wants, would bring about the biggest differences to improving outcomes.
- Whilst mental health outcomes were significantly below average in Norfolk, this was not entirely down to an aging population suffering from dementia as younger people and adolescents presenting with mental health issues also registered significantly on the Health Index.
- Prevention was also thought to have a key role in improving outcomes and much of this could be delivered at Place Level although resources would be needed. Developing a strategy for children's learning, focusing on children with special educational needs and disabilities to involve communities and schools. It was suggested that this might be a report that should be considered by HWB at a future meeting.
- It was thought that working directly with health care professionals at an individual level could provide confidence and support to understand, identify and challenge any discriminatory practice.
- It was considered that introducing a premium for tackling inequalities would see greater change at pace, although the funding for such an initiative would be challenging given the current financial pressures.

- Local initiatives such as Protect Now and Covid Protect had identified that engagement needs to be innovative to encourage those hard to reach residents. Specialist call handlers had been trained on how to engage and encourage residents to take up services. This was a testament as to how those service providers at Primary Care Network (PCN) level and below could make the greatest impact.

10.3 The Health and Wellbeing Board **resolved to:**
Approve the publication of the Director of Public Health's Annual Report on the Joint Strategic Needs Assessment (JSNA) website.

11 Five Year Joint Forward Plan

11.1 The HWB received the report which introduced the concept of the Joint Forward Plan (JFP) and highlighted the linkages to the transitional Integrated Care Strategy for Norfolk and Waveney/Joint Health and Wellbeing Strategy for Norfolk. There was a requirement to include opinion from HWB within the published JFP document. It was advised that the item will return to the HWB in June 2023 but conversations will be ongoing with partners across the system as the content of JFP is developed.

Tracey Bleakley, Chief Executive Norfolk and Waveney ICB presented the report and advised that it will return to the HWB for ratification in June. A public consultation was also in progress that had seen over 700 responses. The plan had to take in to account 17 legal requirements and also include the 8 priorities of ICB. The plan will be able to be revised twice over the next 5 years once finalised. The ICB will have to reduce its budget by 20% in 23/24 and by a further 10% the following year and no further uplift for pay rises. The ICB were looking to spend money to invest to save money in future years, although this would require discipline to achieve.

11.2 The following points and comments were discussed:

- The financial challenges of the decreasing budget were thought to be very difficult and prevention was key to help reduce the need for services, although this part of the budget required protection.
- It was hoped that any budget savings did not effect those in most deprived areas disproportionally and how could the System, Partnerships and Boards work together to protect the most vulnerable.
- It was thought the 8 priorities of the ICB should be the focus of the plan to achieve the best outcomes and plans should be put in place to underpin these to help identify what is required to be achieved from each stakeholder within the system.
- Engagement with communities on how the 8 priorities are targeted would be key to making the greatest impact. Lots of marginal change should hopefully add up to a significant level of positive outcomes over time. Older person focus was really welcomed.

11.3 The Health and Wellbeing Board **resolved to:**

- Support the development of the JFP as described in this report, with the more detailed work on the content led through partnership working across the System and reporting to the ICB Board.
- Receive the near final JFP at the next HWB meeting on 14 June 2023 and provide an opinion for inclusion in the published JFP.

The Health and Wellbeing board closed at 11:05am

Bill Borrett,
Chair of the Health and Wellbeing Board

Integrated Care Partnership (Norfolk and Waveney)

Before the formal start of the meeting the Chair Cllr Bill Borrett asked Sara Tough, Executive Director Children's Services to update everyone present on the results of the Ofsted inspection that took place in November 2022. The outcome was that the department was judged as Good with many aspects of the department considered to have exceptional and exemplary practices. In February 2023 the Care Quality Commission (CQC) and Ofsted undertook a revisit to consider if sufficient progress had been made addressing the serious weaknesses identified previously in special educational needs and disabilities. The inspection concluded good progress had been made and no further weaknesses existed. Sara Tough thanked the department staff for their hard work in achieving those results.

1. Minutes

1.1 The minutes of the Integrated Care Partnership (ICP) meeting held on 9 November 2022 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 No public questions had been received.

5. Amendments to the Integrated Care Partnership Terms of References

5.1 The Integrated Care Partnership (ICP) received the report which proposed changes to the terms of reference for the ICP.

5.2 The Integrated Care Partnership **resolved to:**

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

6. Norfolk and Waveney NHS System Capital Distribution 2023/2024

6.1 The ICP received the report which highlighted the process and progress made by the NHS in distributing the £42m of available capital resource for 23/24. The system was prosing to distribute £46.5m which accounted for a £4.5m over plan which was available as an option fwithin NHS planning guidance. This over planning could be scaled back if spending within the programme was on track and no slippage had occurred.

6.2 Steven Course, Director of Finance Norfolk and Waveney ICB presented the report and advised that in preparing the plans that statutory spending to ensure compliance with regulations and ensuring patient safety had to be considered and had consumed 60% of the available budget. A further 30% of the budget had been allocated to ensure an acceptable level of service was provided. The remaining 10% was allocated to strategic and business cases strategy. All requests for capital spending across the NHS partner organisations had amounted to £73m so a weighting system was used to allocate funding appropriately.

6.4 The Integrated Care Partnership **resolved to:**

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

7. Strategic Workforce Priorities for the Integrated Care System

7.1 The ICP received the report which provided an update to members on the work to date to ensure the Norfolk and Waveney People Strategy and Ambitions for the workforce align to the strategic system priorities, and national guidance, and that the System is actively working towards the ICS commitment to make Norfolk and Waveney the best place to work in health and care. Also to ensure workforce priorities are included in all of the system strategic priorities and planning activities, with the ambition to include the whole workforce across primary, secondary, tertiary and social care, local authorities and VCSE partners.

7.2 Tracey Bleakley, Chief Executive of Norfolk and Waveney ICB presented the report and gave Ema Ojiako's apologies as she was unable to attend.

7.3

- The following points and comments were discussed:
- The best Systems have a joint approach to workforce. Health, Housing and Social Care have lots of comminalities. Need to acknowledge the role of NORCA in the development.
- There was a general agreement that the Health and Care system had to work together on this issue but acknowledged that differences between sectors did exist and could be difficult to resolve, especially around the area of pay.

- It was suggested that recruitment in the most deprived areas should be targeted to help achieve the best outcomes.
- The voluntary sector had particular issues in keeping in line with general NHS pay increases as grants to provide services for the sector had no inflationary increases attached to protect real cost increases in wages.
- The voluntary sector often provided jobs at or just above minimum wage levels and this was proving difficult to recruit people to those roles. It was hard for the voluntary sector to compete with NHS employment terms and conditions.
- It was thought the priorities should include plans for retention and not just recruitment as better retention of staff would reduce the need for recruitment.
- The challenge to introduce a living wage in the whole sector should be considered although financial pressures made this unviable for just one provider to pursue this option unilaterally.
- Whilst care home pay was low it should be recognised that care homes stays do stop people from entering the wider mainstream system and demanding resources. Given this position it was thought consideration should be given to providing more resource to care homes from other parts of the system to alleviate pressures elsewhere.

7.4
- The Integrated Care Partnership **resolved to:**

- a) Endorse the planned approach to development of a refreshed We Care Together People Plan for the Norfolk and Waveney ICS in 2023/24.
- b) Support system partners to further integrate workforce approaches across NHS and Social Care where possible.

Meeting Concluded at 11.56am

Bill Borrett,

Chair of the Integrated Care Partnership

Report title: Norfolk & Waveney Joint Forward Plan (JFP) Update

Date of meeting: 21 June 2023

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

Reason for the Report

As mandated by the Health and Care Act 2022, ICBs and partner NHS Trusts / Foundation Trusts must prepare a five-year Joint Forward Plan (JFP) in collaboration with system partners. Go to England.nhs.uk to read the guidance on developing the joint forward plan. The guidance stipulates a requirement to include an opinion from relevant HWB's within the JFP. The Norfolk & Waveney Joint Forward Plan (N&W JFP) will therefore need to include an opinion from both the Norfolk and Suffolk HWB's.

Report summary

The N&W JFP describes how Norfolk & Waveney Integrated Care Board (N&W ICB) and its partner trusts intend to arrange and provide NHS services to meet the population's physical and mental health needs and how it will work with partners across the Integrated Care System to achieve this.

This report provides an overview of the engagement undertaken in developing the JFP, the approach taken to develop the JFP and information regarding the areas of ambition for the population set out in the JFP, including how we plan to work together to achieve these. The JFP is supported by a separate engagement workstream which commenced with an online survey in December/January that had more than 700 responses.

A copy of the draft JFP is in Appendix 1 and comprises of 2 parts: Part 1- main JFP and Part 2 - legal duties. It should be noted that this is a pre-design draft for opinion on the content. The published copy will be in the ICS colours with visuals, case studies, a glossary of terms and clear navigation to guide the reader through the document.

Recommendations

The HWB is asked to:

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

b) To agree to delegate to the Chairman of the Committee to provide a statement of opinion on behalf of the Norfolk Health and Wellbeing Board for inclusion in the JFP to meet the publication deadline of 30 June 2023, based on the comments raised by the Board at today's meeting.

1. Background

1.1 This report provides an update on progress with the development of the JFP, and follows a previous report presented to the HWB at the March 2023 meeting that introduced the statutory requirement. There has been considerable progress made during April and May to develop the JFP. Appendix 1 is the culmination of collaborative

work across our system partners and feedback received. The JFP can be updated in year and will be refreshed each year.

2. Developing our Joint Forward Plan

2.1 Norfolk and Waveney adopted the following five-point approach to develop the JFP, drawing together all the major components of our plan into a coherent vision for improvement over the medium to long term:

1. **Why** we are we doing this – use our ICS transitional Integrated Care Strategy and Joint Health and Well-Being Strategy for Norfolk & Waveney to set out the needs of our population using evidence, data and existing strategies, to compile an overall *case for change* to improve the health and outcomes for our local population.
2. **What** our ambitions for improvement are – group together the changes we need to make thematically, seen through the lenses of *cohorts of our population* and service *pathways,* to create an overall portfolio of change, with initial objectives identified and agreed.
3. **Outcomes** we will improve and the measures of success – define the individual projects and developments that will make up our portfolio of change, whether they will be delivered at system or local level, and how they will directly contribute to improving outcomes for our population.
4. **How** we are going to work together differently to deliver this.
5. **Commitment** – confirm a small number of achievable and impactful improvements and set these out in our first JFP release in detail for the period 2023 - 2025. Ensure these are aligned to our NHS Medium-Term Financial Plan so they are affordable, recognising capacity constraints and competing priorities to ensure they are deliverable.

2.2 **Eight Ambitions for Improvement**

2.3 Our ambition for the population is set out across eight areas of focus, that have been developed with System partners. They are evidenced through a data led approach using Public Health information, and the feedback to date from our public and stakeholder engagement:

1. Population Health Management, Reducing Inequalities and Supporting Prevention.
2. Developing a resilient and integrated model of Primary Care.
3. Improving services for Babies, Children and Young People and developing our Local Maternity & Neonatal System (LMNS).
4. Transforming Mental Health services.
5. Transforming care for people in later life.
6. Improving Urgent and Emergency Care.
7. Improving Elective Care.
8. Improving Productivity and Efficiency.

2.4 Ambitions 1, 3 and 5 were added in response to engagement with stakeholders and further discussion with system partners.

2.5 Each of these ambitions have a series of underpinning objectives and are set out in the JFP with clarity on what they will achieve, by when, and how we will measure the improvement.

2.6 **Working Together:** Working together is critical to being successful in delivering our ambitions for the population and also signals the commitment to working collaboratively as an ICS. We will do this by:

2.7 **Place based approach** – with clearly defined remit, responsibilities and decision making. Be clear about what we do at System level and what would be more effectively determined and delivered more locally, closer to our population.

2.8 **Provider Collaboration** – confirming our acute hospital, mental health and integrated community collaborative arrangements, so we understand remit, responsibilities and decision making.

2.9 **ICS Strategies** – ensure the JFP is aligned with existing strategic commitments such as those set out in our transitional Integrated Care Strategy and Joint Health & Well-Being Strategy, Clinical, Digital, Research and Innovation, Quality, Estates and Net Zero / Green strategies and our People Plan. This ambitions in our JFP and our enabling strategies need to work together as one, all pulling in the same direction.

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

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

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

2.13 Empowering and working with the **VCSE sector** differently and integrating VCSE provision into our design and delivery models for services.

2.14 Appendix 1 to this report provides a copy of the draft JFP and comprises of 2 parts, Part 1 (main JFP) and Part 2 (legal duties).

2.15 **Next Steps:** The JFP is being considered by both the Norfolk and Suffolk Health and Wellbeing Boards before being finally considered by the N&W ICB Board for approval at its meeting on 27 June 2023. The JFP will then be formally published by 30 June 2023. Thereafter, the JFP will be refreshed on at least an annual basis, including reporting on achievement of the ambitions and objectives set out in the plan.

Officer Contact

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

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

Norfolk and Waveney Joint Forward Plan

Part 2: Legal duties and other content

Contents

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

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

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

1. Population Health Management (PHM), 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 (BCYPM)
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

The eight ambitions are explained in detail in the JFP, including clear objectives, trajectories and milestones.

Duty to promote integration

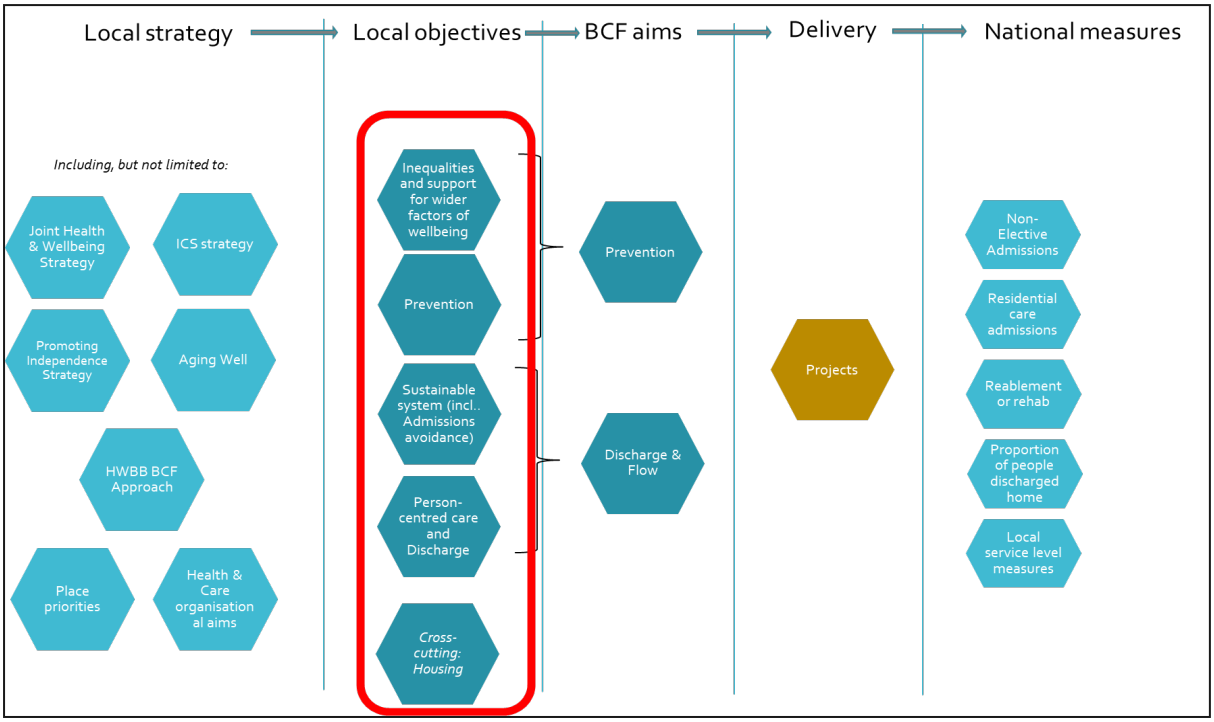
Norfolk and Waveney is committed to integrated working and joint commissioning across the health and social care system. This is reflected in the local approach to the Better Care Fund (BCF) - a nationally mandated programme with the aim of joining up health and care services, so that people can manage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

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

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

- Prevention, including admission avoidance
- Sustainable systems

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



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

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

- A Social Impact Bond for Carers – support carers with information, advice, support and Carers Assessments to improve their wellbeing and help them

maintain their caring role. This is joint funded by NCC and NHS N&W, with joint membership at the Strategic Board.

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

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

Duty to have regard to wider effect of decisions

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

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

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

People's health and wellbeing:

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

The quality of services:

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

The sustainable and efficient use of resources:

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

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

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

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

Financial duties

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

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

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

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

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

Capital resource planning and approvals

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

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

Revenue resource planning and approvals

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

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

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

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

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

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

Duty to improve quality of services

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

Shared Commitment to Quality

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

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

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

Well-led through a culture of compassionate leadership

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

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

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

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

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

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

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

Improving Care Quality and Outcomes

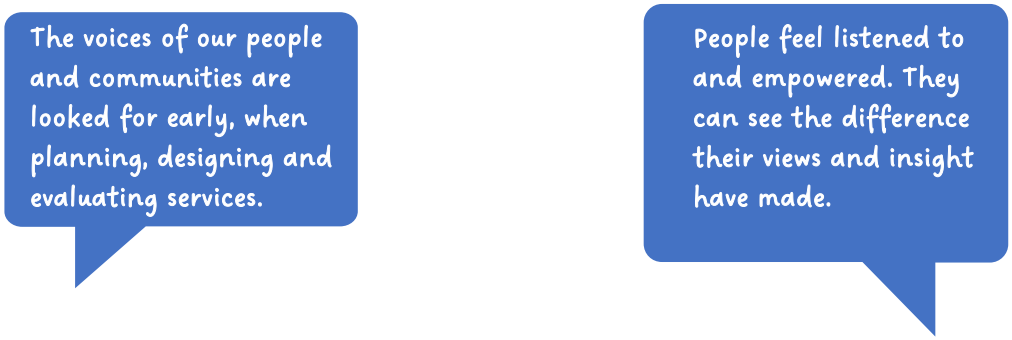
Quality Management Approach

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

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

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

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



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

Quality And Addressing Health Inequalities

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

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

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

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

Safe System

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

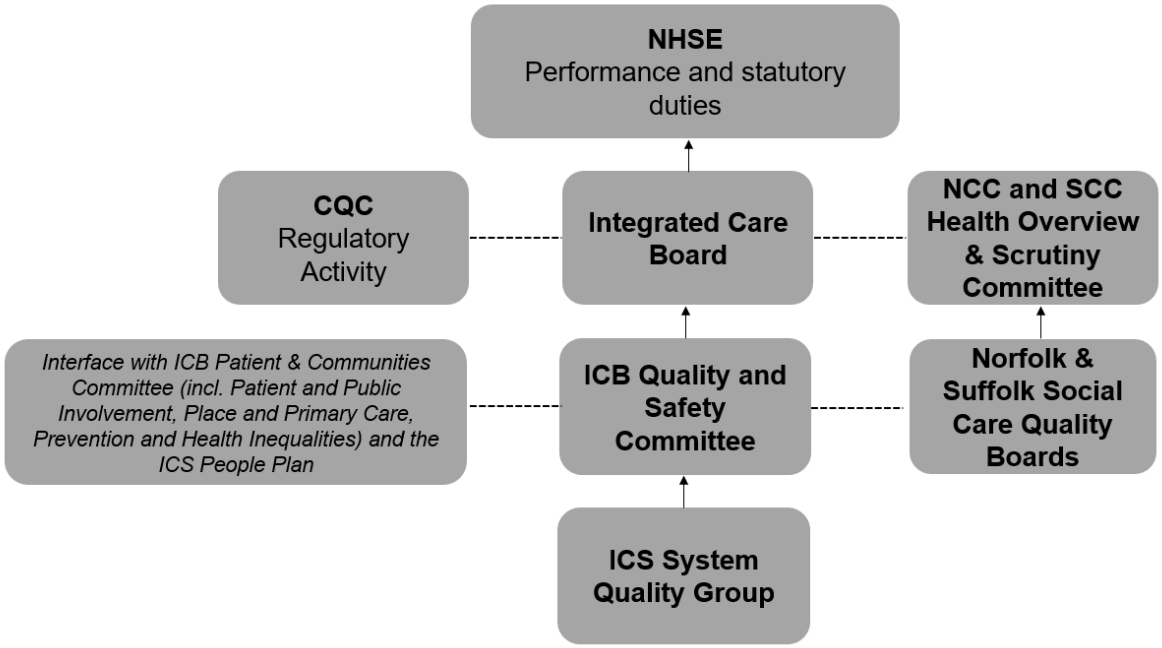
- Embedding a learning culture
- Supporting people to live healthier lives
- Safeguarding
- Safe and effective staffing
- Equity in access
- Equity in experience and outcomes

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

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

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

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



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

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

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

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

Sustainable System

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

Duty to reduce inequalities

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

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

The actions that will deliver the Health Inequalities strategy will be included in future versions of our Joint Forward Plan, informing all elements of what we do and how we work. More information about this is included in section 3.0. [check]

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

Using data to identify the needs of communities experiencing inequalities

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

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

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

This is alongside the "5" clinical areas of focus for adults (maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension case-

finding and optimal management and lipid optimal management) and the “5” clinical areas of focus for children and young people in the Core20Plus5 approach (asthma, diabetes, epilepsy, oral health and mental health). NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people

A number of these are reflected within specific objectives in this plan, for example a focus on asthma and epilepsy for children and young people. This will complement the established work that is already ongoing within the system in relation to diabetes, respiratory disease and medicines management, together with the Protect NoW approach that is described in the Population Health management section.

Working with and listening to people experiencing inequalities

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

The five strategic priorities for healthcare inequalities

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

Priority 1: Restore NHS services inclusively

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

Priority 2: Mitigate against digital exclusion

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

Priority 3: Ensure datasets are complete and timely

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

Priority 4: Accelerating preventative programmes (including Core20PLUS5 approach)

- **Vaccine inequalities** – a programme to improve the uptake of vaccines, including flu and COVID-19 – including data analysis, using local and national data resources; a roving model has been developed to target and achieve positive outcomes for underserved communities; development of Wellness Hubs to make every contact count and to offer a wider range of immunisations to local children and young people.

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

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

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

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

Duty to promote involvement of each patient

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

Norfolk and Waveney ICS is fostering a new relationship between people, professionals and the health and care system. This change shifts the power and decision making to enable people to feel informed and empowered to have a voice by working in partnership, connected to being focussed on a positive patient

experience through their local communities having choice on control of health and wellbeing outcomes that are important to them.

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

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

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

Personalisation for carers

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

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

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

so, through coaching, peer support and educating through collaborative and partnership approach, with patient's voice being heard in decision making and having more choice and control about their health and wellbeing needs.

Duty to involve the public

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

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

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

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

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

The ICB Communications and Engagement Team is divided into two key areas - Partnerships and Programmes – that work closely together to ensure that the ICB maintains focus on the strategic People and Communities work as well as offering

professional support and guidance for the day to day and transformational work undertaken by the ICB staff. A toolkit has been developed and is being refined to enable communications and engagement to become part of everyone's core business.

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

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

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

Duty as to patient choice

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

Our demographics mean it is very important that we provide realistic options for enabling patient choice, for example for people living in areas of deprivation and in rural areas with limited public transport. We must take this into account when commissioning new services. This means that the location of new services such as Community Diagnostic Centres and community dermatology clinics for example need to be easy for patients to access with extended opening hours, and that a wider range of services can be delivered closer to home, or, by maximising use of new

technology, in the patient's home. The use of Equality Impact Statements when designing new services or reviewing existing ones helps to focus attention on the needs of different patient groups and how best to deliver services that are inclusive and accessible to all.

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

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

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

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

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

Duty to obtain appropriate advice

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

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

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

We have a comprehensive Clinical and Care Professional Leadership Programme to further develop our approach. This is explained in more detail in section 6.5 [check]. As part of this, the ICB has recently conducted a review of its clinical advisors to ensure the organisation has the right expert advice to effectively discharge its functions effectively.

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

Introduction to duties to promote research and innovation

The ICS research and innovation strategy developed with system partners was published in May 2023: Research and Innovation Strategy

It sets out how we will ensure that research and innovation is focused on our communities, that we have a confident and capable workforce, that research and innovation is collaborative and coordinated and that evidence is incorporated in the commissioning and delivery of services and infrastructure - see below for more detail. There are many opportunities locally to embed research and innovation in all that we do. We have great assets, including the University of East Anglia with a large Faculty of Medicine and Health Sciences and a health and care workforce of over 55,000 people.

Duty to promote innovation

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

Innovation is a cross-cutting theme within the ICB and across the ICS, and we aspire for it to be integral to everything we do. We wish to ensure that the opportunities for receiving innovative services are equitable across the ICB boundary and will consider mechanisms to support the adoption and spread of innovations.

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

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

Duty to promote research

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

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

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

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

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

#WeCareTogether, the Norfolk and Waveney People Plan

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

#WeCareTogether refresh

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

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

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

The 10 ICS People Function Outcomes

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

This work will include updating the way we attract and retain staff, refreshing education programmes (including lifelong learning and quality improvement), changing the shape of existing services and developing new ones, and using technology to take over tasks (not jobs) to release capacity. The activities below will

form a key part of the delivery plan to achieving an integrated workforce across health and social care, and will be incorporated into the #WeCareTogether refresh.

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

Supporting the health and wellbeing of all staff

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

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

Growing the workforce for the future and enabling adequate workforce supply

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

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

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

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

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

Creating a great experience

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

Valuing and supporting leadership at all levels, and lifelong learning
We will continue to invest in leadership and management development programmes, mentorship opportunities and other initiatives to support the growth and development of our staff right across the ICS, particularly to ensure our leaders are representative of the workforce and population we serve. The health and wellbeing of our leaders will be a core thread of all programmes to ensure people have the tools and support to remain resilient.

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

Educating, training and developing people, and managing talent
We will work closely with educational providers supporting our medical and non-medical learners, to ensure programmes are reflective of local plans. We shall also work and listen to learners to ensure consistency and quality of experience during

training and having regular careers conversations to support individuals to wish to remain working in our system after they have completed training.

Driving and supporting broader social and economic development

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

Transforming people services and supporting the people profession

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

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

Leading coordinated workforce planning using analysis and intelligence

Our NHS provider workforce planning submissions this year have been collated and show the NHS ambition for workforce growth in 2023/24 to deliver operational priorities aligned to finance and activity. Plans are ambitious and centre on significant growth in the number of staff in post in registered nursing and those roles providing support to clinical staff.

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

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

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

Supporting system design and development

Our approach to delivering this outcome is set out in section 6.5 of our Joint Forward Plan about people and culture.

Duty as to climate change

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

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

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

- **Improving outcomes in population health and healthcare:** Adopting activities and interventions which slow the associated health impacts of climate change will help to improve population health.
- **Tackling inequalities in outcomes, experience and access:** Supporting action to address poor air quality, which disproportionally affects vulnerable and deprived communities through higher prevalence of respiratory illnesses, will help to tackle health inequalities.
- **Enhancing productivity and value for money:** Improving energy efficiency and using renewable energy sources across the ICS estate footprint will reduce long-term energy bills for the NHS and local councils.
- **Helping the NHS support broader social and economic development:** Ensuring all NHS procurements include a minimum 10% net zero and social value weighting will help to achieve this, as will adhering to future requirements set out in the NHS Net Zero Supplier Roadmap. Council procurements similarly place emphasis on reducing scope 3 carbon emissions and both the NHS and county councils require that bidders for

contracts valued at over £5m per annum have a carbon reduction plan in place.

Governance

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

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

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

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

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

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

Collaboration

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

The system works with partners to reduce system-wide emissions, including local authorities and the voluntary, community and social enterprise (VCSE) sector,

patients and the public. The Norfolk Climate Change Partnership and the Suffolk Climate Change Partnership support local government in Norfolk and Waveney to deliver Net Zero objectives and their objectives align well with the NHS Net Zero ambitions. This programme of work is integral to our forward plan to reduce impacts on the environment and embed a 'one public estate' approach that positively impacts our journey toward net zero.

Workforce and Resources

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

The system is engaged with the regional Greener NHS team and neighbouring ICSs to learn and share ideas and best practice. Through the green plan delivery group work the subject matter experts and sustainability leads collaborate to develop enable ICS Green Plan and Operating plan delivery. Existing pilot programmes for green initiatives are captured to harness their benefit to enhance positively, impacts on climate change and the environment.

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

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

Adapting to the impact of climate change

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

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

Norfolk and Waveney already experience the effects of considerable coastal erosion and is subject to many flood areas associated with increases in sea levels. Many of the impacts of climate change, including those for health, will be felt locally.

Therefore, the system needs to develop responses which encompass national guidance and yet are specific to our local circumstances. The system's Green Plan sets out the approach to mitigating climate change emissions from our activities and ensuring business continuity in a changing climate and includes a focus on increased readiness for changing times.

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

Addressing the particular needs of children and young people

Leadership has been identified in health and social care to drive forward the agenda and to ensure that the voice of children, young people and families is represented at the most senior level. The Children and Young People's Strategic Alliance Board provides oversight and assurance and is underpinned by thematic sub-groups leading on priority workstreams.

The voice of babies, children, young people (BCYP) and their families

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

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

Data and insight

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

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

Reducing health inequalities

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

In addition to those areas identified within Core20PLUS5, our Flourish strategy Flourishing in Norfolk: A Children and Young People Partnership Strategy – Norfolk County Council identifies four priority areas for system focus:

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

Family Hubs

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

Safeguarding

All systems have a statutory duty to safeguard. The Designated Safeguarding and Looked After Children teams influence, advise and support us to ensure it accords with the principles of the Children Act 1989 and is aligned to the Norfolk and Suffolk Safeguarding Children Partnership and priorities. The Teams ensure health and care services meet the statutory requirements of Section 11 of the Children Act 2004. The priority is to ensure 'safeguarding is everyone's' business' and remains at the heart of service delivery.

Our safeguarding teams work in collaboration with all partners in Norfolk and Waveney in the early identification of children at risk, including risk of exploitation, and recognition of all types of abuse and non-accidental injury promoting the needs of looked after children, those within the youth justice system and unaccompanied asylum seekers. Integrated working will support colleagues to work and communicate effectively across organisational boundaries, to ensure safety and provide child-centred care.

Safeguarding teams support information sharing and provide training to recognise presentations that are safeguarding relevant primary care through training to help GPs to prioritise safeguarding relevant meetings, and to efficiently complete requested reports. This will be further strengthened by the development of Family Hubs and will be vital in the development of early intervention and prevention.

Going forward our teams will drive greater integration through matrix working and multi-agency collaboration. Digital solutions to enable safeguarding information to be disseminated will be further developed and sharing data will be integral to the partnership approach.

Safeguarding professionals will advocate for BCYP, and champion early intervention and prevention services to avoid long term damage that has implications across society. We aspire to be a trauma informed system, recognising the importance of the early days of a child's life and development, and impact of adverse childhood experience on long term health and economy.

Continuing care for children and young people, including palliative and end of life care

The Council for Disabled Children describes a vision of a society in which “children’s needs are met, aspirations supported, their rights respected, and life chances assured” (https://councilfordisabledchildren.org.uk/about-us). This underpins the work of our Children and Young People’s Continuing Care Team where the aim is to achieve “gloriously ordinary” lives for the BCYP.

Continuing care packages are required “when a child or young person has needs arising from a disability, accident or illness that cannot be met by existing universal or specialist services alone” (NSF for Children and Young People’s (CYP) Continuing Care 2016, p5). Unlike adult continuing healthcare packages, which are entirely NHS funded, these packages can be jointly funded with education and social care and are very complex.

Norfolk and Waveney ICB currently offer two main approaches to the provision of continuing care – either a personal health budget (PHB) or a commissioned package of care, delivered by one of five agencies procured specifically for care of children.

Palliative care is a low volume, but significant part of the care delivered to babies, children and young people with continuing care needs. Our fast-track system in place complies with statutory guidance.

Partners have developed joint commissioning and quality oversight arrangements to ensure that all agencies are working together to meet the holistic needs of babies, children, young people and their families. We collaborate with regard to quality assurance and improvement and work together to develop provision closer to home.

Special Educational Needs and Disabilities (SEND)

The Children and Families Act 2014 is a statutory framework for the integration and personalisation of services for children and young people that require education, health, and care services. To fulfil this statutory duty, we work collaboratively with children and young people with SEND and their families, alongside education and social care services to provide the right support. This must be using the key principle of co-production and be person centred.

This includes identification of children and young people with SEND and to support them to access everyday activities with the right support and adjustments. We share support and resources across agencies for those on NHS waiting lists and skilling-up those working with children and young with key neurodevelopment difficulties, such as autism. We are committed to developing the wider workforce on key areas of SEND and to support workers to understand their duties and responsibilities. Children and young people with SEND are a vulnerable group and work will continue to drive equity of services and resources by raising awareness of the need and duty on services to make reasonable adjustments.

There will be key contact points across the health system to provide communication and support for children, young people and their families on health pathways. This

will ensure families, young people and those working in education and the care system know where to go to get NHS health advice and resources.

We will continue to ensure that there are opportunities for children, young people and their families to contribute to service development and to ensure their lived experience is heard and understood.

There is a programme to review and improve health pathways. Publications on local websites and Just One Norfolk will also be reviewed and improved.

Working with local authorities and wider stakeholders, we will further develop the SEND annual survey, increase the survey response rate and disseminate the learning to further influence commissioning.

Joint quality assurance visits will take place into complex needs schools to further strengthen quality improvement and build confidence within settings to manage heath/medical needs.

Work is underway to strengthen the use of shared data and analysis to inform commissioning of services for children and young people with SEND.
We aim to have a multi-agency SEND training platform that is accessible to all stakeholders, including children, young people and their families.

We will develop a shared understanding and vision across children, young people and adult commissioning to ensure SEND is seen as everyone's business.

Partnership working will be strengthened through the SEND Partnership board, multi-agency working, and we will feed in regional and national systems to develop innovations and initiatives.

System partners will work together to develop high quality information and support for children and young people with SEND, so that they know what can be accessed, what they can do to self-serve and to signpost to the most appropriate service when it is needed.

We will work as a system to become needs led and not medical and diagnostic driven and we will build confidence in the services and resources available by celebrating difference and individuality.

Autistic Spectrum Disorder (ASD) and Learning Disability (LD)

Individuals with Autistic Spectrum Disorder (ASD) and Learning Disability (LD) face significant health inequalities compared with the rest of the population. The NHS Long Term Plan states a commitment for the NHS to do more to ensure that all people with a learning disability, autism, or both can live happier, healthier, longer lives. This means that we must provide timely support to children and young people and their families and ensure health and care services are accessible and make reasonable adjustments.

As part of the system commitment to improving quality and outcomes through the learning from deaths process, we will continue to contribute to the Learning Disabilities Mortality Review Programme (LeDeR), to ensure that health improvements can be targeted to those areas which will have the biggest impact. Working as a system, we will aim to meet emerging need early.

Children and young people's mental health

We aim to prevent mental illness, early identification of need and the promotion of initiatives that increase resilience to ensure children and young people are supported earlier around their wellbeing needs and reduce the burden on specialist mental health services in the future. Priority areas of focus include:

- Increasing access to mental health services through the Talking Therapies Collaborative to deliver an integrated service offer from VCSE sector and independent partners, where therapeutic care can be accessed from a range of providers.
- Providing early support in schools through Mental Health Support Teams
- By 2030 we aim to have 100% coverage of mental health support teams across all schools in Norfolk and Waveney and we will adopt a whole family approach to meeting mental health needs across Norfolk and Waveney, with a focus on communities and primary care.
- Providing 24/7 assessment and care to children and young people presenting in a crisis through an Integrated Practice Model, bringing together system partners to support children and young people with complex needs that present in crisis.
- To support early intervention and prevention, we will develop an all-age social prescribing offer ensuring that access to positive activities that improve wellbeing is tailored and accessible to all.
- Building on the use of the Just One Norfolk Platform and Kooth, we will ensure all CYP have access to self-help resources and information about resources and support within Norfolk and Waveney.
- Working with the Anna Freud Centre, The Charlie Waller Trust, The National Children's Bureau and NHS England, we will co-produce, deliver and evaluate a whole system mental health training offer for the wider children's workforce.

Through the Strategic Alliance, decisions are made at a system level and challenges within the system are discussed and resolved in collaboration. To support the integration of services we are launching an integrated front door for all emotional wellbeing and mental health services, providing a trusted assessment and onward referral to the most appropriate service. The Integrated Front Door is an objective within the Transforming Mental Health Services ambition in the JFP.

Local Maternity and Neonatal System (LMNS)

The LMNS brings together the NHS, local authorities and other local partners with the aim of ensuring women and their families receive seamless care, including when moving between maternity or neonatal services or to other services such as primary care or health visiting.

Alongside this, NHS England will publish a single delivery plan (SDP) for maternity and neonatal services in Spring 2023 from which the recommendations will be implemented.

We will continue to focus on addressing exclusion and inequalities. The LMNS has undertaken analysis of the needs and characteristics of its communities and has published an action plan to address these (Norfolk and Waveney Maternity Equity and Equality action plan).

The LMNS will continue to put in place the infrastructure needed to enable rollout of Midwifery Continuity of Carer, so it is the default model for all women and so that 75% of women of Black, Asian and Mixed ethnicity and from the most deprived neighbourhoods are placed on pathways.

Addressing the particular needs of victims of abuse

The ICB is committed to working with all partners across Norfolk and Waveney to consider the needs of and provide support to victims of abuse (including victims of domestic abuse and sexual abuse, both children and adults).

We have important arrangements in place in Norfolk and Waveney for partnership working on this agenda:

- The ICB is an active member of our two local Community Safety Partnerships:
    - Norfolk County Community Safety Partnership (NCCSP), which sits under the jurisdiction of the Office of the Police and Crime Commissioner for Norfolk (OPCCN).
    - East Suffolk Community Partnership (ESCSP), which is hosted by the Suffolk County Council.
- The ICB is represented on the Norfolk Domestic Abuse and Sexual Violence Group (DASVG) by the designated safeguarding professionals (who represent the health sector).
- The designated safeguarding professionals from both Adult and Children teams chair the Norfolk and Waveney Domestic Abuse and Sexual Violence Health Action Forum subgroup of the DASVG.
- The ICB is represented by the Safeguarding Teams at the DASVG's Adult and Children's sub-groups.
- The ICB has strong links with the OPCCN and the Norfolk Integrated Domestic Abuse Service.

Here are some examples of the work we are doing as a system in Norfolk and Waveney, and ways in which the ICB is delivering against its duty to address the particular needs of victims of abuse:

- The ICB undertook a stocktake review of health services and responses to domestic abuse and sexual violence, in the summer of 2022.

- With system partners, the ICB signed-up to and widely promoted the HEAR campaign – Norfolk County Council's commitment to zero tolerance of domestic abuse in the workforce.
- There are appropriate policies in place in large NHS organisations.
- A template policy has been created for primary care and dedicated domestic abuse training sessions have been held for Lead Safeguarding GPs.
- There is full and active engagement with the Domestic Homicide Review process, that also coordinates and supports the engagement of providers of health services.
- The ICB led work to ensure our three acute hospital trusts provide monthly anonymised assault data, as per the NHS Digital 'Information Sharing to Tackle Violence Minimum Dataset ISB1594'.
- The ICB commissions a range of health specific pathways within a portfolio designed to support children and young people who are victim to serious violence. This includes but is not limited to: talking therapies for victims of and witnesses to sexual violence, trauma informed mental health provision and targeted support for children exposed to and at risk of displaying harmful sexual behaviours.
- The ICB also engages with relevant Suffolk workstreams, in tandem with NHS Suffolk and North East Essex ICB safeguarding leads.

The Serious Violence Duty

In December 2022, guidance on the Serious Violence Duty was published by the Home Office. The 'lead' authority for meeting the Serious Violence Duty in Norfolk is the Office of Police and Crime Commissioner, while in Suffolk it is the county council. Each lead agency has convened a partnership group that the ICB attends through its Safeguarding Adult and Children and Young People's Teams.

In line with the duty and the guidance, as an ICS, the ICB's are undertaking a strategic needs assessment and producing a plan to tackle 'serious violence' with partners such as local authorities and the police. The definition of 'serious violence' includes domestic abuse and sexual offences.

This work is being further supported by Crest Advisory, who have been commissioned by the Home Office. There will be two phases of support: Phase 1 is a readiness assessment designed to understand the preparedness of local areas to comply with the Serious Violence Duty, and Phase 2 is tailored support that will be based on the findings of the readiness assessment. The ICB's Adult Safeguarding Lead is engaged in the readiness assessment workshops being held in the first and second quarters of 2023.

The strategic needs assessment and publication of the two local strategies must be completed and published by 31 January 2024.

The ICS is committed to engaging in the regional led scoping and mapping exercises and attending the relevant events being hosted to support the implementation of the

duty. This will support us to plan and deliver preventative action and a focus on training, data collection and analysis.

Services within the scope of the NHS Standard Contract must comply with the Domestic Abuse Act 2021 and associated guidance from April 2023.

Implementing any joint local health and wellbeing strategy

The Norfolk and Waveney Integrated Care System covers the whole of Norfolk and part of Suffolk. As upper-tier local authorities, Norfolk and Suffolk each have their own joint health and wellbeing strategy:

- Norfolk's Joint Health and Wellbeing Strategy (which is also the Integrated Care Strategy for Norfolk and Waveney)
- Suffolk's Joint Health and Wellbeing Strategy

There is close alignment between the priorities in the Norfolk strategy and the cross-cutting themes in the Suffolk strategy:

Norfolk priority	**Suffolk cross-cutting themes**
Driving integration	Greater collaboration and system working
Prioritising prevention	Prevention: stabilising need and demand
Addressing inequalities	Reducing inequalities
Enabling resilient communities	Connected, resilient and thriving communities

The JFP is a delivery mechanism for these local Health and Well-Being Strategies and the Norfolk and Waveney Integrated Care Strategy is specifically referred to in section 1.2 of the JFP.

We are committed to supporting the implementation of both strategies and the Joint Forward Plan sets-out how health services in Norfolk and Waveney will do this. We have involved both health and wellbeing boards in the development of our JFP, asking for their views on the draft document and including their opinions in the document. There is further detail in the JFP about how our eight ambitions align to both Strategies.

We will continue to involve the health and wellbeing boards through the annual refreshing of our JFP (and if we choose to update the plan mid-year). As part of the development of the ICB's Annual Report, the organisation will report to the health and wellbeing boards how they contributed to delivering the priorities in each joint health and wellbeing strategy.

Other content

Digital and data

We are committed to investing in and using technology to improve people's health, wellbeing and care. Our Digital Transformation Strategic Plan and Roadmap sets-out how we will digitise services and connect them to support integration. This will enable new ways of working that can increase efficiency, improve patient experience and outcomes, plus reduce workforce burdens, and help to address health inequalities.

The plan and roadmap are in line with national guidance, such as the NHS Long Term Plan and the NHSX What Good Looks Like framework, as well as the Digital Health and Social Care Plan.

The digital plan and roadmap are a key enabler to the delivery of the eight ambitions in the JFP. Each ambition is co-dependent with digital and our plans for improvement are consistent so we can ensure all our efforts are joined up and focused in the right areas. You can read more about this in section 6.3.

This diagram sets-out our vision and strategic priorities for Norfolk and Waveney:

Using digital systems, we will:

- Enable people to access their health and care records securely, quickly and when they want to see information or data.
- Support clinical and strategic decision making through technology, providing health and social care organisations who deliver care access to relevant, accurate and up-to-date information.
- Improve system wide IT services to increase safety and people's health and care experiences, whilst reducing duplication and waste.
- Support and empower people to maintain their health and wellbeing through digital solutions.
- Enable health and care staff and services to provide the best care in all settings, particularly via the use of mobile technology.
- Ensure personal health and care information is kept safe and secure.
- Invest in the infrastructure and technologies needed to help drive improvements to services and provide better care.

Our roadmap details the key milestones for 2022-26:

Estates

Our Estates Strategy sets-out how we will create stronger, greener buildings, enable smarter, better health and care infrastructure, and use system resources fairly and more efficiently. It is based on extensive engagement, and a review of clinical strategies and investment requirements across the ICS.

Our NHS estate supports delivery of the right care in the right place, enables better patient outcomes, and empowers health, social care and third sector staff to provide the best possible care.

Our strategic estate objectives are:

- **Improving Access** – Ensuring that the right services are delivered in the right place, matching demand and capacity, delivering multi-disciplinary working in 'Places' and 'PCNs'.
- **Improving Quality and Condition** – Providing safe, flexible, modern, and fit-for-purpose estate and supporting services for our patients, visitors, and staff.
- **Improving Sustainability** – Implementing interventions to decarbonise our estate and reduce carbon emissions arising from our buildings, infrastructure, and services.
- **Improving Efficiency** – Providing a right sized estate and supporting services that deliver value for money and long-term financial sustainability.

During 2023 – 2024, the development of detailed delivery plans will demonstrate the programmes of work and investment to implement our Estates Strategy. The ICB's strategic estates team provides leadership through an integrated programme of

planning, improving and adapting the estate to support and enable health and care services to meet the needs of the Norfolk and Waveney population.

Systemwide, Person-Centred Estate

We have a significant part to play in supporting and enabling the delivery of a system-wide person-centred estate that serves the needs of all its users, enhancing both patient and staff experience. We will enable the integrated care strategy through our estate objectives by:

- Developing a collaborative approach across the NHS to estates and facilities service provision, ensuring our assets enable integrated accessible services.
- Ensuring our estate supports the provision of preventative models of care.
- Working with local planning authorities and public health to ensure their programmes of work and ours are linked and we cooperatively help people live in healthy places, promote healthy lifestyles, prevent ill-health and reduce health inequalities.
- Support delivery of specialist housing programmes that enable people to remain independent and reduce demand on services.
- Enabling relocation of services closer to areas of high need, where clinically appropriate, and supported by investment decisions.
- Delivering our Net Zero Green Plan to reduce our carbon footprint and emissions and tackle the negative impact this has on health and our communities.

Managing the Estate Portfolio

Through our systemwide estates team we collaborate to inform investment decisions for the benefit of the Norfolk and Waveney population. The Estates workstream links operationally to the ICS Executive for its direction through its Senior Responsible Officer.

The Estates Programme Board is an enabling service function within the ICS. It brings key system partners together to develop and deliver the strategic estates vision and objectives that support the Norfolk and Waveney ICS to realise its vision, purpose, goals, and deliver upon its priorities.

Empowered and Skilled Estates Workforce

In order to provide an effective, safe, and efficient service, now and in the future, we need to have the right estates and facilities resource and expertise available. The ICS Estates workstream use an estates and facilities workforce plan and policy that builds on and further promotes system wide workforce planning. It aligns with the Norfolk and Waveney People Plan, as well as the national estates and facilities workforce strategies.

Net Zero Estate

Our Net Zero Green Plan is described in the Legal Duty as to climate change. Emissions resulting from NHS building energy, water, and waste account for 11% of our total emissions, and 55% of the emissions we control directly. The Estates ‘Net

Zero' Carbon Delivery Plan provides a managed approach that will embed and enable the decarbonisation of the estate across the ICS.

Working through the ICS Green Plan delivery group, we will explore and implement interventions to decarbonise our estate and reduce carbon emissions arising from our buildings, infrastructure, and services.

Adapting to Climate Change

Climate change adaptation means responding to both the projected and current impacts of climate change and adverse weather events. Adaptation for our health and care estate is two-fold:

Health and Wellbeing:
- Investing in and managing estate that avoids negatively impacting the physical and mental health and wellbeing of our population.
- Flexibly managing our estate so that our health and care system can respond to different volumes and patterns of demand.

Operational delivery:
- The system infrastructure (such as buildings and transport) and supply chain (for example fuel, food and care supplies) need to be prepared for and resilient to weather events and other crises.

Transformed Models of Care

Transforming through the national New Hospital Programme

The New Hospital Programme delivers Government investment in the replacement of aged NHS hospital estate across the NHS. Norfolk and Waveney have been successful in securing funding that will see the planned rebuilding of the James Paget and Queen Elizabeth Hospitals. These investments will transform patient experience, providing innovative and modern and highly equipped hospitals from which our clinical services will continue to go from strength to strength.

Transforming through digital infrastructure and SMART buildings

The use of digital infrastructure and technology is important in delivering our vision and objectives. Digital innovation and enhanced infrastructure, devices, and information systems will help form SMART buildings that advance the experiences of our building users, improve sustainability, and drive financial efficiency.

SMART buildings will monitor, measure, and manage key aspects of a building's fabric and operational use, providing the data and knowledge to drive improvement. Good estates and facilities management can be ensured through the ongoing monitoring of maintenance, operations, and utilisation data generated by SMART building technology.

Digital infrastructure and platforms will include proactive use of digital systems to improve the performance, reliability, quality, and productivity of our estate, and reduce reactive and backlog maintenance costs. This is consistent with our Digital Strategy and Roadmap.

Infrastructure Design and Investment

Improving integration through One Public Estate

One Public Estate (OPE) is an established national programme delivered in partnership by the Office of Government Property and the Local Government Association. We have been an integral part of this programme for a number of years and we will continue this work. The OPE Board provides practical and technical support and funding to councils and other public organisations to deliver ambitious, property-focused programmes in collaboration with central government and other public sector partners.

Procurement / supply chain

Our local NHS providers established the Norfolk and Waveney Procurement Collaborative (NWPC) to bring purchasing teams closer together under a formal agreement to buy in common wherever possible and they have already agreed common standing financial instructions. As our frontline teams work more flexibly across the system, this will help us improve clinical effectiveness through use of standard equipment and products across all our sites. To ensure we maximise these opportunities our clinically led, system wide Clinical Product Evaluation Group will review all proposed purchasing decisions to ensure every opportunity for standardisation has been taken.

This collaboration has already delivered over £4m of procurement savings in 2022/23 and will continue to ensure we get the very best value from our non-pay spend by aggregating our volumes such that suppliers see us as an important strategic customer and all trusts gain the benefit of the best available prices. We have developed category strategies for each of our key spend areas and will deliver a programme of product range consolidation, volume aggregation and commitment to strategic supplier partnerships across the system to support the development of integrated patient pathways.

We will also collaborate regionally with partners across the East of England where this makes sense, notably in the areas of cardiology and diagnostics where we already work very closely with other trusts, such as Royal Papworth Hospital NHS Foundation Trust and the East of England Collaborative Procurement Hub. We will continue our support for the NHS England strategy of using NHS Supply Chain wherever possible, so that nationally there is the greatest opportunity for the NHS as a whole to leverage its buying power.

Procurement will also make a vital system contribution to key strategic programmes, such as Diagnostic Assessment Centres and the Electronic Patient Record, to ensure we secure value from long term partnership agreements.

We are fully engaged with the new NHS Central Commercial Function and will ensure our procurement services are assessed and showing improvement against the UK Government's Commercial Continuing Improvement Assessment Framework. Currently all our provider procurement teams are rated as 'Good' and we will seek to achieve 'Better' status in 2023/24.

This improvement will be enabled in part through significant development of our procurement information toolkit. NWPC has taken a lead in the NHS's development and deployment of the UK government commercial system known as Atamis. All contract information is now shared across the system's providers with spend analytics to provide in depth analysis on where we can further improve our spend efficiency. We will use this intelligence to prioritise our procurement resources effectively as we align our contracts.

Following our successful partnering with NHS Shared Business Services to provide efficient transactional purchasing services across the system, we will be upgrading our ordering system to offer end users a more 'Amazon' style service. This will help front line teams identify the products they need more quickly and reduce waste across the system. We will also reduce waste through further deployment of modern inventory management systems and NWPC are part of a pilot project with NHS Supply Chain reviewing distribution logistics, which will inform a system strategy on how we should efficiently maintain resilient stock levels, learning important lessons from the COVID-19 pandemic.

Social value and sustainability will be an increasingly important factor in our procurement decision making. 62% of NHS carbon emissions occur in the supply chain, with many of these emissions occurring in the UK. As part of our sustainability commitment, we will work with our supply partners to reduce our packaging and transport carbon impacts. For all contracts over £5m per annum, we will require the supplier to provide a carbon reduction plan.

We will also ensure our procurement tender activity supports UK government social value targets, the Greener NHS Programme to deliver a net zero health service and the drive to eliminate modern day slavery. For each tender we initiate we will evaluate prospective supplier's proposals against requirements in some or all of the following criteria:

- Fighting climate change
- Wellbeing
- Equal opportunity
- Tackling economic inequality
- COVID-19 recovery

This is consistent with our Net Zero Green Plan which is within the legal duty as to climate change.

We will proactively engage with small to medium enterprises in the local area and will publish our forward pipeline of potential procurement activity so that there is greater visibility of opportunities to work in partnership with the NHS in Norfolk and Waveney.

We are fortunate to have skilled and experienced commercial professionals available across the NWPC partners, with a number of 'MCIPS' qualified staff which is the gold standard for procurement. We will continue to invest in the professional development

of our commercial team as this is a growing key strategic competence required across the NHS.

The ICB continues to directly host its own procurement function. This manages predominantly procurements for healthcare and non-healthcare services reflecting the commissioning responsibilities of the ICB. The focus of the ICB procurement team is to ensure that the ICB complies with the legal requirements for awarding service contracts that deliver the best services for patients at the best value for the system. We will review our approach to this in the light of prospective new 'provider selection regime' legislation currently making its way through parliament.

As separate legal entities and to reflect the different obligations of commissioning and provider organisations, to date the ICB and provider collaborative procurement functions have operated independently. These teams are however in regular dialogue and work together to identify the most efficient and effective routes to complying with our responsibilities under legislation to the benefit of the whole system. As the system continues to develop, the way in which procurement activities are undertaken and responsibilities for specific programmes of work will continue to be reviewed to ensure that the procurement function is being delivered in the most effective way.

Population Health Management

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

Our newly created ICS Population Health and Inequalities Board is leading the development and implementation of a strategy for Population Health Management, which will be in place by March 2024. This is a specific objective within the PHM, Reducing Inequalities and Supporting Prevention ambition.

The new strategy will set out our ambitions in relation to the delivery of population health management, our priorities and plans for a system level programme and our approaches for all partners within the system to take forward their own programmes of population health management, focussing on local communities.

By focussing on prevention and health inequalities, and by partners working together to identify new things that can really help to improve health, the strategy will support people to live as healthy a life as possible. It will impact on the way we plan, prioritise and deliver care. It will be one of the key ways we can act together to improve health and wellbeing, making the best use of the resources we have available to us, removing barriers and supporting integrated working across our system.

The strategy will set out our approaches to use joined up data and information to better identify and understand the health and care needs of our population, to identify opportunities for improvements and put in place targeted interventions to support these.

We will be aspiring to a reduction in the differences in outcomes we currently experience in terms of accessing services and improvements in the health care processes for our most deprived populations.

We will also be seeking to prioritise prevention activities, particularly relating to smoking, alcohol, diet and physical activity and uptake of cancer screening and immunisations.

Our approach will also be driven by the needs of local communities and interventions designed to support them. We will be supporting place-led projects to deliver local priorities and to support working with wider partners to develop joint initiatives to address the wider determinants of health, such as housing.

Our strategy will include an ongoing programme of evaluation to measure progress and impact. Progress reports will be received by the newly established ICB Population Health and Inequalities Board, led by our Executive Medical Director, which have a broad membership of ICS representatives, including county council, adult social care and Children's Services, Public Health, NHS providers, and place board and health and wellbeing partnership representatives. In addition, there will be workshops held to develop the strategy and the Clinical Care Assembly will be a key consultative forum. Primary Care Networks, place boards and health and wellbeing partnerships will also be consulted.

We have identified initial Population Health Management priorities at a system level to address health inequalities and meet the Core 20 plus 5 priorities, which will have the greatest impact and where we know there are opportunities to improve. These are:

- Smoking, especially smoking in pregnancy,
- Serious Mental Illness,
- Chronic conditions – cancer (including earlier diagnosis), cardiovascular and respiratory

We already have an approved ICS PHM "roadmap" and our dedicated PHM team have achieved a number of improvements as part of our "Protect NoW" programme of work. This programme is a collaboration between NHS organisations, local authorities, the voluntary sector and independent partners working across Norfolk and Waveney. It comprises a growing number of projects, each focused on optimising physical and/or mental health and wellbeing. Alongside clinical leadership, our PHM digital supplier provides the bespoke data analysis, technical solutions and digital platforms that underpin the "Protect NoW" projects.
Projects to date have included topics such as:

- **COVID-19 vaccination uptake**- Increasing vaccine uptake and gaining insight into how we can support people to take up the vaccine offer.
- **Falls prevention**- Engaging with people who are vulnerable to having a fall or waiting for a hip or knee operation and assessing if any adaptations or equipment are required, in partnership with the Local Authority Home Adaptations team.
- **Pain management**- Triaging patients on the pain waiting list so that those suffering the most pain are prioritised.

- **Improving Access to Psychological Therapies *(*IAPT) uptake**- Increasing referrals to the wellbeing service and addressing clinical variation.
- **Cervical screening uptake**- Increasing the uptake of Cervical Cancer Screening - reducing inequalities and unwarranted clinical variation.
- **Long Covid clinic design**- Gaining insight from those with lived experience of Long Covid to inform design of service specification for commissioning Long Covid clinics from the community provider.
- **Diabetes prevention**- Increasing referrals into the National Diabetes Prevention Programme to prevent / reverse type 2 diabetes and address clinical variation.
- **Priority Patient Review**- Reducing hospital admissions through primary care risk alerts relating to six biomedical markers. The pilot is seeking to demonstrate that the proactive management of patients with reversible risk across six clinical pathways will result in reduced hospital admissions.
- **ActiveNOW -** focused on supporting health and care professionals to quickly and easily refer patients into suitable physical activities based on their needs.

In order to better understand the health needs of our population and plan and deliver the PHM programme in an integrated way, we need to further develop our infrastructure that underpins it. The development of this infrastructure is closely linked to our ICS digital strategy.

At the moment, data is mostly held within separate organisations and this limits the ability to see the bigger picture. PHM will be optimised when we can join up data sources (including hospital, general practice and social care) to analyse need and plan care at a population level. This includes accessing linked-up data across our system using the ICS's new data hub. More details about how we are doing this can be found in our Digital Transformation Strategic Plan and Roadmap.

Clear and robust information governance systems and agreements enable us to share and analyse data safely and appropriately. As we develop our PHM programme, we will be ensuring that our cross-system information governance systems and safe access controls are clear and communicated to all partners and break down existing barriers to sharing data.

Access to such data will allow us to undertake sophisticated analysis, modelling future demand, and using techniques known as "population segmentation", "risk stratification" and "financial risk modelling"- identifying where we can make the most impact and supporting more personalised care. We will be supported to do this by skilled analytical support from our ICS-wide intelligence function. We will also be training our wider workforce to interpret the available information and identify their own, more local, priorities for action.

System Development

To create the change that we want to see and to make the most of the opportunity arising from the transition to an Integrated Care System, it is vital that we look at and understand what needs changing in our governance, processes, leadership and culture. This is why we are going to undertake a governance review in 2023/24, to

make sure that we are operating as effectively as possible and are seizing all the new opportunities available to us.

The governance review will build on the plans we already have in place for developing and strengthening how our system works. Information about our plans for the future can be found in the following sections of this plan:

- **Neighbourhood level working:** Working at this very local level is a theme throughout our ambitions and underpinning objectives which are about ensuring provision is very accessible, is what our population needs, and finding out what matters most so it can be delivered as effectively as possible. Examples of this include the Family Hub, starting our journey to develop integrated neighbourhood teams and the maternity pathway to reduce tobacco dependency.
- **Place level working:** Our place-based approach is set out in section 6.1 of our Joint Forward Plan.
- **Closer working between providers of health and care services:** Our plans for working collaboratively are set out in section 6.2 of our Joint Forward Plan.
- **Working with the Voluntary, Community and Social Enterprise (VCSE) sector:** Our plans for developing how we work with the sector, including through our VCSE Assembly, are set out in section 6.7 of our Joint Forward Plan.
- **Improving the quality of care:** Our plans for how our system will build our capability to identify and address quality challenges are set out in the section about **quality of services,** included in these legal duties.
- **Our financial performance:** Our plans for how our system will build our capability to identify and address financial challenges are set out in our **financial duties,** included in these legal duties.

Our Integrated Care Partnership was built on the well-established Norfolk Health and Wellbeing Board, incorporating additional members from Suffolk to cover the Waveney part of our system. We put considerable thought and effort into developing our partnership in advance of its launch, so it is in a good position to deliver its key functions. How the system relates to the partnership will be considered as part of the governance review. For 2023/24 though, we have adjusted the membership slightly, adding the chairs of our place boards to further strengthen the relationships and links between system and place level.

For Norfolk and Waveney to be a really thriving system, staff need to be supported to work in different ways and this is why we have put in place a comprehensive organisational development programme for our system and for staff at all levels. Specific programmes of work have been developed for the ICB Board, the ICB's senior managers and the system's Executive Management Team, along with training packages and support for the wider workforce, all of which is complemented by the Clinical and Care Professionals' Leadership Programme.

This organisational development work started well before the Health and Care Act (2022) came into force and has played an important role as our system has moved

towards greater collaboration over the past few years. The work will continue as our system develops and matures.

Supporting wider social and economic development

We recognise our role as anchor institutions to explore opportunities to collaborate to influence the wider determinants of health within the heart of communities. This ranges from creating opportunities to listen and hear the voice of citizens, sharing data to alleviate respiratory conditions and improve the quality of housing, to accessing and signposting to partners' skills, training and employment pathways in order to grow our system's workforce and create a vibrant local employment market.

Our work to support wider social and economic development will be underpinned by asset-based community development principles, utilising all of our collective assets including workforce, estates and the people themselves to create system change. We will utilise tools such as the Community Voices programme to listen to communities and empower them to be their own agents for change, utilising their insights to influence the services and interventions we develop.

Our eight Health and Wellbeing Partnerships (HWPs) play a significant role in supporting decision making that reflects community need, assets and strengths. They provide a platform to engage a wide range of partners at a local level, that can support the design and transformation of health and care services, whilst ensuring connectivity to other services that can support their wider needs. These HWPs will provide the vital infrastructure, expertise and reach to support development and delivery of the proposed system Health Inequalities and PHM strategies.

Over the coming months we will co-ordinate baselining activity utilising the NHSE measurement framework currently in development, to understand the relationship between employment in the NHS and our local communities, particularly those that experience the greatest inequalities, as well as how we procure and how we currently utilise our estates.

Through this baselining exercise we will determine where we can improve our employment strategies in collaboration with our HWPs, seeking to work alongside the Department of Work and Pensions, local government, educational settings and VCSE organisations to proactively target those furthest away from the labour market and promote access to good, inclusive employment, skills development, and career progression.

Through our HWPs and Place Boards strong equitable relationships exist with local government. Working together we can influence, support and add value to a wide range of programmes that seek to improve access to green spaces, provide access to our collective facilities to support health and wellbeing, support local regeneration and generally provide opportunities for residents to improve their own health and wellbeing. An example of this is the adoption by Norfolk's seven Local Planning Authorities of the 'Norfolk Planning in Health Protocol' (2019).

Through our system Health Inequalities governance arrangements will seek to scale up the projects being delivered through a place-based approach, such as the James Paget University Hospital ‘Anchor Pilot’ that works with local VCSE organisations and communities in Great Yarmouth. This project is creating accessible green spaces on hospital owned land that can support the health and wellbeing of staff and visitors, which enables local procurement of services whilst supporting local volunteers to access employment skills and training and empowering them to access local job opportunities.

Our Net Zero Green Plan which is described in the legal duty as to **climate change**, sets out how we seek to reduce our environmental impact across the system. Underpinned by a robust communications and engagement plan, we will coalesce partners around shared ambitions, providing the tools and expertise to effect change.

Report title: Norfolk Better Care Fund End of Year Return (2022/2023) and Norfolk Better Care Fund 2023-2025 Update

Date of meeting: 21 June 2023

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

Reason for the Report

As part of bringing the 2022/23 Better Care Fund (BCF) to a close, we are asked to complete an end of year return. This enables us to reflect both on our achievements against the key metrics, our spend, and also how the BCF has been used to support integration between the Integrated Care System. This end of year return must be agreed by the Norfolk Health and Wellbeing Board. This report also updates Health and Wellbeing Board members on the development of the 2023-2025 BCF Plan, including changes to the BCF national conditions and reporting requirements. A supporting presentation is also enclosed in appendix 1 for this item.

Report summary

The BCF is a nationally mandated programme, aiming to join up health and care services so people can manage their health and wellbeing and live independently in their communities for as long as possible. Alongside key national metrics that the BCF must deliver, the Health and Wellbeing Board (HWB) set the following delivery priorities, that reflect key local strategic direction for the Board, the Integrated Care System (ICS) and its partners, including emerging place-based priorities:

- Inequalities and support for wider factors of wellbeing.
- Prevention.
- Sustainable system (including Admissions Avoidance).
- Person centred care and discharge.
- The DFG and housing as a theme across all of these priorities.

For 2023-25 we are asked to submit Norfolk's BCF Plan, with guidance released in April 2023. Split across narrative, financial and metrics plans, a submission is being developed for sign off at the September 2023 Norfolk Health and Wellbeing Board. Whilst developing the plan we need to ensure that we both meet national planning requirements, and also drive forward Norfolk's ambitions for the BCF. This includes:

- A single BCF plan that combines system and Place ambitions and brings together teams and leaders who are delivering services and change that drive the BCF priorities.
- Development of Norfolk's BCF approach, in anticipation of future national changes.
- Increasingly align the BCF with new ICS Places, supporting local joint health and care working. This includes collaborative proposals from Health and Wellbeing Partnerships with funding through the annual BCF uplift to support localised delivery of the BCF.

Recommendations

The HWB is asked to:

a) Receive and agree the 2022/23 Better Care Fund End of Year Return
b) Support the progress of the Better Care Fund (BCF) planning approach, including the local priorities and alignment with Place.
c) Sign off the Norfolk BCF 2023-25 Plan at the September Health and Wellbeing Board, for full and final submission.

1. Background

1.1 The BCF supports local health and care systems to successfully deliver integration in a way that supports person-centred care, sustainability and better outcomes for people and carers. It represents a national collaboration between: The Department of Health and Social Care; Department for Levelling Up, Housing and Communities; NHS England; and The Local Government Association. Since 2013, the BCF has allocated funding to each Health and Wellbeing Board (HWB) area, for joint decision making.

1.2 The BCF is a key element of future joint working, focusing on some of the most important integration priorities. It is executed through four funding streams under the BCF 'banner':

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

1.3 Partners in Norfolk have long utilised the BCF to fund and develop critical services that support the health and wellbeing of our population, including care from the provider market, key health and care operational teams, and community-based support from the VCSE sector.

2. 2022/2023 Better Care Fund

2.1 On 9 November 2022 the Health and Wellbeing Board approved Norfolk's overall Better Care Fund (BCF) submission for 2022/23 which was formed of:

- A narrative plan, describing our approach to integration, discharge, housing and health inequalities.
- An excel template, describing the BCF income and expenditure, our planned performance against the four key metrics and affirmation that we are meeting the national conditions asset out in the current BCF Planning Guidance.
- A Capacity and Demand plan for supported discharge and intermediate care services.

2.2 The Better Care Fund (BCF) is a nationally mandated programme, launched in 2013 with the aim of joining up health and care services, so that people can manage their own health and wellbeing and live independently. Delivered locally under a statutory requirement of HWBs, it is executed through three key funding streams under the BCF 'banner':

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

2.3 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. Delivered locally under a statutory requirement of HWBs, it is executed through three key funding streams under the BCF 'banner':

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

2.4 In late November 2022 the *Adult Social Care Discharge Fund* was announced, as an additional fund forming part of the Better Care Fund. The value of the fund in Norfolk is £9.67m, with funding split between NHS Norfolk and Waveney ICB and Norfolk County Council. The funding must also be pooled into our local BCF section 75, that forms the technical agreement between the NHS and County Council for the pooling of the BCF.

2.5 For the 2022/23 End of Year return we are asked to reflect on our performance against all of these areas of spend, including our achievement against the metrics and how the fund has been used to improve integration in the Integrated Care System. A supporting presentation

3. 2022/23 Better Care Fund End of Year Return

3.1 For the 2022/23 End of Year Return we are asked to submit one template, in two parts (See appendix 2). The contents of the template is summarised below:

3.2 **Adult Social Care Discharge Fund (Tab 7)**
This spreadsheet focuses in detail on the Adult Social Care Discharge Fund, including information on:

- Which programmes were funded and any new programmes added.
- What area of service was supported by the funding.
- Value of the programme and actual spend.
- Achievement of the programme, either in beds, care hours, or number of additional hours worked for recruitment initiatives.
- A space for us to make any further comment.

3.3 **2022/2023 End of Year Return**
The rest of the spreadsheets focus on the overall Better Care Fund, including the Adult Social Care Discharge fund.

- Guidance (Tab 1) gives guidance as to how the form should be completed.
- Cover (Tab 2) acts as a cover sheet, and allows us to understand the completeness of the return.
- National Conditions (Tab 3) confirms that we are in compliance with the National Conditions set out.
- Metrics (Tab 4) looks at whether we are on track to meet our target against the four BCF metrics, our achievements and any challenges we had.
- I&E Actual (Tab 5) confirms our actual BCF income against the original plan, and any changes to expenditure.
- Year End Feedback (Tab 6) first asks us to respond to three statements about how the delivery of the BCF has improved joint working in Norfolk, and then second asks us to outline two successes and two challenges in delivering the BCF.

4. How will the Better Care Fund changed in 2023-25?

4.1 The key change for the BCF is that we are being asked to create a plan for delivery over two years (2023/24 and 2024/25), as opposed to one year as we have been doing until now. This means that we have an opportunity to look further forward with our planning cycle, allowing Norfolk County Council, Norfolk and Waveney Integrated Care Board and our

partners to better meet our aims. The BCF Planning Requirements sets out “the vision for the BCF over 2023-25 is to support people to live health, independent and dignified lives, through joining up health, social care and housing service seamlessly around the person.”

4.2 This vision for the BCF in 2023-25 is supported by two core objectives:

- Enabling people to stay well, safe and independent at home for longer.
- Provide the right care in the right place at the right time.

4.3 As a result of this, the National Conditions, which we must meet, for 2023-25 have been adjusted to focus on these two objectives, which were previously combined into a single condition. Our 2023-25 BCF Plans will focus more closely on these areas.
The four new National Conditions are:

1. Plans to be jointly agreed.
2. Enabling people to stay well, safe and independent at home for longer.
3. Provide the right care in the right place at the right time.
4. Maintaining NHS’s contribution to adult social care and investment in NHS commissioned out of hospital services.

4.4 Alongside this change to the National Conditions, there is now an additional metric that has been introduced focussing on falls. The metric looks at emergency hospital admissions due to falls in people aged 65+ directly age standardised per 100,000. This means the five metrics we will need focus on within the BCF are:

1. Avoidable Admissions.
2. Discharge to usual place of residence from acute hospital.
3. Residential and nursing care admissions for people aged 65+.
4. People aged 65+ still at home 91 days after discharge from hospital into reablement services.
5. People aged 65+ with an emergency admission due to a fall.

4.5 The BCF Planning Requirements also advise a further metric will be introduced later in the planning cycle, which will focus delayed discharge, and will be linked to information on people who no longer have criteria to reside in hospital. This then links with the introduction of the new Adult Social Care Discharge Funding stream, which aims to develop better discharge services.

4.6 In 2022/23 a new Intermediate Capacity and Demand Plan was introduced into the Better Care Fund, looking at intermediate care covering both admissions avoidance and hospital discharge across health and social care. For 2023-25, this has been embedded in the financial and metrics return, and now specifically also includes our mental health services. The plan will be developed in alignment with our wider planning and delivery for capacity and demand, alongside Urgent and Emergency Care plans.

5. BCF Planning Process in 2023-25

5.1 For 2023-25 we are asked to submit Norfolk’s BCF plan, split across a narrative plan, and a financial and metrics plan, including our capacity and demand plan.
It will need to include:

- Our priorities for 2022/23 and key changes made to the previous BCF Plans.
- Our overall approach to integration in Norfolk, including: joint priorities; joint commissioning; supporting people to remain independent at home; and how BCF funded services are supporting this.
- How we engaged stakeholders in developing and preparing the plan.
- The governance routes for the BCF.

- Our overall approach to key themes the BCF must deliver on, including discharge and intermediate care.
- Our approach to the Disabled Facilities Grant and wider housing services.
- Our priorities for addressing health inequalities and equality for people with protected characteristics (under the Equality Act 2010).
- Detailed income, expenditure and impact associated with the BCF, and our expected performance against the metrics.
- An Intermediate Care Capacity and Demand Plan
- Confirmation that we have met the National Conditions set out in the BCF Planning Requirements document.

5.2 Overall, for 2023-25, the core elements of the BCF planning requirements remain consistent with an aim to continue strengthening the integration of commissioning and delivery of services, as well as continuing to provide person-centred care. The increased focus on the two new National Conditions strengthens focus on person centred outcomes, and reflect our system wide ambitions, to make sure everyone can live as healthy a life as possible.

Officer Contact

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

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

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Norfolk and Waveney Integrated Care System

Better Care Fund

- 2022/23 Better Care Fund End of Year Return
- Better Care Fund planning approach for 2023-25

Norfolk Health and Wellbeing Board

21 June 2023

Nick Clinch, Assistant Director Social Care & Health Partnership Commissioning, Norfolk County Council

Bethany Small, Commissioning Manager, Social Care and Health Partnerships Team, Norfolk County Council & NHS Norfolk & Waveney ICB

Introduction

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

The BCF is made up of a number of elements:

- The 'Core BCF' brings Local Authorities and NHS partners together to agree integrated priorities, pool funding and jointly agree spending plans. A nationally-determined minimum contribution is made each year. This contribution is not 'new' money, being drawn from core funds, which includes requirements to deliver:
  - reablement services
  - support of unpaid carers as defined in the Care Act 2014, including carers' breaks
  - out of hospital services.
- Local Authorities also receive a Disabled Facilities Grant (DFG), to help towards the costs of making changes to a person's home so they continue to live there, led by District, Borough and City Councils in Norfolk; and an integrated BCF (i-BCF) Grant for meeting adult social care needs, ensuring that the social care provider market is supported, and reducing pressures on the NHS.
- In November 2022, ICB's and Local Authorities also received a new Adult Social Care Discharge Fund (ASDF) which is also considered to be part of the BCF.
- We work together to agree:
  - the allocations between the ICB and the LA of the minimum NHS contribution, and
  - an annual, joint BCF plan.
- The BCF joint plan and the funding allocations are signed off and governed by the Health and Wellbeing Board. The allocations are governed in a Section 75 Agreement.

2022/23 BCF

- The BCF is a priority for our Health and Wellbeing Board and a key element of joint working, focusing on some of the most important integration priorities in our 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 .

BCF 2022-23	Mandated NHS minimum contribution to the BCF by NWICB (£m)	Agreed Adult Social Care allocation (£m)	Agreed NWICB allocation (£m)	
'Core' BCF	73.032	36.048 (NCC)	36.984	Pooled funding for integrated priorities and joining up health and care services.
iBCF		£ 39.619 m		Meeting adult social care needs, ensuring that the social care provider market is supported, and reducing pressures on the NHS.
Disabled Facilities Grant		£ 9.324 m		Help towards the costs of making changes to a person's home.
ASC Discharge Fund - NCC		£ 3.482 m		Develop services which support discharge.
ASC Discharge Fund – ICB (to fund Norfolk and Waveney)		£ 6.189 m		

Elements of the BCF in our system:

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Norfolk
B. BCF schemes funded via NWICB's allocation of the Norfolk BCF minimum contribution

Norfolk
C. BCF schemes co-funded by NWICB and NCC sharing their allocation of the Norfolk BCF NHS minimum contribution

Norfolk
D. BCF schemes funded via NCC's allocation of the Norfolk BCF minimum contribution

Norfolk
E. Adult Social Care Discharge schemes funded via NWICB's allocation of the ASDF

Norfolk
F. Adult Social Care Discharge Fund schemes funded via NCC's allocation of the ASDF

Norfolk
G. DFG schemes funded via nationally determined DFG fund

Norfolk
H. i-BCF schemes funded via NCC's nationally determined iBCF fund

Norfolk

Waveney
A. BCF schemes funded via NWICB's allocation of the Suffolk BCF minimum contribution

Waveney
(for reference)

Priorities

- A key priority of the Health and Wellbeing Board was to lead a review of Norfolk's BCF to shape the future BCF to further deliver local priorities, strengthen joint commissioning and service design, and focus strategy and funding on some of the most important emerging priorities for integration.
- As a result of this work, a set of priorities for the BCF was developed and agreed, which guide our local development of the BCF. These are:

Inequalities and support for wider factors of wellbeing

Prevention

Sustainable system (including admissions avoidance)

Person centred care and discharge

Housing and Disabled Facilities Grant

BCF Principles

A set of principles were also established to help direct the impact of the BCF towards system priorities and integration. They included:

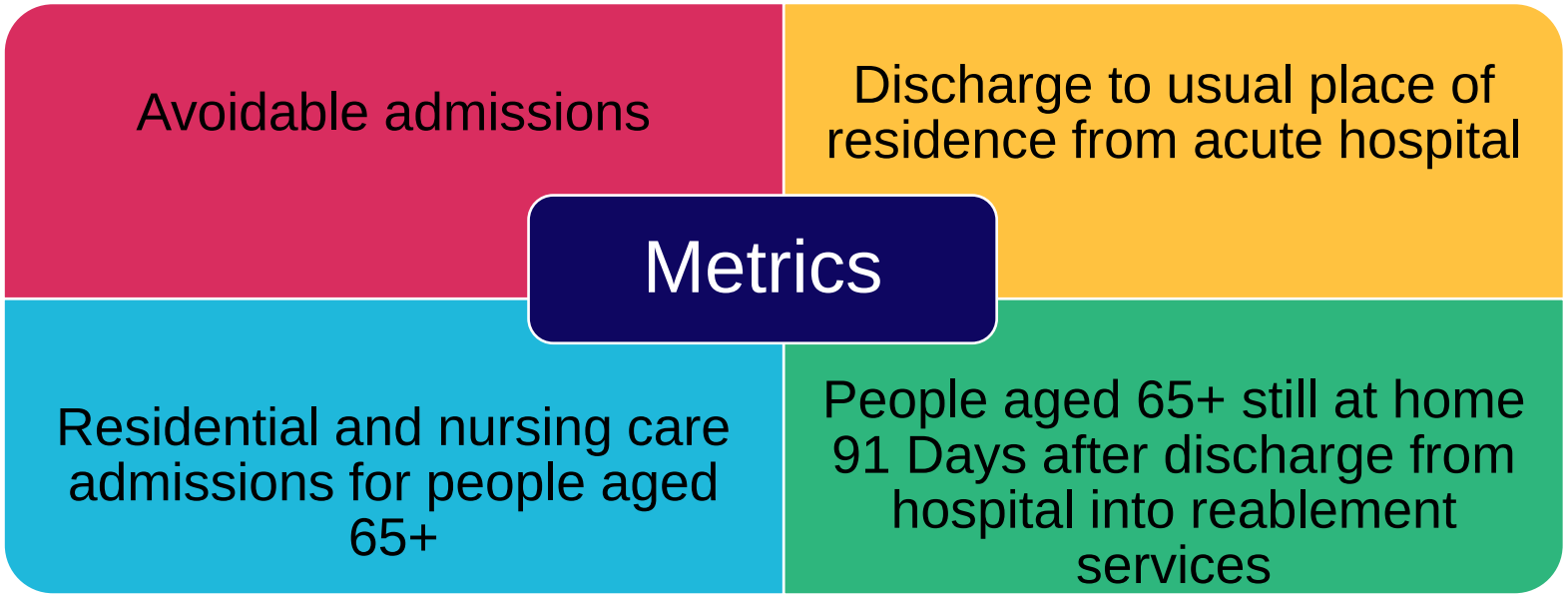
- Integrated governance, made up of senior staff, to
  - support the BCF review.
  - provide strategic leadership of the BCF under the HWB.
  - develop processes to strengthen joint commissioning at System and Place within the opportunities provided by the BCF.
- Using the BCF to fund programmes which would benefit from joint funding and would have joint impact across health and social, or benefit from joint oversight.
- Funding ‘whole services’, to more closely monitor their impact on the system.

The ambition was to develop a more cohesive BCF programme which:

- Reflected Norfolk’s integration priorities.
- Improved our understanding of the impact that the BCF has in Norfolk.
- Acts as a key delivery arm of System and Place priorities for integrated health and care working.
- Supports the aims of the local health and social care system.

2022/23: Metrics

For 2022/23, we were required to report to NHS England against four national metrics for the Better Care Fund. These were:



Norfolk delivered against target on all four metrics - including 86.5% of older people still at home 91 days after discharge from hospital into reablement/rehabilitation, and supporting that a 90% reduction in packages of home care that cannot be fully sourced since January 2022 – bringing it to one of its lowest levels in four years. This performance is an example of delivery supported by the BCF, which funds a range of core services delivering intermediate care and flow in to long term support, including reablement, rehabilitation, district direct, and VCSE support in the community.

2022/23: Core BCF

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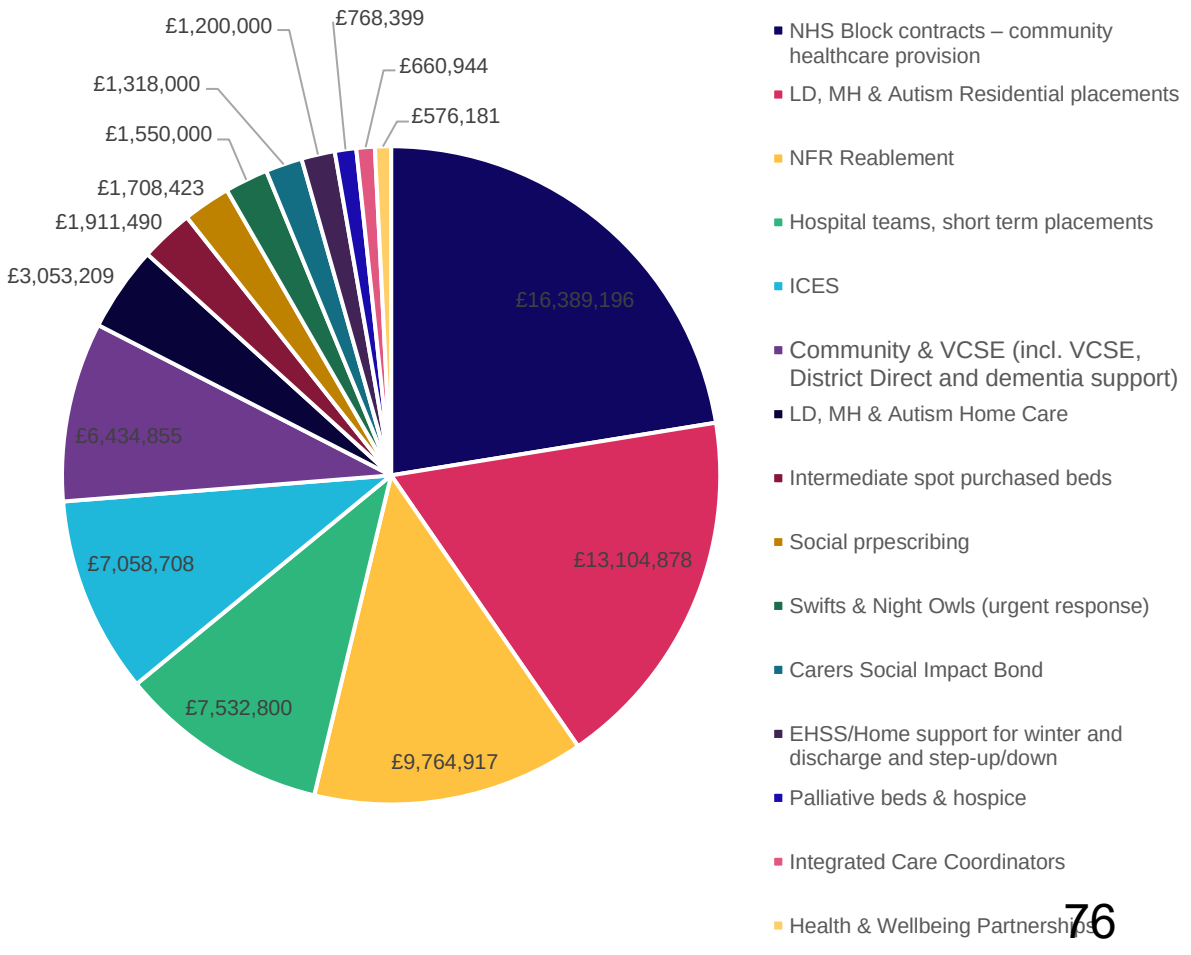
In 2022/23, the 'Core BCF' funded a range of service provision delivering some of the most important integration priorities in our ICS, including services that deliver community healthcare provision, reablement support, integrated equipment services and community-based support from District Direct and VCSE.

The BCF does not always deliver the entire cost of these schemes – for example, the majority of community healthcare block contracts within the Norfolk and Waveney system does not come from the BCF.

Priority	£ (22/23)	%
NHS community healthcare provision	£16,389,196	22.44
LD, MH & Autism Residential placements	£13,104,878	17.94
Reablement (Norfolk First Response)	£9,764,917	13.37
Hospital and follow-up teams, short term placements	£7,532,800	10.31
Integrated Equipment Service (ICES)	£7,058,708	9.66
Community & VCSE (incl. VCSE, District Direct and community dementia support)	£6,434,855	8.81
LD&A, MH Home Support	£3,053,209	4.18
Intermediate care beds	£1,911,490	2.68
Social prpescribing	£1,708,423	2.33
Swifts & Night Owls (urgent response)	£1,550,000	2.12
Carers Social Impact Bond	£1,318,000	1.80
Home support for winter and discharge	£1,200,000	1.64
Palliative care beds & hospice	£768,399	1.05
Integrated Care Coordinators	£660,944	0.90
Health & Wellbeing Partnerships	£576,181	0.78
Total:	£73,032,000	



2022/23: BCF and Place

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- As part of our ICS structure we have introduced seven Health and Wellbeing Partnerships in Norfolk which are established as multi-agency groups well positioned to understand and improve the health and wellbeing needs of their local areas. Alongside this, we also have introduced five new Place Boards, with bring together partners integrate services with a focus on effective operational delivery and improving people's care.
- An annual inflationary uplift for the Core BCF is issued by the national BCF team (currently set at 5.66 %). This uplift must be ring-fenced and spent on BCF-related initiatives, and primarily funds annual uplifts to services funded by the BCF.
- In August 2022, we chose to use the allocation of the BCF inflationary uplift available (after individual service uplifts) to the Health and Wellbeing Partnerships within Norfolk to self-determine new BCF schemes that would suit the needs of the local population. Alongside the new Adult Social Care Discharge Fund, this was the key area of discretionary spending in 2022/23, and resulted in a wide range of local programmes emerging, including:
    - A pilot offering social prescribing in secondary care outpatient services.
    - An expansion of handy person and adaptation services focussed orthopaedic waiting lists to include. those with rheumatology to prevent falls.
    - A fund for agencies to innovate hardship support services.
    - An expansion of an Age UK Community Support service to enable more people to benefit.
    - A new falls prevention initiative.
- In Q3 of 2023/24, Health and Wellbeing partnerships in partnership with BCF team will be evauilating the success, impact and outcomes of these schemes

Adult Social Care Discharge Fund

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In November 2022, an additional Discharge Fund (ASC Discharge Fund) was announced as part of the Better Care Fund. Norfolk has a fund of £9.67m, split between NHS Norfolk and Waveney Integrated Care Board (ICB) and Norfolk County Council, for ratification by the Norfolk Health and Wellbeing Board.

The ASC Discharge Fund is recurrent funding, over 2023/24 and 2024/25. The recurrency of this funding has helped us build a programme where the services being funded support a model of intermediate care and HomeFirst approach that supports our local ambitions, and has been instrumental in delivering additional capacity to support people home following crisis, including:

- Housing with Care Flats – Deployment of 21 flats since November 2022, within Housing with Care, as step down to support acute and community hospital discharge and flow out of intermediate care (Norfolk County Council; Broadland Housing & Saffron; Norse Care; County Kitchen Foods, Norfolk & Waveney ICB).
- Home Support Enhanced Discharge Incentive – 10 additional discharges per week via additional financial support to homecare providers to pick up new packages within 24 hours, covering increased complexity and discharge requirements (Norfolk County Council, Home Support providers).
- Home Support Rate Increase – Increase of £1.08 to the hourly rate to increase workforce and enable providers to take on additional work that supports flow in to, and through, community care, supporting increased discharge activity (Norfolk County Council).
- Carers Hardship Support – Additional Information and advice support for unpaid and family carers at point of discharge (acute and community) – focused on winter hardship support (Citizens Advice Bureau and Carers Matters Norfolk).
- Bed based intermediate care capacity – 158 intermediate care beds commissioned across Norfolk and Waveney to support patients leaving hospital with associated ‘wrap around’ workforce support from primary care, therapy and social work.

The Adult Social Care Discharge Fund is constituted of four specific National. Requirements for its use:

- Discharge of patients from hospital to the most appropriate location for their ongoing care;
- Discharge to Assess (D2A) and provision of homecare;
- Boost general adult social care workforce capacity through staff recruitment and retention;
- Complex care needs – a concerted focus on supporting discharge of these patients may be important to free up hospital capacity.

Next Steps: BCF in in 2023/24 – 2024/25

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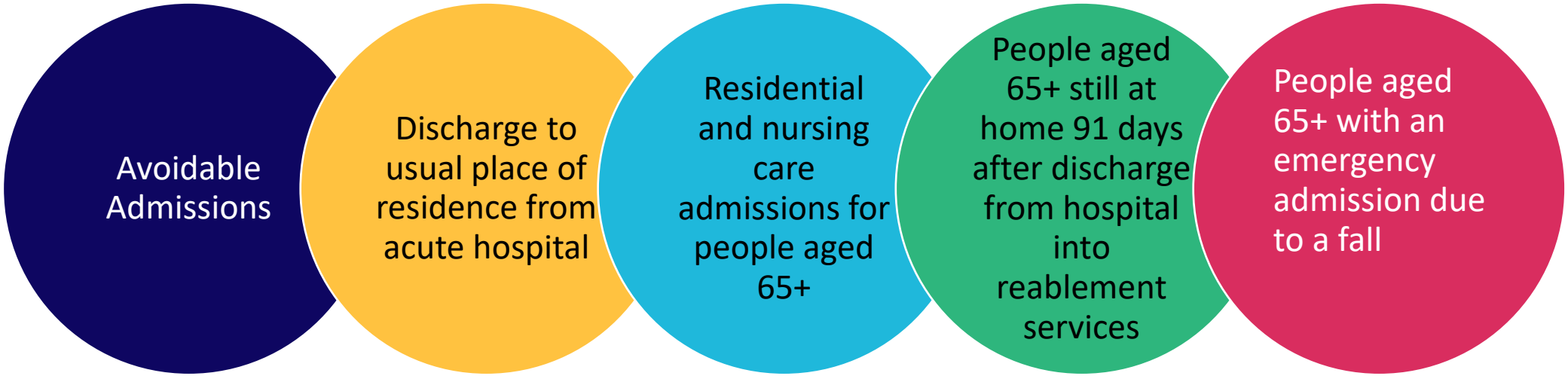
For 2023-25 we are asked to submit Norfolk's BCF Plan, with guidance released in April 2023. Split across narrative, financial and metrics plans, a submission is being developed sign off at the September Health and Wellbeing Board.

The national vision for the BCF in 2023-25 is supported by two core objectives:

- Enabling people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

There is now an additional metric that has been introduced focussing on falls. The metric looks at emergency hospital admissions due to falls in people aged 65+ directly age standardised per 100,000. This means the five metrics we will need focus on within the BCF are:



Next Steps: BCF in in 2023/24 – 2024/25

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Whilst developing the plan we need to ensure that we both meet national planning requirements, and also drive forward Norfolk's ambitions for the BCF. It is recommend that this includes:

- A single BCF plan that combines system and Place ambitions and brings together teams and leaders who are delivering services and change that drive the BCF priorities.
- Development of Norfolk's BCF approach, including: metrics of success/outcomes for all BCF funded services, not just the five overarching national metrics; and a county-wide 'demand and capacity plan' for discharge and community support
- Increasingly align the BCF with new ICS Places, supporting local joint health and care working. This includes collaborative proposals from Health and Wellbeing Partnerships with funding through the annual BCF uplift to support localised delivery of the BCF.
- The Health and Wellbeing Board previously agreed a set of priorities locally for the BCF that align strongly with the new national guidance and are guiding our local development of the BCF:

Inequalities and support for wider factors of wellbeing	Prevention	Sustainable system (including admissions avoidance)	Person centred care and discharge	Housing and Disabled Facilities Grant

The Health and Wellbeing Board is asked to:

1. **Receive and agree the 2022/23 Better Care Fund End of Year Return**
2. **Support the progress of the Better Care Fund (BCF) planning approach, including the local priorities and alignment with Place.**
3. **Sign off the Norfolk BCF 2023-25 Plan at the September Health and Wellbeing Board, for full and final submission.**

Better Care Fund 2022-23 End of Year Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) To confirm actual income and expenditure in BCF plans at the end of the financial year
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF reporting is likely to be used by local areas, alongside any other information to help inform 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 ICB's, local authorities and service providers) for the purposes noted above.

BCF reports submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website in due course.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey 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.

ASC Discharge Fund-due 2nd May

This is the last tab in the workbook and must be submitted by 2nd May 2023 as this will flow to DHSC. It can be submitted with the rest of workbook empty as long as all the details are complete within this tab, as well as the cover sheet although we are not expecting this to be signed off by HWB at this point. The rest of the template can then be later resubmitted with the remaining sections completed.

After selecting a HWB from the dropdown please check that the planned expenditure for each scheme type submitted in your ASC Discharge Fund plan are populated.
Please then enter the actual packages of care that matches the unit of measure pre-specified where applicable.
If there are any new scheme types not previously entered, please enter these in the bottom section indicated by a new header. At the very bottom there is a totals summary for expenditure which we'd like you to add a breakdown by LA and ICB.

Please also include summary narrative on:
1. Scheme impact
2. Narrative describing any changes to planned spending – e.g. did plans get changed in response to pressures or demand? Please also detail any underspend.
3. Assessment of the impact the funding delivered and any learning. Where relevant to this assessment, please include details such as: number of packages purchased, number of hours of care, number of weeks (duration of support), number of individuals supported, unit costs, staff hours purchased and increase in pay etc
4. Any shared learning

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.
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 2022-23 (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/publication/better-care-fund-planning-requirements-2022-23/

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, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: NHS contribution to adult social care is maintained in line with the uplift to NHS Minimum Contribution
National condition 3: Agreement to invest in NHS commissioned out-of-hospital services
National condition 4: Plan for improving outcomes for people being discharged from hospital

4. Metrics

The BCF plan includes the following metrics: Unplanned hospitalisation for chronic ambulatory care sensitive conditions, Proportion of discharges to a person's usual place of residence, Residential Admissions and Reablement. Plans for these metrics were agreed as part of the BCF planning process.

This section captures a confidence assessment on achieving the plans 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 that have been achieved.
The BCF Team publish data from the Secondary Uses Service (SUS) dataset for Dischaege to usual place of residence and avoidable admissions at a local authority level 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 plans and the related narrative information and it is advised that:
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.
- In providing the narrative on Challenges and Support needs, and Achievements, most areas have a sufficiently good perspective on these themes and the unavailability of published metric data for one/two of the three months of the quarter is not expected to hinder the ability to provide this useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.

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

5. Income and Expenditure

The Better Care Fund 2022-23 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and NHS. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant, minimum NHS contribution and additional contributions from LA and NHS. This year we include final spend from the Adult Social Care discharge fund.

Income section:
- Please confirm the total HWB level actual BCF pooled income for 2022-23 by reporting any changes to the planned additional contributions by LAs and NHS as was reported on the BCF planning template.
- In addition to BCF funding, please also confirm the total amount received from the ASC discharge fund via LA and ICB if this has changed.
- The template will automatically pre populate the planned expenditure in 2022-23 from BCF plans, including additional contributions.
- If the amount of additional pooled funding placed intothe area's section 75 agreement is different to the amount in the plan, you should select 'Yes'. You will then be able to enter a revised figure. Please enter the **actual income** from additional NHS or LA contributions in 2022-23 in the yellow boxes provided, **NOT** the difference between the planned and actual income.
- Please provide any comments that may be useful for local context for the reported actual income in 2022-23.

Expenditure section:
- Please select from the drop down box to indicate whether the actual expenditure in your BCF section 75 is different to the planned amount.
- If you select 'Yes', the boxes to record actual spend, and explanatory comments will unlock.
- You can then enter the total, HWB level, actual BCF expenditure for 2022-23 in the yellow box provided and also enter a short commentary on the reasons for the change.
- Please include actual expenditure from the ASC discharge fund.
- Please provide any comments that may be useful for local context for the reported actual expenditure in 2022-23.

6. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2022-23 through a set of survey questions
These questions are kept consistent from year to year to provide a time series.
The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 5 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:

- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2022-23
3. The delivery of our BCF plan in 2022-23 had a positive impact on the integration of health and social care in our locality

Part 2 - Successes and Challenges
This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

Please highlight:
4. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2022-23.
5. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2022-23?

For each success and challenge, please select the most relevant enabler from the SCIE logic model and provide a narrative describing the issues, and how you have made progress locally.
SCIE - Integrated care Logic Model

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rurual factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Better Care Fund 2022-23 End of Year Template

2. Cover

Version 1.0

Please Note:

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

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the 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:	Nicholas Clinch		Yes
E-mail:	nicholas.clinch@norfolk.gov.uk		Yes
Contact number:	01603 223239		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 21/06/2023	<< 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'. This does not apply to

Please see the Checklist on each sheet for further details on incomplete fields

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income and Expenditure actual	Yes
6. Year-End Feedback	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 End of Year Template

3. National Conditions

Selected Health and Wellbeing Board: Norfolk

Confirmation of Nation Conditions			Checklist
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in 2022-23:**	Complete:
1) A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006? (This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes		Yes
2) Planned contribution to social care from the NHS minimum contribution is agreed in line with the BCF policy?	Yes		Yes
3) Agreement to invest in NHS commissioned out of hospital services?	Yes		Yes
4) Plan for improving outcomes for people being discharged from hospital	Yes		Yes

Better Care Fund 2022-23 End of Year 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.

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

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

Metric	Definition	For information - Your planned performance as reported in 2022-23 planning	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements	Checklist Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	728.3	On track to meet target	Although we are on track to meet the target, demand remains high and to support work in the community a programme of work around Falls Prevention has commenced, additionally our Active Now programme is encouraging	677.4 projected using SUS M10 Freeze submission. Where crisis does occur, rapid response and intervention can prevent a hospital admission and enable people to recover with additional support at home.	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	92.2%	On track to meet target	Market and workforce challenges continue in discharging people to their normal place of residence. However we are starting to see an improvement in the Home Care Market and our community services continue to	92.7% of people discharged to usual residence for 2022/23 using SUS M11 Flex submission. Our Integrated Community Equipment Service went out to tender and was re-	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	607	On track to meet target	We are awaiting full end of year data. For 12 month period ending Jan 23, our rate of residential admissions was 538	Through a programme of transformation, we are re-designing our front door ways of working, evolving the connection of our social care teams with communities and building the capacity and impact of our short-	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	86.5%	On track to meet target	We want to be able to offer more effective short term recovery services in people's homes, like reablement, to everyone we support. No one should enter long term homecare without reablement if they could	Following targeted work, the number of Norfolk residents for whom packages of home care cannot be fully sourced has reduced since January 2022 by 90%, from – bringing it to one of its lowest levels in 4	Yes

Better Care Fund 2022-23 End of Year Template

5. Income and Expenditure actual

Selected Health and Wellbeing Board: Norfolk

Income

	2022-23	
Disabled Facilities Grant	£9,157,782	
Improved Better Care Fund	£39,618,564	
NHS Minimum Fund	£73,032,095	
Minimum Sub Total		£121,808,441

	Planned		Actual			
NHS Additional Funding	£0		Do you wish to change your additional actual NHS funding?	No		
LA Additional Funding	£0		Do you wish to change your additional actual LA funding?	Yes	£2,782,610	
Additional Sub Total		£0				£2,782,610

	Planned 22-23	Actual 22-23
Total BCF Pooled Fund	£121,808,441	£124,591,051

	ASC Discharge Fund					
	Planned		Actual			
LA Plan Spend	£3,482,232		Do you wish to change your additional actual LA funding?	No		
ICB Plan Spend	£6,189,372		Do you wish to change your additional actual ICB funding?	Yes	£6,195,700	
ASC Discharge Fund Total		£9,671,604				£9,677,932

	Planned 22-23	Actual 22-23
BCF + Discharge Fund	£131,480,045	£134,268,983

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2022-23	Income for ICES (Community equipment).

Expenditure

	2022-23
Plan	£121,808,442

Do you wish to change your actual BCF expenditure?	Yes
Actual	£124,591,051

	ASC Discharge Fund
Plan	£9,671,604

Do you wish to change your actual BCF expenditure?	No
Actual	£73,032,095

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2022-23	Expenditure to the ICES service for Social Care.

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

Better Care Fund 2022-23 End of Year Template

6. Year-End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF.
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board: Norfolk

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate to what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response	Checklist Complete:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	The overall delivery of the BCF has strengthened joint working between health and social care in our system. The introduction of the Capacity and Demand Tracker and the Adult Social Care Discharge Fund has meant we have had to work more closely together to collate the necessary data and make quick decisions about how best to allocate funding. This is	Yes
2. Our BCF schemes were implemented as planned in 2022-23	Agree	Overall, our BCF schemes were implemented as planned and agreed between NCC and the NWICB in 2021/22. Our ASC Discharge Fund did have some changes to the programme, to better meet our discharge need as things developed. We are also on track to meet our planned metrics.	Yes
3. The delivery of our BCF plan in 2022-23 had a positive impact on the integration of health and social care in our locality	Agree	We have continued to work closely between health and social care over the past year, particularly in the first year of the Norfolk Integrated Care System. The process we went through in 2021 to review the contents of our BCF focussed on including services that we jointly fund, commission or need oversight of, and delivery of these services improves joint	Yes

Part 2: Successes and Challenges

Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing.
Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes	
Success 1	1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)	As part of our ICS structure we have introduced seven Health and Wellbeing Partnerships in Norfolk which are established as multi-agency groups well positioned to understand the health and wellbeing needs of their local areas. Alongside this, we also have introduced five new Place Boards, with bring together partners integrate services with a focus on effective operational delivery and improving people's care. In 2022/23 we asked the Health and Wellbeing Partnerships to use part of the BCF to fund prevention services in their area, particularly focussed on reducing care home admission and admission	Yes
Success 2	9. Joint commissioning of health and social care	Using the Adult Social Care Discharge Fund in 2022/23 we funded step down flats with housing with care schemes. This ensured people who no longer met criteria to reside, but who were also unable to directly return to their own home, were offered support at the appropriate level, helping them to stay as independent as possible. Feedback from people who used the scheme was very positive, with people saying they felt more confident and indpendent, and that the workers helped them to do more for themselves. Alongside this, specialist exercise in reach support was also commissioned, who could	Yes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges	
Challenge 1	Other	Whilst additional funding through the Adult Social Care Discharge Fund was welcommed, the timescales given to develop, mobilise and deliver services was a challenge. It put pressure on teams already working at pace to deliver winter programmes, and meant the services were developed at haste. Not all of the services we planned were fully / successfully delivered, particularly those that required recruitment, though any underspend was repurposed to additional schemes. Longer lead in times, now available with the two year BCF commitement, allow for a more planned development of services	Yes
Challenge 2	8. Pooled or aligned resources	In 2022/23 DFG spending was also a challenge, with increased costs for building works against static DFG budgets. This has impacted our City, District and Borough Councils, who completed nearly 1,400 adaptations in 2022/23. Demand is such that our Councils have had to identify different funding sources for additional housing services, such as handyperson schemes, where in the past they may have been DFG funded.	Yes

Footnotes:
Question 4 and 5 are should be assigned to one of the following categories:
1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care
Other

Better Care Fund 2022-23 End of Year Template

ASC Discharge Fund

Selected Health and Wellbeing Board: Norfolk

Please complete and submit this section (along with Cover sheet contained within this workbook) by 2nd May

For each scheme type please confirm the impact of the scheme in relation to the relevant units asked for and actual expenditure. Please then provide narrative around how the fund was utilised, the duration of care it provided and and any changes to planned spend. At the very bottom of this sheet there is a totals summary, please also include aggregate spend by LA and ICB which should match actual total prepopulation.
The actual impact column is used to understand the benefit from the fund. This is different for each sheme and sub type and the unit for this metric has been pre-populated. This will align with metrics reported in fortnightly returns for scheme types.
1) For 'residential placements' and 'bed based intermediary care services', please state the number of beds purchased through the fund. (i.e. if 10 beds are made available for 12 weeks, please put 10 in column H and please add in your column K explanation that this achieve 120 weeks of bed based care).
2) For 'home care or domiciliary care', please state the number of care hours purchased through the fund.
3) For 'reablement in a person's own home', please state the number of care hours purchased through the fund.
4) For 'improvement retention of existing workforce', please state the number of staff this relates to.
5) For 'Additional or redeployed capacity from current care workers', please state the number of additional hours worked purchased through the fund purchased.
6) For 'Assistive Techonologies and Equipment' , please state the number of unique beneficiaries through the fund.
7) For 'Local Recruitment Initiatives', please state the additional number of staff this has helped recruit through the fund.

If there are any additional scheme types invested in since the submitted plan, please enter these into the bottom section found by scrolling further down.

Scheme Name	Scheme Type	Sub Types	Planned Expenditure	Actual Expenditure	Actual Number of Packages	Unit of Measure	Did you make any changes to planned spending?	If yes, please explain why	Did the scheme have the intended impact?	If yes, please explain how, if not, why was this not possible and any learning	Do you have any learning from this scheme?
7 day working Discharge Planning Team	Other	(blank)	£50,000	£25,000		N/A	No	N&W WIN 117	Yes	Planning team improved discharge flow at weekends	Would want to recruit substantively to deliver seven day service
7 day working for discharge lounge	Other	(blank)	£25,000	£25,000		N/A	No	N&W WIN 118	Yes	Discharge lounge improved discharge flow	Would want to recruit substantively to deliver seven day service
Acacium - D2A1 capacity Central Norfolk	Reablement in a Person's Own Home	Reablement to support to discharge step down	£160,000	£160,000		N/A	No	N&W WIN 39	Yes	Reablement provision to P1	
Acacium - Expansion of West Interim Care Pilot across Central Norfolk	Reablement in a Person's Own Home	Reablement service accepting community and discharge	£1,234,000	£1,234,000	13,104	N/A	No	N&W Bed 46	Yes	1008 hours/visits a week of care activity deliver avg 30 discharges per month	
Additional bed at All Hallows	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	£13,750	£13,708	1	Number of beds	No	N&W Bed 108	No	Early suspension of scheme due to quality issues within the care home	
Additional bed at Dell House	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	£15,625	£15,625	1	Number of beds	No	N&W Bed 109	Yes	13 weeks of bed based care achieved - 1 bed commissioned weekly for 13 weeks	
Additional discharge ward round consultant cover	Additional or redeployed capacity from current care workers	Costs of agency staff	£107,000	£107,000	390	hours worked	No	N&W WIN 104	Yes	Increased weekend support for consultant cover / front door	
Beach View Surge	Bed Based Intermediate Care Services	Other	£66,747	£66,700	5	Number of beds	No	N&W WIN 58	Yes	Achieved 26 weeks of bed based care which supported hospital discharge and admission avoidance	Call off contract utilised to prevent payment for beds not required
Bridging the gap	Reablement in a Person's Own Home	Reablement to support to discharge step down	£36,000	£36,000		N/A	Yes	N&W WIN 114	No	Pump priming scheme for complex home care to be funded recurrently	
Brokerage (Proactive Sourcing Posts to target discharge)	Other	(blank)	£50,000	£50,000		N/A	No	N&W WIN 35	Yes	Improvements to brokerage of longer term packages of care	
Carers Hardship Support	Other	(blank)	£11,666	£11,666		N/A	No	N&W WIN 34	Yes	Additional advice and support provided to carers focussed on winter hardship	
Clinical Support for Secondary to Primary Care Discharge Interface.	Other	(blank)	£110,000	£0		N/A	No	N&W WIN 56-didn't go ahead	No	Did not proceed	
Complex Needs Support at Home	Home Care or Domiciliary Care	Domiciliary care packages	£107,390	£99,950	2,240	Hours of care	No	N&W WIN 90	Yes	Integrated 'complex' home care offer used a multidisciplinary approach in Gt Yarmouth to support earlier discharges	
Core AMHP Provision (CTOs) & Additional psychiatry and CLDT to Airey Close (step	Other	(blank)	£116,500	£116,500		N/A	No	N&W WIN 6 & N&W WIN 6a	Yes	Additional MH Act Assessments to reduce delays	
Cresta Lodge - Poringland (Beds)	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	£99,750	£90,900	5	Number of beds	No	N&W Bed 104a	Yes	This achieved 65 beds of care	
Cresta Lodge - Poringland (Primary Care)	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	£9,500	£7,500	0	Number of beds	No	N&W Bed 104b	Yes	An enabler - no extra capacity created	
Dementia Support	Other	(blank)	£54,000	£54,000		N/A	Yes	N&W WIN 7	Yes	Reduced discharge delays and readmissions	
Discharge Support Community Nurse	Additional or redeployed capacity from current care workers	Costs of agency staff	£17,000	£0	0	hours worked	Yes	N&W WIN 82	No	Did not proceed - Unsuccessful recruitment of B7 nurse for discharge support	
Discharge Wellfare Call	Other	(blank)	£5,000	£5,000		N/A	No	N&W WIN 125	Yes	Supported discharge from hospital and prevention of readmission	
Distribution / reporting	Administration	(blank)	£71,370	£0		N/A	No	N&W WIN 131 & N&W WIN 132	Yes	Administration, distribution and tracking of winter funded schemes - WIN132 - Currently not being used, formed part of the winter war chest to use against other schemes - front door,	
Domiciliary Team	Other	(blank)	£160,000	£160,000		N/A	Yes	N&W WIN 116	No	Did not proceed - reallocated to Homelink	Did not get up and running (bridging the gap), unable to recruit to the posts
Enhanced Discharge - Primary Care	Other	(blank)	£50,000	£50,000		N/A	No	N&W WIN 55	Yes	Improve Primary Care support for complex discharges	
Enhanced Primary Care Discharge Support Model	Other	(blank)	£125,568	£143,000		N/A	No	N&W WIN 14	Yes	GP support in discharge hub to facilitate complex discharges and prevent readmission	
Evening Sanctuary Expansion	Other	(blank)	£99,148	£13,500		N/A	No	N&W WIN 9 & N&W WIN 10	No	Low referrals - service stood down	
Evolve Beds	Bed Based Intermediate Care Services	Other	£114,423	£114,423	6	Number of beds	No	N&W WIN 5	Yes	Reduction in CRFD delays due to CTO completion delays. 129 placements achieved	
Expand complex discharge team to cover 7 days (Band 5 x2)	Local recruitment initiatives	(blank)	£42,320	£42,320		N/A	No	N&W WIN 99	Yes	Improved complex discharge flow at weekends	
Fund 6 months of social care capacity for the additional D2A2/3 beds coming on line	Additional or redeployed capacity from current care workers	Local staff banks	£133,371	£133,371	616	hours worked	No	N&W Bed 107	Yes	Enabler - Delivered flow through additional winter beds via in-reach support and exit planning	
Glendon House Cromer (Beds)	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	£120,000	£148,935	7	Number of beds	No	N&W Bed 106a	Yes	85 weeks of bed based care achieved	
Glendon House Cromer (Primary Care)	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	£46,000	£12,100	0	Number of beds	No	N&W Bed 106b	Yes	Enabler - Primary care support in place to support flow	
Hickerthrift	Bed Based Intermediate Care Services	Other	£160,000	£160,000	4	Number of beds	No	N&W WIN 63	Yes	37 weeks of bed based care achieved	
Home Support Block Rounds	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£270,000	£270,000	7,700	Hours of care	No	N&W WIN 31	Yes	Reduced holding list for NFR (intermediate care back door) and increased hours of home for discharge (D2A)	
Home Support Enhanced Discharge Incentive	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£200,000	£200,000	2,520	Hours of care	No	N&W WIN 32	Yes	Increased discharge flow	
Home Support Rate Increase	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£792,000	£792,000	25,388	Hours of care	No	N&W WIN 27	Yes	Supported flow and increased discharge activity	
Homeward Bound Discharge Pilot	Other	(blank)	£25,000	£0		N/A	No	N&W WIN 87	No	This project was removed	
Increase establishment of case managers to ensure ward cover 7 days a week and during	Local recruitment initiatives	(blank)	£10,883	£10,883		N/A	No	N&W WIN 98	Yes	Robust discharge planning and expedited discharges and transfers of care	
Insulin Project	Increase hours worked by existing workforce	Overtime for existing staff	£2,950	£0		N/A	No	N&W WIN 84	No	Did not proceed	
Intermediate Care Beds	Residential Placements	Discharge from hospital (with reablement) to long term care	£175,000	£71,250	12	Number of beds	No	N&W WIN 126a	Yes	Achieved 172 weeks of bed based care	
Live in Carers	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£285,000	£285,000	3,780	Hours of care	No	N&W WIN 20	Yes	79% utilisation - supported discharges	Limited uptake, would not recommend requesting future funding
Manor House Blofield (Beds)	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	£84,000	£72,500	4	Number of beds	No	N&W Bed 105a	Yes	36 weeks of bed based care achieved	
Manor House Blofield (Primary Care)	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	£23,000	£6,900	0	Number of beds	No	N&W Bed 105b	Yes	Enabler - no beds attached	
Mind Psychiatric Liaison Expansion	Reablement in a Person's Own Home	Reablement to support to discharge step down	£20,250	£20,250		N/A	No	N&W WIN 1	Yes	Improved flow and supported delayed discharges	
Nordelph ICB Beds	Bed Based Intermediate Care Services	Other	£47,000	£40,000	2	Number of beds	No	N&W WIN 62	Yes	20 weeks of bed based care achieved	
Norfolk Interim Care Service (Provider of Last Resort)	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£1,000,000	£1,000,000	3,640	Hours of care	No	N&W WIN 33	Yes	Improved flow through pathway 1 via releasing capacity in NFS	
Orchard House	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	£252,000	£230,000	5	Number of beds	No	N&W WIN 93	Yes	47 weeks of bed based care achieved	
Pathway 2/3 Beds	Additional or redeployed capacity from current care workers	Costs of agency staff	£28,860	£28,860	0	hours worked	Yes	N&W WIN 66b	No	Unable to recruit	
Pathway 2/3 Beds	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	£40,150	£40,150	4	Number of beds	No	N&W WIN 122	Yes	52 weeks of bed based care achieved	
Pathway 2/3 Beds	Other	(blank)	£10,000	£10,000		N/A	Yes	N&W WIN 67	Yes	Exercise Coordinators / Health Coach supported P2/3 beds	

Pathway 2/3 Beds	Residential Placements	Discharge from hospital (with reablement) to long term care	£75,400	£102,600	8	Number of beds	No	N&W WIN 65a	Yes	104 weeks of bed based care achieved	
Pharmacy discharge support	Other	(blank)	£65,000	£32,500		N/A	Yes	N&W WIN 121	No	Did not proceed - recruitment issues	*
Place based (ie NN, SN, N) initiatives to avoid admission to hospital and 7 day working to	Other	(blank)	£675,000	£663,166		N/A	No	N&W WIN 40, WIN 40 A-J	Yes	Support admission avoidance	
Pre noon discharge liaison support	Other	(blank)	£15,000	£7,500		N/A	No	N&W WIN 120	Yes	Improved flow and supported delayed discharges	
Priority Patient Review	Other	(blank)	£243,700	£75,700		N/A	No	N&W WIN 15 & N&W WIN 59	Yes	Reduction of readmission	
Quality Improvement	Local recruitment initiatives	(blank)	£16,875	£0		N/A	Yes	N&W WIN 19	No	Did not proceed - recruitment	*
Rapid Access to Integrated Support	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£345,000	£345,000	756	Hours of care	No	N&W WIN 36	Yes	Reduced hospital length of stay, ED attends, and emergency admissions (89.5 bed equivalents)	There were slightly lower level of appointments in the first couple of days to
Replacement dementia beds in the west (cost to include Primary Care - maybe provided by home)	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	£160,000	£160,000	7	Number of beds	No	N&W Bed 110	Yes	Improved flow - 82 weeks of bed based care achieved	
Residential Step Down Bed	Bed Based Intermediate Care Services	Other	£19,175	£19,175	1	Number of beds	No	N&W WIN 8	Yes	Achieved 25 placements of bed based care over 10 weeks	
Social Prescriber for Pre-Op	Local recruitment initiatives	(blank)	£18,400	£8,492		N/A	No	N&W WIN 85	Yes	Improved flow and supported delayed discharges	
St Martins Hospital Discharge Liaison	Other	(blank)	£15,300	£15,300		N/A	No	N&W WIN 2	Yes	Reduced CRFD delays due to housing/homelessness	
Step-down Housing with Care Flats	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	£352,000	£352,000	21	Number of beds	No	N&W WIN 28	Yes	Achieved total 251 weeks of bed based care (251 over 13 weeks - average 19 per week)	
Stroke Reach Project	Reablement in a Person's Own Home	Reablement service accepting community and discharge	£16,000	£10,700	0	N/A	No	N&W WIN 89	No	It is anticipated it will have the desired impact, due to recruitment delays we are unable to provide hours of care currently	
Surge Capacity Coordinators	Local recruitment initiatives	(blank)	£25,500	£25,500		N/A	No	N&W WIN 21	Yes	Improve flow and increase discharge capacity	
Thomas Towell beds	Residential Placements	Nursing home	£264,000	£0	0	Number of beds	Yes	N&W WIN 128	No	Scheme never mobilised	
Winter Capacity Provision Fund	Contingency	(blank)	£688,034	£165,165		N/A	No	N&W WIN 129 & N&W WIN 130b	Yes	Supported winter resilience and rapid response as required	

Schemes added since Plan											
Intermediate Care Beds	Bed Based Intermediate Care Services		£0	£5,700		Number of beds	No	N&W WIN 126b	Yes	As above 126a	
Intermediate Care Beds	Residential Placements		£0	£12,857	2	Number of beds	No	N&W WIN 126c	Yes	As above 126a	
Intermediate Care Beds	Residential Placements		£0	£1,100	0	Number of beds	No	N&W WIN 126d	Yes	Enabler of 126 a - c	
Redlands Additional Beds	Residential Placements		£0	£146,500	8	Number of beds	No	N&W WIN 133	Yes	83 weeks of bed based care achieved	
Additional Homelink	Home Care or Domiciliary Care		£0	£126,594	504	Hours of care	No	N&W WIN 134	Yes	Improved flow and supported delayed discharges	
Reservists Core	Local recruitment initiatives	Other	£0	£28,000		N/A	No	N&W WIN 130a	Yes	Increased availability of discharge support - improved flow	
CHS Brokerage		Other	£0	£45,000		N/A	No	N&W WIN 136	Yes	93 weeks of bed based care achieved	
Optimal care project	Other	Reduce double up packages of care	£0	£482,784		N/A	No	N&W WIN 137	Yes	***Scheme recently commenced and recruitment is in progress - enhance the utilisation of single handed care and significantly reduce the need for double up care in Norfolk	
Acacium / Pulse	Other	Extension of round times	£0	£45,000		N/A	No	N&W WIN 138	Yes	DUPLICATION OF WIN 40a so remove Facilitate more discharges through increased round times	
Care Home	Additional or redeployed capacity from current care workers		£0	£50,000		hours worked	No	N&W WIN 139	Yes	Support safe discharge and prevent unnecessary hospital admissions	
Learning Disability and Autism and serious mental illness	Other		£0	£50,000		N/A	No	N&W WIN 140	Yes		

Planned Expenditure	£9,671,604
Actual Expenditure	£9,150,324
Actual Expenditure ICB	£5,668,092
Actual Expenditure LA	£3,482,232

Report title: Our approach to improving pharmacy, optometry and dental services

Date of meeting: 21 June 2023

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

Reason for the Report

On 1 April 2023, the NHS Norfolk and Waveney Integrated Care Board (the ICB) became responsible for pharmaceutical services, primary care optometry services and dental (primary, community and secondary care). This means the ICB is now responsible for all primary care services, as the organisation was already responsible for general practice.

This report informs the Integrated Care Partnership (ICP) about the transition of these services and provides an update on the challenges and risks in relation to current service provision, as well as our approach to improving these services.

Report summary

This report describes the position for the ICB on transfer of delegated responsibility for pharmaceutical, optometry and dental services. The ICB is listening to and working with professionals from all the services to understand what can be done to recruit more staff and retain the existing workforce, and what else we can do to make it easier for people to access these services. There are actions we will be able to take relatively quickly that will make a difference. We know there are lots of opportunities to improve services, but also that sustainable, long-term change will take time to achieve.

Understanding the views and experiences of local people will give us vital insights into the challenges facing each of these services, as well as aid our understanding of whether we are making a difference and what more we need to do. We will continue to engage with local people, groups and partner organisations as we work to improve pharmaceutical, optometry and dental services over the short, medium and longer term.

Recommendations

The ICP is asked to:

a) Endorse the ICB's approach to improving pharmaceutical, optometry and dental services.
b) Support the ICB's engagement with local people regarding these services.
c) Consider and discuss how we can make the most of the new opportunities open to us now that the ICB is responsible for commissioning all primary care services.

1. Background

1.1 The NHS Long Term Plan commits to developing more joined-up and coordinated care across primary and community health services and a more proactive approach in the services provided. Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care is an umbrella term which includes general practice, community pharmacy, dentistry and optometry (eye health) services.

1.2 On 1 April 2023, the ICB became responsible for pharmaceutical services, primary care optometry services and dental services. There are 181 community pharmacies and 66 optometry contracts in Norfolk and Waveney. There are also 102 primary care dental contracts, one Special Care Dental service (community dental) contract, contracts with three secondary care providers and contracts for Level 2 specialist services and the out of hours service for weekends and bank holidays.

1.3 As part of the agreed transition of services, the team responsible for pharmaceutical and optometry services is being hosted by NHS Hertfordshire and West Essex ICB. NHS Norfolk and Waveney ICB works collaboratively through a memorandum of understanding to manage service delivery and performance matters. We are directly responsible for commissioning and quality improvement of these services, and for directly managing all primary, community and secondary care dental services.

The challenges facing primary

1.4 Primary care's two biggest (and interlinked) challenges are access to services and the sustainability of the workforce. Improving access to primary care services is a priority for us, as it is for local people. In particular, we need to improve access to dentistry and pharmaceutical services:

- The ICB is not aware of any NHS dental practices in Norfolk and Waveney currently accepting new patients for treatment. This situation is not unique to Norfolk and Waveney.
- An increasing number of pharmacies are requesting to provide core hours only, due to workforce challenges and financial sustainability. This means that there is a reduction in the number of pharmacies offering services in the evenings, at weekends and over bank holidays. Again, this situation is not unique to Norfolk and Waveney.

1.5 A lack of access to primary care services impacts other parts of the system, for example, through the number of calls to NHS 111 and visits to Emergency Departments and general practice.

1.6 Challenges with recruiting and retaining the primary care workforce also impacts our ability to ensure equitable access to services for patients, to address health inequalities and to commission adequate service provision based on the health needs of the population. Nationally, all primary care services are facing greater challenges than ever due to workforce shortages, alongside an increasingly complex workload. This why we are also focused on the health and wellbeing of our workforce.

Our approach to improving services

1.7 As a result of having responsibility for all primary care services, opportunities exist for the ICB to commission differently. We aim to do this by understanding our population's health needs, designing care pathways that deliver integrated care and supporting our local providers to improve access to services and health outcomes for Norfolk and Waveney's population.

1.8 We have three priorities that will help us to better understand and address the challenges facing all primary care services:

- Our first priority is to listen to the views of the different primary care professions and hear about their concerns about the future of services in Norfolk and Waveney and how we can support them.

- Our second priority is to consider how we can retain our local workforce and allow them to develop their skills and expertise, offer opportunities for them to provide some services in a different way where possible, and also to encourage individuals to come and work in our area.
- Our third priority is to listen to our patients and their lived experience, and to ensure our local population has access to primary care services when needed.

1.9 We believe that successful delivery of these priorities can only be achieved by working in partnership with these professions, our other system partners such as secondary and community care, NHS England (formerly Health Education England) and voluntary organisations.

1.10 Here is some further information about the each of the services, the challenges they face and the steps we are taking to improve care.

2. Community pharmacy

2.1 The NHS Long Term Plan supports expanded community multidisciplinary teams aligned with PCNs. It determines to make greater use of community pharmacists' skills and opportunities to engage patients. It also identifies community pharmacies as being able to support urgent care and promote patient self-care and self-management as a key part of developing a fully integrated community-based health care system. The Delivery Plan for Recovering Access to Primary Care published on 9 May 2023 further highlights the important role that community pharmacy services provide in delivering patient care and how these services can develop in the future.

2.2 The Pharmaceutical Needs Assessment was agreed by the Health and Wellbeing Board in November 2022. This sets-out the current provision of pharmaceutical services and any gaps in service provision from pharmacies across Norfolk based on population growth forecasts. It is used to support commissioning decisions based on patient needs. Waveney comes under the Suffolk Pharmaceutical Needs Assessment. In 2019, a new Community Pharmacy Contractual Framework was agreed for five years, however it is not yet known how community pharmacy will be funded from March 2024.

2.3 Owing to the increasing pressures on community pharmacy and challenges with workforce recruitment and retention issues in Norfolk and Waveney, an increasing number of pharmacies are requesting to provide core hours only. This means that there is a reduction in the number of pharmacies offering services in the evenings, at weekends and over bank holidays. The region will be coordinating a fundamental review of Bank Holiday commissioning arrangements going forward.

2.4 The East of England Partnership Strategy for Community Pharmacy was developed in partnership with all ICBs and NHS England in the region. This document outlines our strategic visions and goals to support and enable community pharmacy in the East of England to realise its full potential. It supports integration and transformation, building on the strong foundations in place and to deliver on the vision of the NHS Long Term Plan. It plays a part in prevention of diseases, reducing health inequalities, helping to tackle obesity and high blood pressure, and providing enhanced public health care as part of a whole system approach.

2.5 Like many professions within Norfolk and Waveney, community pharmacy is facing significant and challenging workforce shortages that can affect the ability of the profession to consistently engage with service transformation. The development of a Norfolk and Waveney pharmacy workforce plan is now well-advanced and is currently being integrated

into our wider system workforce planning. Supporting pharmacies through this challenging time to successfully deliver the ambitions above, seeking to maintain and improve working relationships between our community pharmacies, general practices and PCNs, is fundamental to securing the foundations for future integration and development.

3. Optometry

3.1 The ICB's responsibilities for eye health care include:

- decisions in relation to the management of Primary Ophthalmic Services
- undertaking reviews of Primary Ophthalmic Services locally
- co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in Norfolk and Waveney where appropriate

3.2 The ICB will take an integrated approach to working with stakeholders, including NHS England, Local Eye Health Networks, local authorities, Healthwatch, acute and community providers, the Local Optical Committee, and other stakeholders to co-ordinate a common approach to the commissioning of Primary Ophthalmic Services.

4. Dental

The challenges facing dental services

4.1 Looking in more detail at the challenges facing dentistry:

- There are significant challenges with access to dental services, including oral health prevention, treatment, urgent care, and access for vulnerable groups, children and young people, and those living in areas of high deprivation.
- Norfolk and Waveney has the highest prevalence of dental decay in five year olds in the region. Our hospitals are seeing an increase in the number of children aged 15–19 being seen in secondary care for treatment for dental decay.
- Lack of access to dental services can result in other physical and mental healthcare problems for patients. It also has an impact on other parts of the health system, including NHS 111, emergency departments and general practice.
- In the last 10 years, the number of dentists has declined in our area compared to the Eastern region and England. There is no dental training school in the East of England, which is important as we know people are more likely to stay working in the area where they train.
- Some providers have stopped offering NHS care. In March, BUPA Dental gave notice that Eye and Brandon in Suffolk and Harleston in Norfolk would close, all of which are on the border. A further 48 are under review for potential sale, including their NHS practice in North Walsham. BUPA has since advised that the practice in Harleston may also be offered for sale.
- Between July and December 2022, 14,767 dental appointments were not attended in Norfolk and Waveney. This is 9% of all appointments (although it should be noted the regional average for missed appointments was 15%).

Improving dental services

4.2 We won't be able to solve all the challenges overnight, but we can make a difference. For example:

- Last year new dental service providers were procured in King's Lynn, Lowestoft and Norwich that are offering services 8am – 8pm every day. All three are now offering their full range of services, however they have reached capacity and are not able to take on any more NHS patients. In total the three services are providing NHS dental care to c6,800 patients (4,343 adults and 2,449 children).
- The University of Suffolk is establishing a Centre for Dental Development to enhance local education and training opportunities in dental therapy and hygiene, apprentice dental technicians and post graduate dentists. The Centre will sit alongside a community interest company that will be able to bid for future locally commissioned dental services.
- In April we increased investment in domiciliary dental services which treat housebound patients in Norfolk and Waveney.

4.3 There are actions we will be able to take relatively quickly that will make a difference. However, sustainable, long-term change will take time to achieve. So, our approach is three-fold:

1. **To take any immediate actions we can to improve services**, such as the investment in domiciliary dental services.
2. **To agree a one-year plan by September 2023 for short-term interventions to address the most immediate concerns.** A more flexible commissioning approach will help to deliver services that patients need and can access more easily. It will also help to support our ambition to build relationships with and resilience among dental providers in Norfolk and Waveney.
3. **To develop a dental strategy by March 2024 which sets out our commissioning approach and intentions for the next five years**, how we plan to build resilience into our NHS dental services and improve general dental access, alongside the development of our local workforce plan.

4.4 This autumn we will receive a full assessment of Oral Health Needs data from the Consultant in Dental Public Health, which will further inform our planning.

4.5 The ICB has been and will continue to engage with the dental profession. Over the past six months this has been through monthly meetings with the Local Dental Committee and more recently through the East Anglia Local Dental Professional Network and Managed Clinical Networks. The ICB has also established a Dental Development Group to bring together representatives from across the dental profession in Norfolk and Waveney with key stakeholders and system partners to develop solutions for securing access to NHS dental care for the whole population.

Officer Contact

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

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IN TRAN communication for all

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

Report title: Update on establishment of the Adult and Children and Young People's Mental Health System Collaboratives

Date of meeting: 21 June 2023

Sponsors
(ICP members): Norfolk County Council (NCC), Norfolk Community Health and Care NHS Trust (NCHC), Norfolk and Suffolk NHS Foundation Trust (NSFT) and Norfolk and Waveney Integrated Care System (ICS)

Reason for the Report
The ICP is asked to Endorse the approach, outlined in the attached papers, to establishing the Adult and Children and Young People's Mental Health System Collaboratives.

Report summary
Discussions over collaboration across mental health in Norfolk and Waveney have been a focus for several years. In 2019, both the adult and children and young people's (CYP) mental health strategies respectively placed integration at the heart of their service models moving forward. Initially at least, we are proposing to establish an adult mental health system collaborative and a CYP system collaborative. A system collaborative means that health and care providers, including voluntary sector organisations and primary care, should organise themselves around the needs of the population rather than planning at an individual organisational level, in delivering more integrated, high-quality, and cost-effective care.

The areas of focus for year 1 (23/24) have been identified as:

1. For CYP the redesign of community-based support to meet mental health needs and for neurodiverse children and young people, individuals with SEND and their families.
2. For adults/older people – dementia pathways inclusive of delirium and depression.

Working groups have been established to describe the ambitions and scope for each of the collaboratives. They have drafted the following documents:

- Appendix 1 – ICB Board paper that gives context to the collaboratives.
- Appendix 2 – CYP System Collaborative common paper that describes their ambition and scope.
- Appendix 3 – Adult Mental Health System Collaborative partnership agreement.
- Appendix 4 – Adult Mental Health System Collaborative Terms of Reference.

Recommendations
The ICP is asked to:

a) Endorse the approach outlined to establishing the Adult and Children and Young People's Mental Health System Collaboratives.

Officer Contact

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

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Norfolk and Waveney
Integrated Care Board

Agenda item: 9

Appendix 1

Subject:	Establishment of the Mental Health System Collaboratives
Presented by:	Jocelyn Pike, Acting Director of Mental Health Transformation
Prepared by:	Anne Borrows, Associate Director of Special Projects
Submitted to:	ICB Board
Date:	28 March 2023

Purpose of paper:

The ICB Board is asked to:

- Agree to the establishment of the adult mental health system collaborative and a children and young people's system collaborative from April 2023.
- Endorse the direction of travel set out in this paper.

Context

Discussions over collaboration across mental health (MH) in Norfolk and Waveney (N&W) have been a focus for several years. In 2019 both the adult, and children and young people's (CYP) MH strategies respectively placed integration at the heart of their service models moving forward.

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

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

During 2022 the formation of system collaboratives for mental health was further accelerated in light of:

- The need to support local providers – namely Norfolk and Suffolk Foundation Trust (NSFT) – in delivering optimal patient care and, in so doing, respond to the objectives laid out in their CQC Improvement Programme,
- The desire to align timescales and ambition with neighbouring ICS's – namely Suffolk and North East Essex (SNEE) – to ensure our population does not observe or experience inequity of provision (particularly relevant on the boundaries of our systems),
- To meet national expectations – as referenced above.

Current thinking

Initially at least, we are proposing to establish an adult MH system collaborative and a children and young people's (CYP) system collaborative. This is because the current providers and

models of delivery in each 'space' differ. For example, CYP already has an Alliance (established 2019/20), building on the previous CYP strategic partnership with a signed Alliance agreement in place. It has four priorities of which one is children's mental health with an established system children and young people's mental health executive.

The responsibility for the focus on transition services (18-25 yrs) will need to be agreed for one of the collaboratives to lead, with the ambition to converge over time.

Whilst both collaboratives are prioritising mental health services, they both want to include physical health outcomes and a focus on the wider determinants of health.

Progress to date

A series of half-day meetings were held bringing together the principal providers in each of the collaboratives (on 'day 1') to discuss their ambitions and initial scope. The VCSE sector was also represented as was primary care and members of the ICB.

The areas of focus for year 1 (23/24) have been identified as:

1. For CYP the redesign of community-based support to meet mental health needs and for neurodiverse children and young people, individuals with SEND and their families.
2. For adults/older people - dementia pathways inclusive of delirium and depression.

The reasoning behind this is:

- An initial 'sifting' exercise with NSFT, SNEE, NHSEI regional team and the N&W ICS identified these as areas of opportunity
- Specifically in relation to dementia, a good fit with our ICS local ambition to radically improve outcomes and pathways across our aging population
- (to note, the collaborative/s are part of a much larger programme of community transformation in MH, where delivery of the 2019 MH strategies continue)

Working groups have been established to progress describing the ambitions and scope for each of the collaboratives.

Adult MH system collaborative ('the adult collaborative')

Executive and senior representatives from Norfolk County Council Adult Social Services, Norfolk Community Health and Care, East Coast Community Healthcare (ECCH), NSFT and the ICB met on the 20th January. Also in attendance were VCSE and primary care. The meeting concluded with agreement in the following areas:

Ambition

Crucial to the success of the adult collaborative is being able to take action together, to align resources, have mandated authority to act and be equally accountable. To do so would require strong trusting relationships between colleagues and organisations.

Scope

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

Points of note

- It is acknowledged that dementia can span all-age – albeit in smaller numbers.

- Agreement must be reached with the CYP MH collaborative over the 18-25 cohort, transition, and other areas of inter-dependency.
- The University of East Anglia is a world class leader in Dementia; we must utilise their expertise and learning.

Thereafter

1. From February 23 a working group, consisting of a sub-set of leads from the organisations named has met, the output of their work being to:
    - draft a partnership agreement for the adult collaborative
    - further build the 'case for change' on the dementia portfolio.
2. Submit the recommendation to establish the Adult collaborative – March/April 23.
3. Further meeting of the same partners on the 11th April 23 to receive the outputs – namely the partnership agreement and case for change - from the working group for approval.
4. Adult MH system collaborative established – late April 23.
5. Thereafter identified delivery groups, drawn from the wider ICS membership, to further develop and implement the dementia redesign.
6. Review arrangements after 1 year.

<u>CYP system collaborative</u> ('the CYP collaborative')

Executive and senior representatives from Norfolk County Council Children's Services, Suffolk County Council, Cambridgeshire Community Services, ECCH, NSFT and the ICB met on the 31st January. Also in attendance were VCSE and primary care. The meeting concluded with agreement in the following areas:

Ambition

Implementation of the Thrive model. The intention is to look creatively and holistically at all the resources across the key partners and to re-design the support model to achieve the best outcomes. The ambition includes making structural, operational, and cultural changes required to deliver community based multi-disciplinary team working across organisations, to ensure collective support to meet the physical, emotional and mental health and care needs of the child or young person and their family. This is a clear step beyond 'partnership collaboration' to a fully integrated approach.

Scope

The intention is to ultimately consider all community-based support (teams, resources, and pathways) that meets the mental and physical health, education and social needs as within the scope of the new collaborative. This can only be achieved when all health, care, education, community and voluntary sector providers and system leaders (the ICB and Council) fully collaborate to improve the outcomes for our children and young people.

The only resources defined as 'out of scope' are those covered within the Adult Mental Health System Collaborative and the Regional Specialist Collaborative.

It is envisaged that the children and young people's system collaborative will be established in phases over a number of years and that the scope will therefore expand as the work develops.

Initially the focus will be on the redesign of community-based support to meet mental health needs and for neurodiverse children and young people, individuals with SEND and their families. All resources and pathways in those areas will be 'in scope' for the first phase.

Points of note

The Children Act 2004 (the Act) also provides the legislative spine on which to improve wellbeing and integrate children's services, promote early intervention, provide strong leadership, and bring together different professionals in multi-disciplinary teams to achieve positive outcomes for children and young people and their families. Local authorities are given a lead role (DCS) in securing the co-operation of partners in setting up children's trust arrangements - the Act allows some flexibility in how these are structured and organised.

In Norfolk this is the Children and Young People's Strategic Alliance. Complemented by our Norfolk Children Safeguarding Partnership.

The concept of well-being covers physical and mental health and emotional well-being, protection from harm and neglect, education training and recreation, contribution to society and social and economic well-being.

This is captured through the Norfolk ambition for every child to flourish and the eight outcomes it represents.

Therefore;

- The CYP collaborative is not intended to replace the CYP Alliance; the latter will set the strategic direction and oversee delivery.
- Specialist / tertiary care for core CYP mental health care will remain with a specialist provider - namely NSFT. All other services currently commissioned are in scope for the collaborative to consider alternative delivery models.
- The changes in mental health support/service arrangements, will be in line with the N&W CYP strategy signed off by all partners in 2019.
- Change management capacity and leadership is critical to facilitate cultural change.
- There is a preference for those aged 18-25 yrs with mental health, NDD or SEND care needs transitioning to adult support packages to come under the CYP collaborative.
- For clarity the geographical footprint covered is Norfolk; the agreement in discussion (still subject to internal sign-off) is that Waveney provision for children and young people's mental health is overseen in the Suffolk collaborative.

Thereafter

1. The establishment of a core executive. Initially at least made up of Chief Executives or Executive Directors from NCC, NSFT, CCS, and the ICB. The group will:
    - Be the accountable/authorising/delegated body, leading the structural and cultural change; providing clear delineation on what each brings.
    - Define an agreed purpose for those services identified; including priorities and expected outcomes.
    - Provide oversight and accountability for delivery of expected outcomes.
    - The group will meet, in shadow-form to receive and approve the common paper – mid March 23.
2. From February 23 a working group, consisting of a sub-set of leads from the organisations named has met, the output of their work being to:
    - draft a 'common paper' describing the ambition and scope of the CYP collaborative for sign off by each organisation
    - work up a proposal for the areas initially in scope for the CYP collaborative.
3. Submit the final documentation together with a recommendation to establish the CYP collaborative – March/April 23.
4. CYP MH system collaborative established – April 23.
5. Establish delivery groups drawn from the wider membership of CYP Alliance to develop and implement the redesign agreed by the core executive; considering available data, information, and insights to understand enablers i.e., workforce, and identify and agree resource – developmental stage: 1-18 months / implementation 06-24 months.

6. Review arrangements - 24 months.

Waveney

One area that requires clarity in defining the remit of our collaboratives is the position of Waveney. Whilst this area falls within the county of Suffolk, all NHS funded services are the responsibility of the Norfolk & Waveney ICB.

In developing these proposals, there has been extensive engagement between colleagues from the Norfolk and Waveney and Suffolk and NE Essex systems to determine how best to establish arrangements that are clear and practical, whilst considering the need to achieve consistent delivery arrangements for some integrated services.

The position that has been identified by partners as logical and pragmatic is for all NHS funded mental health support for children and young people in Suffolk (including for Waveney) to be in scope for the Suffolk Collaborative. This model reflects the recognition among partners of the key role county councils play in organising and delivering wider children's services (social care, education, public health etc) and the resulting importance of ensuring there are consistent county-based models.

Decisions about NHS funded mental health services for adults and older people in Waveney that are the responsibility of Norfolk and Waveney ICB are not within the scope of the Suffolk Mental Health Collaborative. Decision making for these services will be within the proposed Norfolk and Waveney Adult and Older People Mental Health Collaborative, which will likely include senior representation from Suffolk County Council.

The two ICBs are working together to develop and agree the best way of implementing these arrangements and any addressing and outstanding issues.

Engagement and co-production

During October 2022, an engagement task and finish group was established to oversee, develop, and implement our engagement on the collaboratives.

The group membership includes 3 patient and public advisors, Healthwatch Norfolk, NSFT, Norfolk County Council, voluntary sector and primary care representation with a reach that extends outside of these groups to cover all of Norfolk and Waveney.

The first output from the group has been to launch an engagement exercise, 'Let's Talk…about Mental Health', to help us understand if the priorities as identified in our adult, and children and young people's mental health strategies, 2019, are still correct. The survey ran from January 2023 to February 2023, and was open to responses from service users, staff, family, carers, and members of the public. This was mainly done via an online portal, and was promoted via existing networks, websites, health care settings and via patient and carer representatives. Overall, the spread of responses reflects a range of individual demographics and a mix of service-user, carer, family member, and staff across the system.

The qualitative data is rich in detail and has specific feedback about service lines, individual organisations and occasionally named staff members. We are currently sharing the initial analysis with stakeholders from across the health and social care system and discussing these findings in more detail. In response to the findings, we will establish:

- what work we are already doing to address some of the concerns raised
- what work we have planned to address some of the concerns raised
- where any gaps might be, or where we can work together and provide additional support to address these concerns

- what the root cause of some of the issues raised might be, and what we can do to resolve these wider determinants of mental health and wellbeing

This will inform the specific work of the collaboratives as they seek to redesign clinical pathways.

Further, each collaborative once established will articulate how they intend to co-produce their programmes of work and where experts by experience will feature in their governance and decision-making processes.

Recommendation to ICB Board:

The ICB Board is asked to:

- Agree to the establishment of the adult mental health system collaborative and a children and young people's system collaborative from April 2023.
- Endorse the direction of travel set out in this paper.

NHS
Norfolk and Waveney
Integrated Care Board

Appendix 2

Agenda item: XX

Subject:	Common paper on establishment of the Children and Young People's System Collaborative
Presented by:	Jossy Pike, Acting Director of Mental Health Transformation
Prepared by:	Anne Borrows; Associate Director of Special Projects, NHS Norfolk & Waveney Integrated Care Board (N&W ICB) Steve Bush; Director of Children and Young People's Services, Cambridgeshire Community Services NHS Trust (CCS) Rebecca Hulme; Director - Children, Young People and Maternity, N&W ICB Steff Kamara; Interim Director for Children, Families and Young People's Services, Norfolk and Suffolk Foundation NHS Trust (NSFT) James Wilson; Service Director – Children's Service Norfolk County Council (NCC) Peter Witney; Senior Project Manager - Place Development and System Support, N&W ICB
Submitted to:	Norfolk & Waveney ICB Board
Date:	28 March 2023

Purpose of paper:

To update on the progress in establishing the Children and Young People's System Collaborative.

To secure a mandate from each of the key partners to create streamlined governance arrangements which empower the appropriate leaders to drive forward the new collaborative at pace. This would likely include integrated and co-located teams, new ways of working together, shared leadership and the sharing of caseloads.

Context

Discussions over collaboration across mental health (MH) in Norfolk and Waveney (N&W) have been a focus for several years. In 2019 both the adult, and children and young people's (CYP) MH strategies respectively placed integration at the heart of their service models moving forward.

The 2022 Health and Care Act established the legislative framework to promote better joined-up services. This includes a duty for all health and care organisations to collaborate to rebalance the system away from competition and towards integration. For local government the 2021 national review of Children's Social Care and recent government response provide a further clear national policy direction towards the creation of integrated services and a role for local authorities to bring the system together around a common cause.

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

During 2022 the formation of system collaboratives for mental health was further accelerated in light of:

- The need to support local providers – namely Norfolk and Suffolk Foundation NHS Trust (NSFT) – in delivering optimal patient care and, in so doing, respond to the objectives laid in in their CQC Improvement Programme,
- The desire to align timescales and ambition with neighbouring ICSs – namely Suffolk and North East Essex (SNEE) – to ensure our population does not observe or experience inequity of provision (particularly relevant on the boundaries of our systems),
- To meet national expectations – as referenced above.

Current Challenges

Across the public sector we continue to see high levels of need within communities and demand for services. In particular this manifests in high and increasing numbers of referrals for acute or more specialist support which leaves those specialists struggling with capacity. In turn this stifles investment in more preventative or early intervention support which all recognise is so badly needed. We see this for example in the extremely high rate of referral per head of population to Children and Young People's Mental Health services in Norfolk, in high and increasing numbers of children referred for Education Health and Care Plans, the long waiting times for support and diagnosis across key pathways and in pressure on the social care system which has high caseloads and more children and young people identified with the most complex needs.

Alongside demand pressure, the other key challenge relates to our ability to connect our interventions together across different services. As needs become more complex within children and families it is more important than ever that health and care professionals from different backgrounds can come together as a single team and that we can make support as easy and simple as possible to access and to understand.

It is recognised that although current partnership relationships are strong and there are good examples emerging of integrated work, we cannot achieve the step-change we need without deeper integration of the offer and greater ambition around collaboration.

Ambition

The creation of a new collaborative presents an extremely powerful opportunity to realise our ambition that all children FLOURISH and to create a nationally leading model.

Our intention is to look creatively and holistically at all the resources across the key partners and to re-design the support model to achieve the best outcomes. The ambition includes making structural, operational, and cultural changes required to deliver community based multi-disciplinary team working across organisations, to ensure collective support to meet the physical, emotional and mental health and care needs of the child or young person and their family. This is a clear step beyond 'partnership collaboration' to a fully integrated approach.

Some of the key features and opportunities we want to embed within the new approach are;

- A focus on early intervention and prevention – moving the resource and support further upstream over time and reducing the reliance on specialist and acute support

- A focus on 'place', looking to offer support within local communities and provide help where children, young people and families are day to day – with less reliance on specialist settings, clinics or institutions

- To look holistically rather than separately at needs – resulting in strategic integration but also joined up casework for each child, young person and family and aiming for a single personalised assessment and plan in each case. It is clear that physical and mental health, education and social needs all interact and that we have greater chance of success in any area if we look at the whole – so we want to design ways of working for teams that enable that

- A move away from a clinical model which focuses on diagnosis or labelling of needs to one which is rooted in community-led early help and which exploits the capacity within children and families and communities to help themselves

- An opportunity to look at our portfolio of resources across the partnership and make things more efficient and effective, sharing 'back-office resource' leading our staff teams together and putting our collective scale to work in the interests of children, young people and families

Scope

Our intention is to ultimately consider all community-based support (teams, resources, and pathways) that meets the mental and physical health, education and social needs as within the scope of the new collaborative. This can only be achieved when all health, care, education, community and voluntary sector providers and system leaders (the ICB and Council) fully collaborate to improve the outcomes for our children and young people.

The only resources defined as ‘out of scope’ are those covered within the Adult Mental Health System Collaborative and the Regional Specialist Collaborative.

It is envisaged that the children and young people’s system collaborative will be established in phases over a number of years and that the scope will therefore expand as the work develops.

Initially, and beginning from 1st April 2023, the focus will be on the redesign of community-based support to meet mental health needs and for neurodiverse children and young people, individuals with SEND and their families. All resources and pathways in those areas will be ‘in scope’ for the first phase.

Flourishing in Norfolk

The Flourishing in Norfolk Strategy (2021- 2025) outlines several guiding principles:

- Child and young person focused
- Positively framed – based on aspirations rather than just needs
- Places importance on how children, young people and families feel about their lives
- Inclusive of all children and young people in Norfolk
- Recognises our shared responsibility for children, young people, and families
- Co-produced with young people
- Represents the interests and focus of all Children and Young People Strategic Alliance members

We will be working with our partners to embed FLOURISH as an ambition that underpins all our work, but FLOURISH isn’t just an ambition for social care, education, health, and other professionals working directly with children, young people, and families. Our businesses, communities and every person living or working in our county has a role to play in helping Norfolk’s children and young people to Flourish.

Governance and Delegation

In order to achieve our ambitions, it is recognised that we need to create streamlined governance arrangements which empower the appropriate leaders to drive forward the new collaborative at pace. The intention of this paper is to secure such a mandate for each of the key partners to move forward. This would include integrated and co-located teams, new ways of working together, shared leadership and the sharing of caseloads.

At this stage the proposal does not go as far as recommending consideration of pooled budgets, formal financial delegation, formal delegation of existing accountabilities or the TUPE transfer of staff between organisations. However, potentially as the work develops, these could become recommended options and if so a further paper would be taken through the partnership governance and that of the key partners for approval.

From a partnership perspective the existing Children and Young People Strategic Alliance will provide the strategic endorsement for the creation of the new collaborative and will have oversight of the work as it develops. Achievement of this will support delivery of the objectives within the ICB Joint Forward Plan and the Integrated Care Strategy.

The core partner organisations who will co-design the new collaborative are the NHS Norfolk and Waveney Integrated Care Board (N&W ICB), Norfolk and Suffolk Foundation NHS Trust (NSFT), Cambridgeshire Community Services NHS Trust (CCS) and Norfolk County Council (NCC).

As such each of these organisations will also seek strategic endorsement for the creation of the collaborative from their key governance boards, specifically

- NCC Corporate Board
- N&W ICB Board
- CCS Board
- NSFT Board

To complete the design and implementation work we envisage the following new governance being established.

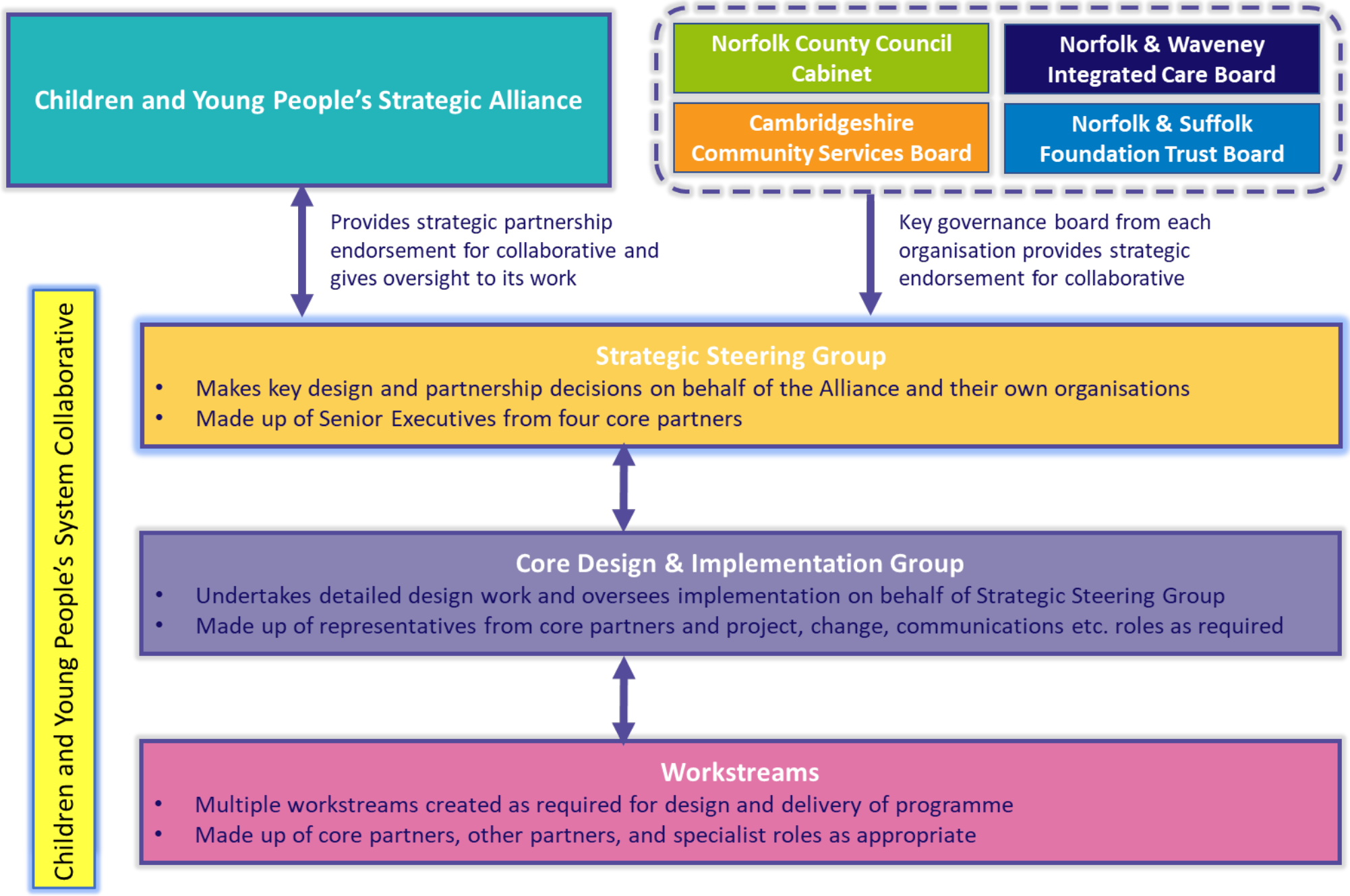
A Strategic Steering Group made up of senior executives from the core partners. This group would be empowered to work on behalf of the Alliance and their own organisations to create the collaborative and would make the key design and partnership decisions. The CYP financial resources currently deployed by the ICB, NHS England and NCC (social care and public health) would be used to transform care under this partnership model. The representatives on this group would be

- Executive Director Children Services, NCC
- Chief Executive, CCS
- Chief Executive Officer, NSFT
- Acting Director of Mental Health Transformation, N&W ICB

A core design and implementation group will work on behalf of the Steering Group to undertake the detailed redesign work and to oversee its delivery on the ground. This group will have representatives from the core partners as well as project, change, communications and other programme roles as required. This group will be the engine room for the programme but will take all key design decisions/options for consideration at the Strategic Steering Group.

The core design group would commit to working in an inclusive way and involving strategic partners as needed. After the initial mandate is established, regular reporting on progress will take place at the Strategic Alliance. Additional opportunities will be provided for members of the wider alliance to engage with relevant detailed design work as it develops.

The diagram below provides an overview of those arrangements.


Children and Young People's Strategic Alliance
Norfolk County Council Cabinet
Norfolk & Waveney Integrated Care Board
Cambridgeshire Community Services Board
Norfolk & Suffolk Foundation Trust Board
Provides strategic partnership endorsement for collaborative and gives oversight to its work
Key governance board from each organisation provides strategic endorsement for collaborative
Children and Young People's System Collaborative
Strategic Steering Group
• Makes key design and partnership decisions on behalf of the Alliance and their own organisations
• Made up of Senior Executives from four core partners
Core Design & Implementation Group
• Undertakes detailed design work and oversees implementation on behalf of Strategic Steering Group
• Made up of representatives from core partners and project, change, communications etc. roles as required
Workstreams
• Multiple workstreams created as required for design and delivery of programme
• Made up of core partners, other partners, and specialist roles as appropriate

Approach and How We Will Work Together

The Collaborative's remit is to build on the Children and Young People's Strategic Alliance and bring together health, care, VCFSE and education partners to support this work and further develop systems to support people using these services.

The CYP system collaborative is not intended to replace the CYP Strategic Alliance; the latter will receive and develop the strategic proposals and oversee delivery.

It is acknowledged there are some co-dependencies with the Adult Mental Health System Collaborative, notably for the 18-25 age group. The responsibility for the focus on transition services (18-25 yrs) will need to be agreed for one of the collaboratives to lead, with the ambition to converge over time. There may need to be an overarching committee in common, or at least a joint meeting to agree on areas of interdependency or commonality either instead of or until such a time as convergence occurs.

The transition in Waveney will also require attention, as for services for children and young people the current decision taken is that this would fall under the remit of the Suffolk Alliance and are therefore not part of this collaborative. This will remain under review by both N&W ICB and SNEE ICB.

However, it should be noted that for adults, the services within Waveney are within scope of the Adult Mental Health System Collaborative.

We will adhere to the following principles:

a) collaborate and co-operate with integrity and respect.
b) be accountable to each other.
c) ensure open and transparent communication, discussing major concerns or issues openly, exhibiting clarity where conflicts of interest arise, and working together to realise opportunities relating to any joint undertakings.
d) deploy appropriate resources to support collaboration and coproduction.
e) act in a timely manner, recognising the time-critical nature of joint activity and respond accordingly to requests for support.
f) make 'best for our population' decisions. Work collaboratively to deliver person centred, sustainable, high-quality care and service outcomes for people using mental health services
g) adhere to statutory requirements and best practice. Comply with applicable laws and standards including procurement rules, competition law, data protection and freedom of information legislation.
h) manage stakeholders effectively.
i) develop capacity and opportunity for greater integration, including joint management/leadership.

Working in Year 1

The initial aim is to develop the governance for this group and set out aims and ambitions which support the existing integrated work being done (see Examples section below).

Some of the principles for this are detailed below:

- The implementation of the Thrive model and outcomes associated with Flourishing in Norfolk. This will include ensuring multi-disciplinary teams working across organisations are in place
- The development of a system collaborative to develop a social model of prevention and intervention; with an initial focus on the redesign of community-based support to meet mental health need and for neurodiverse children and young people, individuals with SEND and their families.

Examples of Integrated Work

The examples below are areas of integration which are either in place or planned to be in place. These areas could be expanded across Norfolk and similar services could be implemented as needed:

- Integrated Front Door, involving the ICB, CCS, NSFT and VCSE partners
- Castle Green (a short-stay unit being developed collaboratively with NCC and NSFT)
- An integrated practice model for children with complex emotional needs which has been co-created by NCC and NSFT
- Flourishing in Norfolk strategy

Considerations / Risks

Some of the risks which have been identified are:

1. Currently CYP and Adults Mental Health services are commissioned separately, which potentially misses areas of co-operation and can make aligning the services challenging.

2. 18-25 years provision and transition.
    a. Different services work to different age ranges, making transition between services complicated.

    b. The distinct needs of 18–25-year-olds can be overlooked. NCC Children's services are only responsible for 18–25-year-olds if they are care leavers or have an identified SEND. The criteria for adult services is different to children's services, which may result in some people no longer receiving care.

3. There is a lack of alignment of planning, development, and provision of maternity services.

Recommendation

To comment on and endorse the continued establishment of the Children and Young People's System Collaborative, and to proceed to design. In particular, the creation

of streamlined governance arrangements which empower the appropriate leaders to drive forward the new collaborative at pace. This would likely include integrated and co-located teams, new ways of working together, shared leadership and the sharing of caseloads.

Improving lives together
Norfolk and Waveney Integrated Care System

Adult Mental Health System Collaborative Partnership Agreement

This agreement is made on the XX day of XX 2023.

1. Status and Purpose of this Agreement

1.1 We agree that:

a) Each member of the Collaborative is a sovereign person or organisation.
b) The Collaborative is not a separate legal entity and as such is unable to take decisions without consultation as agreed in the Collaborative Terms of Reference.
c) One member cannot 'overrule' another member on any matter although all members agree to work together in line with the details of the Agreement.
d) Once signed, this Agreement will be reviewed and renewed annually as an important step in the Collaborative agreeing its annual delivery plan and/or response to significant changes within the ICS (e.g. changes in the direction of government policy).

1.2 As a Collaborative, we have agreed to create a Partnership Agreement to demonstrate our commitment to working together in an even more integrated way to build upon our success-to-date, and strengthen trust, transparency, and collaboration between us to deliver our shared vision.

1.3 Aim of this Collaborative

- To produce and implement a strategy, the outcome and impact of which will help shape Mental Health (MH) services across Norfolk and Waveney.
- To improve and develop mental health and wellbeing in Norfolk and Waveney.

1.4 Purpose of this Collaborative

a) Initially to review Dementia services and identify the case for change, and prioritise opportunities for change
b) To revisit the themes of the 2019 children and young people, and adult strategies to see if they are still relevant. This includes a mental health survey taking place with patients, carers, staff and members of the public, the outcome of which will be considered with any discussion going forward.
c) Support delivery of national and system priorities and commitments.

1.5 Key Outputs in Year 1

1. Agree how the Collaborative work together and capture the case for change
2. Make better use of limited resources to deliver support to patients
3. Learning from other networks on how they deliver services (e.g. South and North-East Essex)

4. Ensure learning from the region is included e.g. 3 Ds (Delirium, Depression and Dementia)
5. Ensure good work done in pilots can be maintained and built upon e.g. Dementia Support Service
6. Members to consider how they want services to work in the future and create and deliver a specific programme for dementia improvement
7. Members to consider, once the case for change has been made, whether to focus on all the dementia pathway, or to focus on specific areas which could include transition (not just the 18–25-year-old transition)

2. The Adult Mental Health Collaborative

2.1 We recognise the Adult Mental Health Collaborative is a coalition of local partners who work together to achieve a common purpose. Initially its core membership comprises the following:

- Norfolk Community Health and Care (NCHC)
- East Coast Community Healthcare (ECCH))
- Norfolk & Suffolk Foundation Trust (NSFT)
- Norfolk County Council (NCC)
- Norfolk and Waveney Integrated Care Board

2.2 There will be active wider engagement via Place Boards, Health and Wellbeing Partnerships, Mental Health Programme Board and VCSE Assembly including but not limited to:

- Suffolk County Council Adult services
- Voluntary Community and Social Enterprise Organisations (VCSEs)
- Primary care
- Secondary Care (physical health)
- District Councils
- Housing

3. Our remit and principles

3.1 The Collaborative's remit is to bring together colleagues from health and care to integrate services with a focus on effective operational delivery and improving the care of people using mental health services.

3.2 It is acknowledged there are some co-dependencies with the Children and Young People's System Collaborative. Both groups will keep each other informed to explore themes and priorities.

3.3 We will adhere to the following principles:

a) collaborate and co-operate with integrity and respect.
b) be accountable to each other.
c) ensure open and transparent communication, discussing major concerns or issues openly, exhibiting clarity where conflicts of interest arise, and working together to realise opportunities relating to any joint undertakings.
d) deploy appropriate resources to support collaboration and coproduction.
e) act in a timely manner, recognising the time-critical nature of joint activity and respond accordingly to requests for support.
f) make 'best for our population' decisions. Work collaboratively to deliver person centred, sustainable, high-quality care and service outcomes for people using mental health services.

g) adhere to statutory requirements and best practice. Comply with applicable laws and standards including procurement rules, competition law, data protection and freedom of information legislation.
h) manage stakeholders effectively.
i) develop capacity and opportunity for greater integration, including joint management/leadership.

4. Resource

4.1 We recognise the strength of the Collaborative is in its ability to work together to deliver outstanding seamless care, irrespective of organisational boundaries and geographic jurisdictions. In determining and managing delivery of our outcomes, we actively support seeking and embracing opportunities to integrate what we do and how we do it (examples may include joint posts, common ways of working, sharing of data, estate, IT).

4.2 Where appropriate and a strong evidence-based case is made, we support ceding agreed resource to the Collaborative to promote delivery of our shared ambition as defined in the Collaborative annual delivery plan. Resource may include (but not to be limited to) funding, workforce, data, estates, and technology. In doing so, it will be clear what resource is being ceded, by whom, and why (to achieve what outcome over what period).

4.3 For clarification, this sharing of resources could be to support the delivery of this programme of work, and the delivery of services for individuals as needed.

5. Entry for Additional Partners

5.1 We acknowledge that additional partners may wish to become a party to this Agreement so that they may benefit from our integrated way of working.

5.2 Any decision to allow an Additional Partner to become a party to this Agreement shall be determined by the existing Partners at a meeting of the Collaborative. The Partners shall consider a range of issues in making this decision but as a minimum standard each Additional Partner shall adhere to the relevant resource commitments (Section 4).

6. Shared risks and rewards

6.1 We agree to jointly share risks and rewards from the integrated working agreed by the Collaborative.

7. Withdrawal from the Partnership

7.1 If the Collaborative becomes aware of any potential withdrawal by (or the dissolution or abolition of) any Partner, the Partners at a meeting of the Collaborative shall undertake a risk assessment considering all relevant factors including but not limited to:
- the impact and viability of the agreed integrated way of working
- the integrity and reputation of the Collaborative
- the costs implications for the remaining Partners.

Signed:…… *[Name & Role]*

- General Practice member

Signed:…… *[Name & Role]*

- On behalf of NCHC

Signed:…… *[Name & Role]*

- On behalf of ECCH

Signed:…… *[Name & Role]*

- On behalf of Norfolk & Suffolk Foundation Trust

Signed:…… *[Name & Role]*

- On behalf of Norfolk County Council

Signed:…… *[Name & Role]*

- On behalf of Suffolk County Council

Signed:…… *[Name & Role]*

- On behalf of Norfolk and Waveney Integrated Care Board

Signed:…… *[Name & Role]*

- VCSE member

Signed:…… *[Name & Role]*

- District Council member

Signed:…… *[Name & Role]*

- Housing member

Terms of Reference for Adult Mental Health System Collaborative

Review date for ToR: October 2023

What is the aim?

To develop and implement the strategic direction of areas within the Adult Mental Health Transformation programme that would benefit from collective focus.
To shape the integration of MH services, with a focus on effective operational delivery and improving mental health and wellbeing in Norfolk and Waveney.

What is the purpose?

a) Identify opportunities to work collaboratively, using available data, intelligence and insights, that focus on improving mental health and wellbeing; initially reviewing dementia services.
b) Consistently using a system-wide perspective when considering how to deliver more integrated, high-quality cost-effective care.
c) Support delivery of national and system priorities and commitments. This includes the outcome of the current mental health engagement that is revisiting the themes of the 2019 adult strategy.

How will the Collaborative operate?

Membership:
- N&W ICB Director
- Norfolk & Suffolk Foundation Trust
- Norfolk Community Health and Care
- East Coast Community Healthcare
- Norfolk County Council

Chair to be agreed amongst membership

Active wider engagement:
via Place Boards, Health and Wellbeing Partnerships, MH Programme Board and VCSE Assembly including but not limited to :
- Suffolk County Council Adult services
- VCSE
- Primary care
- Secondary Care (physical health)
- District Councils
- Housing

Interdependencies:
- Work of the CYP MH System Collaborative
- Mental Health Programme Board
- SNEE MH transformation progress
- Regional direction
- National legislation and guidance

Outputs:
- Wider partners may be invited to attend to support specific agenda items
- Notes and actions will be taken at each meeting
- Working Groups to be created by this Collaborative for discrete pieces of work
- Flexible use of resources

Agenda to include:
- Delivery Group Updates
- Areas of Concern from Attendees
- Areas of Opportunity from Attendees
- Network / Regional Updates

To note inaugural meeting to include:
a) Agree Terms of Reference
b) Election of Chair

Quoracy and cadence:
- For the meeting to be quorate 50% attendance and the Chair and/or aligned ICB Executive Director
- To meet monthly

Governance:
- Make recommendations for approval and identify items for escalation to ICB Board
- Provide routine updates as required and specifically to ICS EMT
- Membership empowered to decide on effective operational delivery such as integrated and co-located teams, new ways of working together, shared leadership and the sharing of caseloads.

Appendix 4

Item 7

Report title: Childrens Social Care Reforms and SEND & Alternative Provision Improvement Plan

Date of meeting: 21 June 2023

Sponsor (ICP member): Sara Tough, Executive Director of Children's Services, Norfolk County Council

Reason for the Report

To ensure that the ICP is fully briefed on the national developments of the Childrens Social Care Reforms and Children with special educational needs and disabilities (SEND) & Alternative Provision Improvement Plan, enabling the ICP to actively endorse, promote, support and challenge future local plans that aim to improve outcomes for children and young people aligned to national reviews, future legislative changes and inspection.

Report summary

In recent years, organisations working with children and families, have seen demand for services increase, for example large increases in the costs of care for looked after children, requests for an Education, Health and Care (EHC) Assessment, mental health support and other cohorts with very high-level needs. There has been significant transformation activity which has partially mitigated these challenges, but there are still significant funding pressures year-on-year across the sector, and the current local and national picture does not suggest that this is likely to naturally abate. The proposed reforms, across social care, education and the SEND landscape have started to acknowledge the impact of the additional demand that is being seen across the country.

Norfolk County Council Children's Services has engaged significantly with the proposed reforms, which cut across social care, education and the SEND landscape. Many aspects of the proposals align with and would help enable our partnership vision that every child in Norfolk should flourish.

The Stable Homes, Built on Love implementation strategy and consultation was published by Department for Education (DfE) in February 2023 and is the government response to three reviews that were published in 2022 including The Independent Review of Children's Social Care, the National Review into the murders of Arthur Labinjo-Hughes and Star Hobson and the Competition and Markets Authority Study into Children's Social Care Placements. The intention of the strategy is to rebalance social care away from costly crisis intervention to more meaningful and effective early support. The vision and strategic aims in the strategy align closely with our existing ways of working and plan and provide us further opportunities to test new ways of working in line with the proposed reforms.

With a similar timescale to the children's social care reforms the SEND & Alternative Provision Improvement Plan was published by the DfE in March 2023 and is the government response to the SEND Green Paper national consultation carried out in spring/summer 2022. This government plan is designed to respond to the SEND reforms set out in the 2014 Children and Families Act, to continue to improve services and provision for SEND but to also tackle challenges within the SEND system. We are confident that local plans in Norfolk, Area SEND Strategy and Local First Inclusion, align fully with these national plans and will enable us to demonstrate further improvements for SEND across the county.

An underlying principle of the reforms is an increased focus on multi-disciplinary working between key agencies working with children and families. A relevant example of how this type of working is being explored in Norfolk is the ambition to create a Children and Young People's System Collaborative (see separate papers on this agenda for further details) to look creatively and holistically at all the resources across the key partners and to re-design the support model to achieve the best outcomes. The ambition includes making structural, operational, and cultural changes required to deliver community based multi-disciplinary team working across organisations, to ensure collective support to meet the physical, emotional and mental health and care needs of the child or young person and their family. This includes the piloting of Family Help multi-disciplinary teams in two out of six Localities from Summer 2023 and will be an opportunity to introduce multi-agency roles, to focus on our priorities for example supporting children and young people's mental health and wellbeing, to truly test the concept and benefits both for families and organisations involved. This is a clear step beyond 'partnership collaboration' to a more fully integrated approach, which reflects the ethos of the proposed reforms and an extremely powerful opportunity to realise our ambition that all children FLOURISH in Norfolk.

Recommendations

The ICP is asked to:

a) Endorse the principle of increased multi-disciplinary working between key agencies working with children and families in Norfolk.
b) Endorse our response to both sets of proposed reforms.
c) Endorse our aim to become a pathfinder authority, if the opportunity is open to Norfolk, as defined in the Stable Families, Built on Love Strategy.

1. Background

1.1 Previously the Health & Wellbeing Board received reports on the Norfolk Area SEND Strategy (2019-2023) and endorsed the 4 key priorities. The Area SEND Strategy will be refreshed this year to complement the national improvement plan and Norfolk's Local First Inclusion SEND strategic improvement programme. Go to Norfolk.gov.uk to read the current Area SEND Strategy.

2. Norfolk Children's Services' response to government reforms

2.1 In recent years, organisations working with children and families, have seen demand for services increase, for example large increases in the costs of care for looked after children, requests for an Education, Health and Care (EHC) Assessment, mental health support and other cohorts with very high-level needs. There has been significant transformation activity which has partially mitigated these challenges, but there are still significant funding pressures year-on-year across the sector, and the current local and national picture does not suggest that this is likely to naturally abate. The proposed reforms, across social care, education and the SEND landscape have started to acknowledge the impact of the additional demand that is being seen across the country.

2.2 Norfolk County Council Children's Services has engaged significantly with the proposed reforms, which cut across social care, education and the SEND landscape. Many aspects of the proposals align with and would help enable our partnership vision that every child in Norfolk should flourish.

2.3 Stable Homes, Built on Love Implementation Strategy and Consultation

2.3.1 The Stable Homes, Built on Love implementation strategy and consultation was published by DfE in February 2023 and is the government response to three reviews that were published in 2022 including The Independent Review of Children's Social Care, the National Review into the murders of Arthur Labinjo-Hughes and Star Hobson and the Competition

and Markets Authority Study into Children's Social Care Placements. The intention of the strategy is to rebalance social care away from costly crisis intervention to more meaningful and effective early support. The six strategic pillars of the reform include:

1. Family Help provides the right support and the right time so that children can thrive with their families.
2. A decisive multi-agency child protection system.
3. Unlocking the potential of family networks.
4. Putting love, relationships and a stable home at the heart of being a child in care.
5. A valued, supported and highly skilled social worker for every child who needs one.
6. A system that continuously learns and improves and makes better use of evidence and data.

2.3.2 The pillars in the strategy align with our existing ways of working and plans including: Our social care model already features a range of different practice disciplines working collaboratively together and is well placed to be re-shaped into a version of the 'Family Help' model envisaged by the review – we have identified existing services in Norfolk ready to pilot this new way of working.

2.3.3 Our partnerships in Norfolk were recognised by Ofsted recently (ILACS 2022) as being exceptionally strong meaning we are well placed to deliver the multi-agency vision in the review – with active programmes in place with both the police and health partners in particular about developing multi-disciplinary teams and service models.

2.3.4 The theme in the review of unlocking the potential in families also aligns directly - Family Networking has been at the heart of our agenda from the outset with a dedicated Family Networking coaching team promoting this way of working across our services and embedded as one of our 5 core mandatory practice principles.

2.3.5 We have led the way in relation to the re-shaping of the nature of care for children looked after with a hugely successful implementation of our New Roads Model (as part of the DfE the Strengthening Families and Protecting Children programme), which is delivering an innovative multi-disciplinary approach which is succeeding with young people with most complex needs.

2.3.6 We are using information in innovative ways to shape the placement market, for example we are leading nationally with a small group of other LAs, on the Valuing Care approach. This is a strengths led model for codifying children's needs to help tailor fostering and residential services that meet that need, improve accountability and Value for Money.

2.3.7 The strategy has proposed a phased approach to reform with phase one taking place during the Spending Review period until c. March 2025. A "pathfinder" approach is being used for the most complex reforms in local areas, before they rolled out at a national scale with an investment of £200m during this two-year period.

2.3.8 The Families First for Children Pathfinders are backed by £45m to test key elements of Family Help, child protection and kinship reforms in up to 12 areas. This will include testing new ways of working including:

1. **Family Help** – a single intensive multi-disciplinary support service based in local communities. Supported by simplified funding arrangements.
2. **Child Protection** – Expert child protection lead practitioner roles and multi-agency operating model.
3. **Family Networks** – Family Group Decision Making offers as standard alongside Family Network Support packages.

2.3.9 Children's Services is interested in becoming a pathfinder authority to test new ways of working proposed by the reforms.

2.4 DfE SEND & Alternative Provision Plan

2.4.1 The SEND & Alternative Provision Improvement Plan was published by the DfE in March 2023 and is the government response to the SEND Green Paper national consultation carried out in spring/summer 2022. This government plan is designed to respond to the SEND reforms set out in the 2014 Children and Families Act, to continue to improve services and provision for SEND but to also tackle challenges within the SEND system.

2.4.2 The DfE have identified 4 main issues with the current SEND system across the country:

a) Outcomes for children and young people with SEND are consistently worse than their peers – across almost every measure.
b) Experiences of navigating the SEND system to secure support are poor.
c) There is too much inconsistency across the country – with decisions made based on where a child lives, not on their needs.
d) Despite unprecedented investment, the SEND system is not delivering value for money for children, young people and families.

2.4.3 They have set out 3 key priorities for improvement:

1. **Fulfil children's potential:** CYP with SEND enjoy their childhood, achieve good outcomes and are well prepared for adulthood and employment.
2. **Build parents' trust:** A fairer, easily navigable system that restores parent and carer confidence that their children will get the right support, in the right place, at the right time
3. **Provide financial sustainability:** LAs make the best use of the high needs budget to meet CYP's needs and improve outcomes, while placing them on a stable financial footing.

2.4.4 Beyond these high-level principles these changes at a national level do provide the opportunity to support changes that we are making through our local SEND strategic improvement plans (Area SEND Strategy and Local First Inclusion), however, as there will be no legislative changes in the current parliament we will have to continue to work within our influencing role as an LA.

2.4.5 Examples of tangible changes are the renewed focus on SEN Support, rather than a reliance on Education, Health and Care Plans and alongside this greater clarity on the respective responsibilities of the LA, ICB and individual education and health providers. There will also be a move to 'national standards' to ensure greater consistency of support and provision across the country and to monitor this the development of 'data dashboards' to monitor the effectiveness of 'Local Inclusion Partnerships' and their associated 'Local Inclusion Plans'.

2.5 Ofsted/CQC Inspection Framework

2.5.1 Within the previous inspection framework, we underwent an Area Ofsted/CQC SEND Inspection in February 2020 which resulted in the need for a Written Statement of Action to address weaknesses within our arrangements for Education, Health and Care Plans, 18-25 Services and Communication and Co-production. In November 2022 Ofsted/CQC carried out their 're-visit' and published their judgement in February 2023 confirming that a Written Statement of Action was no longer required as we had made sufficient progress in addressing the weakness areas.

2.5.2 The new inspection framework will continue to monitor elements of our SEND 'system' in a similar way to the previous framework, for example our joint commissioning arrangements and compliance and effectiveness of our Local Offer. However, the focus of the new inspection framework is about the impact on individual children, young people and their families and, in this way, builds on the inspection framework experienced within our social work arrangements through the Inspection of Local Authority Children's Services (ILACS).

2.5.3 Due to the recent successful outcome of our Ofsted/CQC Revisit we anticipate that inspection within the new framework could be in approximately two years time, however, we will have an annual 'engagement' meeting with the DfE to monitor our progress and to assess our self-evaluation framework.

2.6 Area SEND Strategy

2.6.1 Norfolk's Area SEND Strategy was launched in 2019 and has been subject to regular refreshes and updates which reflect engagement with parents/carers and young people and with the professionals who support them. The current strategy sets out four priority areas:

Priority 1: Working together with children and young people (CYP) with SEND.
Priority 2: Improving what is in place for families and professionals to support CYP with SEND.
Priority 3: Communicating the SEND services and support available in Norfolk.
Priority 4: Preparing young people for adult life.

2.6.2 The SEND Strategy is co-produced and a multi-agency working group, including the parent carer forum (Family Voice Norfolk), oversee the implementation of the strategy and an iterative assessment of impact. We recently published a 'You Said We Have Done' response to last years Annual SEND Survey.

2.7 Local First Inclusion

2.7.1 The DfE are working with over 30 Local Authorities that are experiencing ongoing budget pressures within their High Needs Block budget (the budget from government within the overall 'Dedicated Schools Grant' that is used to pay for Norfolk special schools, specialist resource bases, additional funding for SEND in mainstream schools, alternative provision and commissioned services, e.g. Speech and Language Therapy). This programme of work by the DfE with local authorities is known as 'Safety Valve' and has an explicit aim to develop a joint pack of DfE and LA investment to address cumulative budget deficit and to return to in year balanced budgets.

2.7.2 Norfolk were invited into the 'safety valve' programme in May 2022 and the culmination of over six months of negotiation resulted in a published agreement by the DfE, following Secretary of State approval, in March 2023. The combined investment within this programme is over £100million revenue in addition to capital funding to develop two more special schools.

2.7.3 In Norfolk we have designed this programme on the basis of equal emphasis on mainstream inclusion and further development of specialist provision and this new programme is known as Local First Inclusion'. We have set out 5 workstreams (containing 80 individual projects) to implement these changes of the next 6 years:

- Mainstream school inclusion, culture and practice.
- School and Community teams.
- Responsibility based model of decision making, funding and commissioning for Alternative Provision.

- Commissioning / Use Independent Sector Schools differently.
- SEND Sufficiency and Capital Delivery.

3. Summary

3.1 In summary an underlying principle of both sets of reforms is an increased focus on multidisciplinary working between key agencies working with children and families.

3.2 The intention of the Stable Homes, Built on Love strategy is to rebalance social care away from costly crisis intervention to more meaningful and effective early support. The vision and strategic aims in the strategy align closely with our existing ways of working and plan and provide us further opportunities to test new ways of working in line with the proposed reforms. We await further information for the process to become a pathfinder authority within the Government programme.

3.3 In relation to the SEND and AP Improvement Plans we are confident that local plans in Norfolk, Area SEND Strategy and Local First Inclusion, align fully with the latest national developments, DfE SEND & AP Improvement Plan and the new Ofsted/CQC Inspection Framework, which will enable us to demonstrate further improvements for SEND across the County.

Officer Contact

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

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Report title: Cardiovascular disease: Public Health outcomes and prevention priorities for the system

Date of meeting: 21 June 2023

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

Reason for the Report

The ICP Chairman has asked Public Health to provide a presentation / report on various health conditions with a particular focus on the prevention aspects so that ICP can work together to improve the health of the population. It has been agreed that these reports will cover four major heath conditions at each of its meetings: cardiovascular disease (June), respiratory (September), Mental Health (November) and Cancer (March 2024).

This is the first in the series, on cardiovascular disease (CVD). The PowerPoint presentation complements the main report (and is included in the Appendix below in an accessible format), and there is a web link in the report below to the detailed Public Health information that supports this report.

Report summary

The population of Norfolk and Waveney is increasing, fastest in the older age ranges and at a rate greater than England. This creates a key challenge for our health and care system as risk of cardiovascular conditions increases with age.

There is inequality across Norfolk and Waveney in life expectancy. CVD deaths make up between a quarter and a fifth of the life expectancy gap. CVD leads to more than 10% of all emergency admissions. We can make a difference for people and reduce inequalities in outcomes, to start with, by changing health behaviours and by improving clinical care.

There are the secondary prevention interventions (case finding and optimum management) that help prevent and manage CVD cases. These programmes can have a sizable positive impact on the health outcomes.

The N&W ICB CVD Programme Board has identified areas as requiring special attention and wish to work with ICP Colleagues to ensure a joined-up approach in delivering shared objectives.

Recommendations

The ICP is asked to:

a) Endorse the areas of CVD management as identified by the ICB CVD Board and that they work with ICP Colleagues to ensure a joined-up approach in delivering these areas of work, and facilitate improved provision of integrated care, where all partners are involved so as to improve the cardiovascular health of the population of Norfolk and Waveney and to reduce inequalities.

1. Background

1.1 The ICP Chairman has asked Public Health to provide a presentation / report on various health conditions with a particular focus on the prevention aspects so that ICP can work together to improve the health of the population. This is the first in the series, on CVD.

1.2 The PowerPoint presentation (with its accessible format below in Appendix) and this word document forms the main report. Go to norfolkinsight.org.uk to find further information on CVD and the CVD prevention project. The slides will be published to the Joint Strategic Needs Assessment following approval at this ICP meeting on the same web page.

2. CVD: Public Health outcomes and prevention priorities for the system

2.1 The population of Norfolk and Waveney is growing, growing fastest in the older age ranges and at a rate greater than England. This creates a key challenge for our health and care system as risk of cardiovascular conditions increases with age.

2.2 There is inequality across Norfolk and Waveney in life expectancy. Between the most deprived and least deprived communities it is 9.2 years for men and 7.2 years for women.

2.3 Circulatory deaths made up about 20%-25% of the Life expectancy gap between most deprived and least deprived prior to COVID19 2017-2019, and up about 17%-26% during COVID19 2020-2021.

2.4 There are about 12,500 emergency admissions for Circulatory related conditions each year, more than 10% of all emergency admissions.

2.5 Admissions for heart attack and Ischaemic Heart Disease (IHD) are declining. However, admissions for Stroke and heart failure have not reduced in the same way.

2.6 The most deprived population experience 1,306 additional emergency admissions for circulatory conditions compared to the ICB average. In additions to the health outcomes, they also place extra demand on the system. We can identify the Practices and Primary care Networks (PCNs) to plan the interventions to reduce the number of emergency admissions per year by almost 1,000. Addressing inequalities in hospital admissions for circulatory conditions is an opportunity to improve outcomes for those from the most deprived communities and reduce the demand on the urgent and emergency care pathway.

2.7 We can make a difference for people and reduce inequalities in outcomes, to start with, by changing health behaviours and by improving clinical care.

2.8 There are several risk factors for CVD that we can do something about. Risk factors can be reduced a) by changing health behaviours, e.g., smoking, alcohol, excess weight, diet and physical activity; and b) through clinical care and secondary prevention, e.g., optimum management of hypertension (blood pressure) and diabetes. To reduce inequality in life expectancy due to circulatory conditions over the long term, we will have to address the deprivation gradient in health behaviours.

2.9 There are the secondary prevention interventions that help prevent and manage CVD. These programmes can have a sizable positive impact on the health outcomes.

2.10 Example 1: if 80% of all patients with high blood pressure were treated to target for their age then over three years we might avoid 102 heart attacks, 153 strokes, save £2.8 million and close the life expectancy inequality gap. Currently across Norfolk and Waveney 62% of patients with high blood pressure are treated to target for their age (significantly better than England) but there are several PCNs where the proportion is lower than England.

2.11 Example 2: If 90% of patients with CVD were on statins then we might avoid 511 heart attacks and strokes over five years compared to 80% of patients with CVD on statins.

across Norfolk and Waveney about 80% of patients with CVD are on statins (not as high as England) and there are several PCNs where the proportion is lower than England.

2.12 The N&W ICB CVD Programme Board has identified areas as requiring special attention and wish to work with ICP Colleagues to ensure a joined-up approach in delivering shared objectives, so as to improve the cardiovascular health of the population of Norfolk and Waveney and to reduce inequalities.

2.13 CVD is a major issue for health and social care as 6.8 million people are living with cardiovascular conditions. CVD-related healthcare costs alone in England amounting to an estimated £7.4 billion per year, and annual costs to the wider economy being an estimated £15.8 billion. (Health Matters 2019).

2.14 More integrated care could be beneficial, from prevention to rehabilitation. Common themes and components are personalized, joined-up, coordinated, health and social care, reducing inequalities, decrease hospital admissions, reduce waiting times and hospital stays, care closer to the home. Pathways should be developed from prevention to rehabilitation. Currently hospital discharge could be a critical point for planning integration, with involvement of social care (domiciliary and care homes), VCSE, along with the NHS (secondary, primary and community care); e.g., for medication, monitoring and follow ups; using telehealth, artificial intelligence, etc.

Please see **Appendix 1** below for the accessible version of the PowerPoint slides presented at this meeting.

The **glossary of terms** used in the paper and presentation is shown below..

Glossary

CVD: Cardiovascular disease

Circulatory and heart conditions mean same as CVD in this report

Core 20 population: The most deprived 20% of the national population as identified by the national Index of multiple deprivation (IMD)

ICB: Integrated Care Board

ICP: Integrated Care Partnership

IHD: Ischaemic Heart Disease

Hypertension: High blood pressure

Practices: General Practices (GP)

PCN: Primary Care Network

N&W: Norfolk and Waveney

Officer Contact

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Appendix 1: Accessible version of the PowerPoint slides presented at this meeting

Cardiovascular disease (CVD): Public Health outcomes and prevention priorities for the system. Integrated Care Partnership (ICP) meeting, 21 June 2023.

Norfolk and Waveney Population
The total population of Norfolk and Waveney is increasing and most of the increase is projected to be in those aged 65 years or older.
Between 2020 and 2040:

- The number of people aged 75+ will increase by 56%
- The number of 65–74-year-olds will increase by 20%
- The number of people aged 16-64 will increase by only 4%
- The number of people aged 5-15 will decrease by 4%
- The number of children aged 0-4 will increase by 7%

The communities with a greater proportion of people in later life are generally around the coast with some communities in central Norfolk around Swaffham and Dereham.
Increasing age leads to increased risk of long-term conditions including those linked to cardiovascular disease.

Inequality across Norfolk and Waveney in life expectancy
A male can expect to live to 83.3 years in Loddon but only 75.1 years in Great Yarmouth. A female can expect to live for 86.4 years in Southwold but only 81 years in King's Lynn.
The market town life expectancy gap is 8.2 years for men and 5.4 years for women, but between the most deprived and least deprived communities it is 9.2 years for men and 7.2 years for women.
Source: Local Public Health Intelligence calculations using NHS Digital Civil Registration Data and Fingertips https://fingertips.phe.org.uk/profile/local-health/

Norfolk and Waveney Map of Deprived areas on this slide
There are 42 communities across Norfolk and Waveney where some or all the population live in the 20% most deprived areas in England. However, none of these communities are in Broadland or South Norfolk.

Breckland
In Breckland there are six communities where some of, or all the residents in the community live in the 20% most deprived areas. These are:

- Dereham Central & Toftwood
- Swaffham
- Thetford North
- Thetford South
- Watton
- Wayland, Ellingham & Great Hockham

Great Yarmouth
In Great Yarmouth there are nine communities where some of, or all the residents in the community live in the 20% most deprived areas. These are:

- Caister on Sea
- Gorleston North
- Gorleston South & Beach
- Gorleston West
- Hemsby & Ormesby
- Southtown & Cobholm
- Yarmouth Central & Northgate
- Yarmouth North
- Yarmouth Parade

King's Lynn and West Norfolk
In King's Lynn and West Norfolk there are seven communities where some of, or all the residents in the community live in the 20% most deprived areas. These are:

- Fairstead & Springwood
- Gaywood Chase & Old Gaywood
- Hunstanton
- North Lynn
- Terrington & Clenchwarton
- Town, South Lynn & West Lynn
- Upwell, Delph & Emneth

North Norfolk
In North Norfolk there are two communities where some of, or all the residents in the community live in the 20% most deprived areas. These are:

- Cromer
- North Walsham

Norwich
In Norwich there are twelve communities where some of, or all the residents in the community live in the 20% most deprived areas. These are:

- Bowthorpe & West Earlham
- Catton Grove & Airport
- City Centre East
- City Centre West
- Earlham
- Heartsease & Pilling Park
- Lakenham & Tuckswood
- Mile Cross
- New Catton & Mousehold North
- Thorpe Hamlet & Mousehold South
- Town Close
- University & Avenues

East Suffolk District
In East Suffolk there are six communities where some of, or all the residents in the community live in the 20% most deprived areas. These are:

- Beccles
- Gunton West
- Lowestoft Central
- Lowestoft Harbour & Kirkley
- Normanston & Oulton Broad East
- Pakefield North

What is driving the inequality gap?
Circulatory deaths made up about 20%-25% of the Life expectancy gap between most deprived and least deprived prior to COVID19 2017-2019.
Circulatory deaths made up about 17%-26% of the Life expectancy gap between most deprived and least deprived during the COVID19 pandemic in 2020-2021, this gap in life expectancy equates to about 1 year and 10 months for males and 9 months for females.

Emergency admissions for Circulatory related conditions
Emergency admissions for Circulatory related conditions account for about 12,500 admissions each year, more than 10% of all emergency admissions.

In Norfolk and Waveney, the annual number of emergency admissions for circulatory conditions are broken down as follows:

- Aortic aneurysm and dissection: 120
- Atherosclerosis: 245
- Cardiac arrhythmias (AF): 2,020
- Cerebrovascular diseases (stroke): 2,270
- Diseases of arteries, arterioles & capillaries: 170
- Diseases of veins & lymphatic system: 705
- Heart attack: 1,795
- Heart failure: 1,895
- Hypertensive diseases: 345
- Ischaemic heart diseases (IHD): 1,090
- Pulmonary heart disease and diseases of pulmonary circulation: 565
- Other: 1,250
- Total: 12,470

Trends in emergency and elective hospital admissions: circulatory conditions

- Admissions for heart attack and ischaemic heart disease are declining
- However, admissions for Stroke and heart failure have not reduced in the same way

Additional unplanned hospital admissions

- the core 20 population (most deprived 20%) experience 1,306 more admissions annually for circulatory conditions compared to the ICB average
- This also places extra demand on the system

Addressing inequalities is an opportunity to improve outcomes for those from the most deprived areas and reduce the demand on the urgent and emergency care pathway.

Practices with higher-than-expected admissions

Understanding which practices have higher than expected admissions helps to highlight those with the largest potential opportunity to reduce emergency hospital attendances.
We can identify the Practices and PCNs to plan the interventions.
If the practices with significantly higher admissions compared to the Norfolk and Waveney average had admissions as expected, then we could potentially reduce the number of emergency admissions per year by almost 1,000.

Jigsaw of total health

We can start to make a difference for people and reduce inequalities in outcomes by changing health behaviours and by improving clinical care.
We can make a difference and help reduce the need for urgent and emergency care in the core 20 (most deprived 20%) populations by:

- Working with people to change health behaviours (smoking, diet, exercise, alcohol, screening) – everybody's business, led by the Health Improvement Transformation Group.
- Ensuring better access to care:
    - Accessible financially and physically in the core 20 areas
    - Poverty proof services by considering transport costs and timing of appointments to negate the need for time off work etc.
- Focusing on even better quality of care (and improving patient engagement) both in primary care and in hospital.

Risk factors for CVD

Some risk factors for CVD can be reduced by changing health behaviours and some can be reduced through clinical care and secondary prevention.

Global Burden of Disease information highlights that high blood pressure, high blood sugar, high cholesterol, poor diet, obesity, tobacco and low physical activity all contribute to deaths due cardiovascular disease (source: https://www.healthdata.org/gbd/2019).

Clinical care and secondary prevention examples include:

- Hypertension management
- Blood glucose management
- Cholesterol management

Lifestyle can also help with the risk factors above and with:

- Alcohol
- Excess weight
- Diet (processed food, lack of fibre etc.)
- Smoking
- Physical Activity

Deprivation and Health Behaviours
As deprivation increases the proportion of people with risky health behaviour also increases. Therefore, opportunities are likely to be greater in the core 20 most deprived communities.
To reduce inequality in life expectancy due to circulatory conditions over the long term, we will have to address the deprivation related risks in health behaviours (smoking, physical activity, obesity, and diet).
Source: Office for Health Improvement & Disparities. Public Health Profiles.
https://fingertips.phe.org.uk

Size of the prize for Hypertension case finding and optimum management
There would potentially be an additional 17,000 patients with more than 100 heart attacks prevented and more than 150 strokes prevented if we are able to implement the CVD prevent successfully to diagnose more patients with hypertension and optimise the management the condition for patients.
If 80% of all patients with high blood pressure were treated to target for their age then over three years we might avoid 102 heart attacks, 153 strokes, save £2.8 million and close the life expectancy inequality gap. Currently across Norfolk and Waveney 62% of patients with high blood pressure are treated to target for their age (significantly better than England) but there are several PCNs where the proportion is lower than England.

Size of the prize for high cholesterol case finding and optimum management
By diagnosing more patients with high cholesterol and optimising the management of the condition there would potentially be more than 500 heart attacks and strokes prevented if we are able to implement CVD prevent successfully.
If 90% of patients with CVD were treated with statins then we might avoid 511 heart attacks and strokes over five years compared to 80% of patients with CVD on statins. across Norfolk and Waveney about 80% of patients with CVD are on statins (not as high as England) and there are several PCNs where the proportion is lower than England.

ICB CVD Board Operational Plan: four areas as requiring special attention:

- CVD Prevention (Including Atrial Fibrillation, Familial Hypercholesterolemia, Hypertension, Lipids Management)
- Heart Failure Improvement
- NSTEMI (non-ST elevated myocardial infarction) Outcomes
- Tackling Health Inequalities and CORE20PLUS5 action

The N&W ICB CVD Programme Board wishes to work with ICP Colleagues to ensure a joined-up approach in delivering our shared objectives.

Impact on wider society
CVD is a major issue for health and social care as 6.8 million people are living with cardiovascular conditions.

A chart showing costs of CVD to the NHS and wider society. It shows CVD-related healthcare costs in England were estimated to be £7.4 billion per year, and annual costs to the wider economy around £15.8 billion (Health Matters 2019).

Integrated care: common themes and components
From prevention to rehabilitation
Personalized, joined-up, coordinated, health and social care
Reducing inequalities
Decrease hospital admissions, reduce waiting times and hospital stays
Avoiding duplication, shared decision making
Care closer to the home

Hospital discharge could be a critical point for planning integration
Pathways should be developed from prevention to rehabilitation. Currently hospital discharge could be a critical point for planning integration, with involvement of social care (domiciliary and care homes, VCSE, along with the NHS (secondary, primary and community care); e.g., for medication, monitoring and follow ups; using telehealth, artificial intelligence, etc.

Recommendation:
- The ICB CVD Programme Board to work with ICP Colleagues to ensure a joined-up approach in delivering the areas identified for CVD management.
- Encourage and facilitate improved provision of integrated care, where all partners are involved.

Integrated Care Partnership

Item 9

Report title: CQC Local Authority and Integrated Care System Assessments

Date of meeting: 21 June 2023

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

Reason for the Report

This is to inform the Integrated Care Partnership (ICP) on the new Care Quality Commission (CQC) single assessment framework for Local Authorities and the Norfolk and Waveney Integrated Care System.

Report summary

The Health and Care Act 2022 gave new regulatory powers to the CQC to conduct meaningful and independent assessments of care in Local Authorities to provide assurance to the public of the quality of care in their area, as well as a power to assess Integrated Care Systems, looking at how services are working together and how systems are performing overall. The Secretary of State for Health and Social Care has set objectives and priorities for the CQC assessments. These priorities are likely to change and evolve over time. The current Guidance for both assessments that is available is still interim and awaiting approval from the Secretary of State for Health and Social Care. Further detailed Guidance is expected later this year as the process develops.

Recommendations

The ICP is asked to:

a) To note the new assurance regime and support a collaborative approach to the new CQC assessments of both Adult Social Care and our Integrated Care System.

1. Background

1.1 The Health and Care Act 2022 gave the CQC new powers to conduct independent assessments of care in Local Authorities. It also gave powers to conduct assessment of Integrated Care Systems. This is to understand the quality of care and to be able to provide assurance to people of the quality of care in their areas. This new assessment framework has been effective from 1 April and the CQC are now preparing to commence assessments of Local Authorities and Integrated Care Systems.

2. Local Authority Assessments

2.1 Under the Health and Social Care Act 2008 (as amended by the Health and Care Act 2022), the Secretary of State can set objectives and priorities for assessments of local authorities and integrated care systems. These can sometimes be revised when needed. The Secretary of States objective is: '*The objective of the* assessment framework is *for the CQC to assess how well local authorities are delivering their Care Act duties for people accessing care and support.'* The Secretary of State has also given five priorities, these are:

- Access to care for those who need it, including people who are discharged from hospital.
- Personalisation of care to meet the needs of individual people and their carers.

- Commissioning services to support good outcomes from care.
- Supporting a vibrant and sustainable local care system.
- Support and development for the social care workforce.

2.2 The CQC assessments for Adult Social Care will be based on a new single assessment framework and will focus on how Local Authorities are discharging their duties under Part 1 of the Care Act (2014)**.** This will be assessed on four themes, under which are contained nine quality statement's:

- Theme 1 - How local authorities work with people
  Quality Statements:
  - Assessing Need.
  - Supporting people to lead healthier lives.
  - Equity in experience and outcomes.

- Theme 2 - How local authorities provide support
  Quality Statements:
  - Care provision, integration, and continuity.
  - Partnerships and Communities.

- Theme 3 - How local authorities ensure safety within the system
  Quality Statements:
  - Safe systems, pathways, and transitions.
  - Safeguarding.

- Theme 4 – Leadership
  Quality Statements:
  - Governance, management, and sustainability.
  - Learning, improvement, and innovation.

2.3 The Secretary of State for Health and Social Care will approve the final guidance on our assessments, as required by the Health and Care Act 2022.

2.4 The single assessment framework quality statements that sit underneath the themes were developed using aspects of the Making It Real Framework, co-produced by Think Local Act Personal (TLAP) with a range of partners and people with lived experience of using health and care services. Quality statements are written in the style of 'We' statements from a provider, local authority, and integrated care system perspective, to help us understand what is expected of us and are linked to the 'I statements' from TLAP's Making It Real framework to help people understand what a good experience of care looks and feels like. For example, "I have care and support that is co-ordinated, and everyone works well together and with me." and "We understand our duty to collaborate and work in partnership, so our services work seamlessly for people."

2.5 Beneath each Quality Statement sits six evidence categories of:

- **Peoples experience** - where the source is from people who have experience relating to a specific health or care service, or a pathway across services.
- **Feedback from Staff and Leaders** - from direct interviews, compliments and concerns raised with CQC, surveys etc.
- **Processes** - the series of steps, or activities that are carried out to deliver care and support that is safe and meets people's needs. The CQC will focus on the effectiveness of the processes rather than simply the fact they exist.
- **Feedback from Partners** - commissioners, providers, professional regulators, accreditation bodies, royal colleges, multi-agency bodies. This will include partners involved in the wider determinants of health and wellbeing such as housing, licensing, or environment services.

- **Outcomes** - focused on the impact of processes on individuals and communities, and cover how care has affected people's physical, functional, or psychological status.
- **Audit** – This is appropriate for Local Authorities rather than observation and will include an on-site visit.

2.6 All this evidence will be sought to establish how care is provided for each Quality statement.

2.7 The CQC assessment process commenced from 1 April 2023 and has started with a first phase of establishing a baseline across all Local Authorities under the two Quality statements of Care provision, Integration and Continuity, and Assessing need. The CQC will be looking for themes and insight on access, commissioning, market shaping, workforce, and personalisation. They will not publish this data and evidence at a Local Authority level but will publish this at a national level, i.e., in the annual State of Care report. The CQC are also currently working to test the inspection approach on four Pilot Sites that have been agreed from April 2023 to September 2023.

2.8 The second phase of the formal assessments will commence from October 2023, and it is expected that there will be approximately 20 Local Authorities in each cohort. The assessments will take place and all the required evidence will be gathered for each Local Authority, after which reports, and ratings will be published in batches in the Spring. Local Authorities will be given a single word rating using a four-point scale ranging from Outstanding to Inadequate. This process will then continue throughout 2024 until all Local Authorities have been assessed.

2.9 Norfolk County Council Adult Social Care have already been preparing for this new inspection process over the last few months and an internal Departmental Team has been brought together to scope, plan, and collate evidence with detailed planning underway for each key area of focus in readiness for October 2023. We are actively engaged with Regional and National groups and Norfolk Chairs the ADASS Regional Assurance Preparation Group. A Peer review has been undertaken and there has been a renewed focus on improving performance and quality, engagement with partners, people and families using our services, and our understanding and articulation of these as well as engagement with members, teams, and staff. We are learning from our colleagues in Childrens services, and we will also be speaking to our partners and linking with our peers in Suffolk about the new assessment framework and what that means, as well as exploring how our ICS partners can support us in our preparation.

3. Integrated Care System Assessments

3.1 As required by the Health and Care Act, the CQC assessments of Integrated Care Systems (ICS) will cover:

- The quality and integration of health care and adult social care within each integrated care system.
- How partners in each integrated care system (the integrated care board, local authorities, and registered service providers) are meeting their own responsibilities within the system.
- The functioning of the integrated care system, especially how well system partners are working together to deliver good care and meet the needs of their populations, including through the work of Integrated Care Partnerships.
- The Guidance for the CQC assessment of ICS's is still interim but it is proposed that the assessment will consider the requirements of the legislation and take into consideration the core purpose of the ICS as referenced in NHS England Design Framework. The process will focus on three themes and a subset of 17 Quality Statements taken from the overall assessment framework. This is because ICSs are being assessed against a different set of statutory duties to registered health and care providers. The themes are, Quality and Safety, Integration and Leadership.

3.2 The new single assessment framework focuses on what matters to people who use our local health and social care services and their families, on outcomes and outputs and how system partners are working together across the system and the integration of services. It is similar to the Local Authority assessment where the Quality statements are written using the "I" and "We" approach as detailed in para 2.2 above.

3.3 Again, like the Local Authority Assessment, there will be 6 evidence categories as detailed in para 2.3 above, but instead of the Audit category there will be Observation which will include case tracking, and observation of meetings and forums that coordinate health and care in the system such as integrated board and partnership meetings, place-led meetings and health and wellbeing boards.

3.4 There have been test and learn activities with two pilot sites – North-East London and South Yorkshire ICS's where the CQC looked at the three themes and covered 16 Quality Statements. The report findings and learning from these resulted in adding a further Quality statement of the Freedom to Speak Up.

3.5 From April 2023 to July 2023 the CQC will be forming a national view of performance, initially focussing on themes in one Quality Statement - Equity in Access, across all 42 ICS's. The CQC will be looking at published documentary evidence, i.e., policies, strategies, survey information, JSNA's and contacting local Healthwatch.

3.6 Further pilot assessments will take place over the summer of 2023 and the CQC will be exploring how the sequencing of Local Authority and ICS assessments undertaken together may or may not work. It is anticipated that pilots on full end to end assessments will commence from Autumn 2023 with a tailored assessment approach according to each system. Final learning and evaluation will conclude, and the start of formal baseline assessments of ICS's will commence.

3.7 The scoring approach will be consistent with the CQC inspection of registered providers and for each quality statement in the assessment framework, the CQC will assess the 'required evidence' in the evidence categories and assign a score to the quality statement. This scoring framework will rate from 4 - Evidence shows an exceptional standard down to 1 - Evidence shows significant shortfalls.

4. Next Steps

4.1 The new assessment approach is being looked at and considered within the ICS EMT and amongst colleagues from Norfolk County Council and the Integrated Care Board, on how we can work together collaboratively, as a system, to best prepare for both the assessments to take place. This is to ensure a common understanding of our position and how we communicate this and use a joint approach for gathering feedback from people that use our services.

4.2 Background Documents

- Go to legislation.gov.uk to read The Health and Care Act 2022.
- Go to cqc.org.uk for the Interim Guidance on our approach to local authority assessments.
- Go to cqc.org.uk to read more about the CQC's approach to assessing Local Authorities.
- Go to cqc.org.uk to find out more about the draft Single Assessment Framework.
- Go to cqc.org.uk to read about the CQC approach and Interim Guidance to assessing Integrated Care Systems.
- Go to england.nhs.uk for information regarding the Integrated Care Systems design framework.

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If you have any questions about matters contained in this paper, please contact: