Norfolk and Waveney Integrated Care Partnership Agenda

Meeting details

- Date: 04 March 2026
- Time: on the rise of the Norfolk Health and Wellbeing Board meeting
- Venue: **Council Chamber, County Hall, Martineau Lane, Norwich, NR1 2DH**

Voting Membership

Representative from
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
Norfolk Care Association
Norfolk Community Health & Care NHS Trust
Norfolk Constabulary
Norfolk County Council, Cabinet member for Adult Social Services
Norfolk County Council, Cabinet member for Public Health and Wellbeing
Norfolk County Council, Cabinet member for Children's Services
Norfolk County Council, Director of Public Health
Norfolk County Council, Executive Director Adult Social Services
Norfolk County Council, Executive Director Children's Services
Norfolk County Council, Chief Executive Officer (nominee)
Norfolk & Suffolk NHS Foundation Trust
Norfolk & Waveney Integrated Care Board (Chair)
Norfolk & Waveney Integrated Care Board (Chief Executive)
North Norfolk District Council
Norfolk & Waveney University Hospitals Group (Chair) *(representing the three Acute Hospitals)*
Norfolk & Waveney University Hospitals Group (Chief Executive) *(representing the three Acute Hospitals)*

Representative from
Norwich City Council
Police and Crime Commissioner
Place Board Chair Great Yarmouth & Waveney
Place Board Chair Norwich
Place Board Chair North Norfolk
Place Board Chair South Norfolk
Place Board Chair West
Primary Care Representatives TBC
South Norfolk District Council
Suffolk County Council, Cabinet Member for Adult Care
Suffolk County Council
University of East Anglia

Non-Voting Membership

Representative from
Norfolk Health Overview and Scrutiny Committee (Chair)

Advice for Members of the Public

This meeting will be held in public and in person.

It will be live streamed on YouTube and members of the public may watch remotely by going to youtube.com

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

1. To receive apologies for absence

2. Minutes **Page 4**

To confirm the minutes of the Integrated Care Partnership meeting held on 03 December 2025.

3. Members to Declare any Interests

4. Updates from the Chair

5. Public Question Time

Members of the public are entitled to ask questions at meetings of the Integrated Care Partnership. Please note that all questions must be received by the Integrated Care Partnership Team (norfolkandwaveneyicp@norfolk.gov.uk) by 5pm [insert date]. **by 5pm Thursday 26 February 2026.** Please go to improvinglivesnw.org.uk for further guidance on submitting a public question.

Any public questions received by the deadline and the responses will be published on the website from 9.30am on the day of the meeting. Go to the Integrated Care Partnership Committees details page to view public questions and responses once they have been uploaded.

6. Neighbourhood Plan for Norfolk & Waveney Integrated Care System **Page 10**

Report sponsored by Ian Wake & Ed Garratt

7. Community Mental Health: Summit and Mindful Norfolk **Page 30**

Report sponsored by Cllr Kim Carsok, Cllr Natasha Harpley and Cllr Tristan Ashby

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

Date Agenda Published: 24 February 2026

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Norfolk County Council

Norfolk and Waveney Integrated Care Partnership Minutes

Meeting details

Time and date of meeting: Wednesday 3 December 2025 at 11.40am

Venue: Council Chamber, County Hall, Martineau Lane, Norwich

Voting Representatives Present

Representatives

Borough Council of King's Lynn & West Norfolk

Cambridgeshire Community Services NHS Trust
Chair of Voluntary Sector Assembly
East Coast Community Healthcare CIC
Healthwatch Norfolk
Norfolk Care Association
Norfolk Community Health & Care NHS Trust
Norfolk Constabulary
Norfolk County Council, Cabinet member for Adult Social Services
Norfolk County Council, Cabinet member for Public Health and Wellbeing
Norfolk County Council, Cabinet member for Children's Services
Norfolk County Council, Executive Director Adult Social Services
Norfolk County Council, Acting Director of Public Health
Norfolk and Suffolk NHS Foundation Trust
NHS Norfolk and Waveney Integrated Care Board (Chief Executive)
Norwich City Council
Place Board Chair Great Yarmouth & Waveney
Place Board Chair Norwich
South Norfolk District Council
Voluntary Sector Representative
Voluntary Sector Representative
Suffolk County Council

Officers and speakers Present

Name	Role
Nick Clinch	Director of Transformation, Partnerships and Place Commissioning, Norfolk County Council (NCC)
Stephanie Guy	Advanced Public Health Officer, NCC
Susannah Howard	Suffolk and North East Essex Integrated Care Board
Kirsty Rowden	Director of Intermediate Care and Urgent Community Response, Norfolk Community Health and Care NHS Trust
Rebecca Quinton	Senior Programme Manager, NHS Norfolk and Waveney Integrated Care Board
Ellen Saw	Proactive Intervention and Prevention Manager, NCC
Jamie Sutterby	Director of People, South Norfolk and Broadland District Councils
Andrew O'Connell	Senior Nurse, NHS Norfolk and Waveney Integrated Care Board
Nicola LeDain	Committee Officer, NCC

1. Apologies for absence

1.1 Apologies were received from Cllr Emma Flaxman-Taylor, William Pope, Nicole Horwood, Sarah Taylor and her substitute Gavin Thompson, ACC Chris Balmer, substituted by Superintendent Mark Joyce, Rebecca Driver, substituted by Adam Jackson, Cllr Beccy Hopensberger, Cllr Natasha Harpley and her substitute Cllr Eleanor Laming and David Roberts.

2. Minutes of the last meeting held on 3 September 2025

2.1 The Integrated Care Partnership minutes of the meeting held on 3 September 2025 were agreed as an accurate record and signed by the Chair.

3. Declarations of interest

3.1 There were no interests declared.

4. Updates from the Chair

4.1 There were no updates.

5. Public Questions

5.1 There were no public questions received.

6. Preparing for Seasonal Pressures 2025/26 (ICP)

6.1 Ed Garrett, Chief Executive, Norfolk and Waveney Integrated Care Board introduced the appended report (6) which appraises the Integrated Care Partnership (ICP) of work being undertaken to support residents, and a resilient system, to face the impact of the 2025/26 winter. National guidance was received this year. This year is heavily focused on urgent and emergency care, a national pressure and also present within our own system. Reflections from partners in preparing this paper have highlighted the need for future planning which can increasingly focus on prevention.

6.2 It was noted that pressures continue across our system with the addition of large change programmes also taking place across the whole system and no additional national funding was received this year to support winter. The challenge remains on how we get people home safely and supported, focus on the decision to treat at home, collaboration with all system partners, and deepen integration between health and social care services.

6.3 During the discussion, the following points were noted

6.3.1 The Partnership noted the effective vaccination initiatives that had been implemented. The most impactful measures are often simple, such as encouraging proper handwashing practices, maintaining warmth, and ensuring overall well-being—particularly for those who were most vulnerable.

6.3.2 The Unscheduled Care Coordination Hub brought together the Norfolk and Waveney system to help people remain at home, and its unique impact on improving the system should be celebrated.

6.3.3 In referring to page 26, appendix 3, a member asked if there were sufficient reablement facilities in place across the districts and have we identified the demand that could feature in these spikes. They also queried if there was confidence that there was the available capacity to support that. County-wide demand and capacity planning has been conducted as a system and broken down to district level. Regarding spikes, higher demand is typically seen in January and February; this is managed through a set of commissioned providers (caring for better outcomes) who can adjust the level of reablement provided during winter, based on location across the county.

6.3.4 One of the challenges noted was the increased acuity of patients being discharged and how we plan for that in the future. It's coming in fast with lots of comorbidities and particularly with dementia patients. A member asked how we look to the future with acuity mounting all the time. Officers noted that this was a good example of how our planning is year-round and our approach as neighbourhood teams will help support this and focus on personalised care. This trend was observed throughout the year, highlighting the ongoing challenge of ensuring comprehensive wraparound support.

6.4 Having considered the report, the ICP:

- **NOTED** the report on the Winter Planning in 2025/26.
- **OFFERED** guidance and comment on winter planning, including how seasonal planning could align with a longer term strategic and preventative approach being developed in line with local and national policy changes.

7. Health Inequalities Update report

7.1 Suzanne Meredith, Acting Director of Public Health introduced the appended report (7) which provided an overview of the Health Inequalities Strategic Framework for Action, outlines key progress to date on the year 2 priority actions, and included updates on each of the three leadership groups. The report also sought agreement from the Integrated Care Partnership (ICP) on the proposed recommendations to maintain momentum.

7.2 Tracy Williams highlighted they were developing a digital resource hub, hoped to launch it in the new year, and would continue to develop the advocacy programme which NHSE paused. They are now building on the 35 advocates already in place. As

part of the launch of this framework, we asked organisations undertake self-assessments and commit to addressing inequalities. There have been challenges in capacity to undertake assessments and build improvement plans, but we will focus on further work on this to support more organisations.

7.3 During the discussion, the following points were noted.

7.3.1 It was noted that, to effectively reduce health inequalities financial priorities must include targeted resource allocation to deprived communities. Consideration should be given to NHS plans and the commissioning strategy to identify opportunities for directing additional resources to these areas. Opportunities for investment had already been identified and agreed upon for certain regions. Ultimately, success should be evaluated based on measurable outcomes in these communities.

7.4 Having considered the report, the ICP;

- AGREED to enable workforces to support shaping the Health Inequalities Resource Hub and promote use of it to build capacity in tackling health inequalities, within organisations.
- AGREED to support increased collaboration between Suffolk and Norfolk health inequalities workstreams, identifying opportunities for shared learning, joint initiatives, and aligned strategic planning.
- AGREED to support the actions and development of the three leadership groups, which include but are not limited to:
    - Developing a systems approach to community connection.
    - Further development of the Smoke Free Homes project and future business case for Active NoW.
    - Enhancing the system's Health Inequalities Advocacy Programme.

8. 2024/2025 Learning from Lives and Deaths: People with a Learning Disability and Autistic People (LeDeR) Annual Report

8.1 Ed Garratt, Chief Executive, NHS Norfolk and Waveney Integrated Care Board introduced the appended report (8) noting that compared to the general population there are high number of premature deaths, as on average people with learning difficulties and autism live 20 years less than the general population. This was the eighth Norfolk and Waveney (N&W) Learning from Lives and Deaths: People with a Learning Disability and Autistic People (LeDeR) Annual Report, which covered the reporting period from 1st April 2024 to 31st March 2025. The annual report describes progress in completing reviews, interprets collected data and details completed and ongoing service improvements in response to learning. The report also provided an opportunity to reassess local priorities based on emerging themes or trends.

8.2 During the discussion, the following points were noted.

8.2.1 The Partnership welcomed the increased number of health checks but identified an opportunity to reach individuals who did not currently engage by offering blood pressure screening when they interacted with primary care services. Initiatives such as the WOW bus had been deployed to engage communities and refer individuals as needed. Significant efforts were also being made through outreach to specialist school

provisions and promotion at conferences. Any further actions that could enhance participation were considered valuable.

8.2.2 Health checks should be combined with effective health planning. Efforts were made to ensure participation in screenings, such as cervical, breast, and abdominal aortic aneurysm (AAA) checks. Initiatives focused on raising awareness about screening among people with learning disabilities and autism, providing support within primary care and how to overcome some of those barriers. As well as work with care homes, care providers on how to support people to respond to screening programmes. National guidelines determined how individuals were invited to these screenings, which were sometimes beyond local control, i.e. if that initial contact is made considering a person's reasonable adjustments. An area missed is women's health, and menopausal care is often overlooked.

8.2.3 The Partnership commended the team on the improvements made.

8.2.4 In referring to page 77, members asked what health promotion activities were included and if there was any support relating to nutrition such as screening for vitamin D. It was a confirmed that measures of wider BMI were included, with typical caveats for people with a learning disability. People were supported as much as possible, while considering capacity for choice and ensuring access to a broader range of dietary options.

8.3 Having considered the report, the ICP:

- **AGREED** and **APPROVED** the recommendations from the LeDeR annual report and system learning.
- **AGREED** to champion advocacy and inclusion for people with a learning disability and autistic people in any discussion and/or decision that may impact their health and wellbeing.

The meeting ended at 12.36pm

Councillor Fran Whymark

Chair

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

Member Organisation Represented	Named Member	11 June 2025	03 Sept 2025	03 Dec 2025
Borough Council of King's Lynn & West Norfolk	**Cllr Jo Rust**	X	X	X
Breckland District Council	**Cllr Tristan Ashby**		X	
Broadland District Council	**Cllr Natasha Harpley**		X*	
Cambridgeshire Community Services NHS Trust	**Anna Gill**		X*	X
East Coast Community Healthcare CIC	Ian Hutchison **Adele Madin**	X	X*	 X
East of England Ambulance Trust	**Kyle Hampshire-Smith**	X*	X	
East Suffolk Council	**Cllr David Beavan**			
Great Yarmouth Borough Council	**Cllr Emma Flaxman-Taylor**	X	X	
Healthwatch Norfolk	**Patrick Peal**	X	X	X
Norfolk Care Association	**Christine Futter**	X*	X	X
Norfolk Community Health & Care NHS Trust	**Lynda Thomas**	X	X*	X*
Norfolk Constabulary	**ACC Chris Balmer**	X*	X*	X*
NCC, Cabinet member for Adult Social Services	**Cllr Alison Thomas**		X	X
NCC, Cabinet member for Childrens Services	**Cllr Penny Carpenter**	X		X
NCC, Cabinet member for Public Health and Wellbeing	**Cllr Fran Whymark**	X	X	X
NCC, Executive Director Adult Social Services	**Ian Wake**	X*	X*	X
NCC, Executive Director Children's Services	**Sara Tough**	X	X	
NCC, Director of Public Health	Stuart Lines **Suzanne Meredith**	X*	 X	 X
Norfolk & Suffolk NHS Foundation Trust	Zoe Billingham Stewart Gee **Rebecca Driver**		 X*	 X*
Norfolk and Waveney University Hospitals Group (Chief Executive)	**Prof Lesley Dwyer**	X	X	
Norfolk and Waveney University Hospitals Group (Chair)	Mark Friend **David Roberts**	X	X	
NHS Norfolk and Waveney Integrated Care Board (Chair)	**Prof Will Pope**			
NHS Norfolk and Waveney Integrated Care Board (Chief Executive)	**Ed Garratt**	X	X	X
North Norfolk District Council	**Cllr Liz Withington**	X		X
Norwich City Council	**Cllr Claire Kidman**	X	X	X
Place Board Chair (Great Yarmouth & Waveney)	**Jonathan Barber**	X	X	X
Place Board Chair (Norwich)	**Tracy Williams**	X	X	X
Place Board Chair (North Norfolk)	**Dr Charlotte Florence**	X		
Place Board Chair (West)	**Carly West-Burnham**	X*		
Place Board Chair (South Norfolk)	**Allan Petchey**	X		
Police and Crime Commissioner	**Sarah Taylor**	X*		
South Norfolk District Council	**Cllr Kim Carsok**	X	X	X
Voluntary Sector Representative	**Tim Gardiner**	X	X	X
Voluntary Sector Representative	**Dan Mobbs**	X	X	X
Voluntary Sector Representative	**Daniel Childerhouse**	X		X
Norfolk Health Overview and Scrutiny Committee (Chair)	**Cllr Brenda Jones**		X	
Suffolk County Council, Cabinet member for Adult Care (Guest)	**Cllr Beccy Hopfensperger**	X		
Suffolk County Council Representative (ICP)	**Nicholas Pryke**	X	X	X
University of East Anglia Representative (Guest)	**Prof Nicole Horwood**			

*X member attended, * Indicates Substitute attended*

Report to Norfolk and Waveney Integrated Care Partnership

Item No: 6

Report title: Neighbourhood Plan for Norfolk & Waveney Integrated Care System

Date of meeting: 04 March 2026

Sponsor: Ed Garratt, Chief Executive, NHS Norfolk & Waveney Integrated Care Board
Ian Wake, Executive Director of Adult Social Services, Norfolk County Council

Reason for the Report

The report updates the Norfolk and Waveney Integrated Care Partnership (ICP) on progress in developing the emerging Neighbourhood Plan and seeks the ICP's support for the next phase of the work.

Report summary

The emerging Neighbourhood Plan provides the system's shared approach for organising, governing and maturing neighbourhood working across Norfolk and Waveney. It responds to strong feedback from partners, communities and staff that the Integrated Care System (ICS) must shift towards locally-rooted, relational models that integrate health, care, public health, Voluntary, Community and Social Enterprise (VCSE) partners, housing, local government and community assets around what matters to residents.

The plan describes the cultural and structural shift required to move from transactional, activity-driven models to neighbourhood ecosystems based on trust, shared insight, flexible boundaries and relational ways of working. It outlines a shared evidence approach combining quantitative data, community voice, resident narratives, lived experience and neighbourhood-level insight.

ICP endorsement is required to support the next phase of work: confirming core expectations, enabling resource realignment, supporting shared governance, and providing system-level leadership for implementation across health, care and VCSE partners.

This report should be read alongside the item on the Integrated Care Board Population Health and Commissioning Strategy and the Population Health Improvement Plan (PHIP). Neighbourhood working will be a key delivery mechanism for PHIP commissioning intentions. As the neighbourhood plan is developed in line with national guidance and timelines, it will need to clearly set out how neighbourhood working contributes to key PHIP commitments for example, prevention, equity and development of the learning system.

Recommendations

The ICP is asked to:

a) To endorse the emerging Neighbourhood Plan (Appendix 1) as the shared system framework and confirm this as the strategic direction of travel for neighbourhood working across Norfolk & Waveney.
b) To approve the immediate deliverables and focused action set identified by the Steering Group (including the Natural Neighbourhood Map, updated profiles, integrated timeline, alignment list and coordination mechanism), recognising these as the initial outputs required to move from framework to implementation.
c) To support partners to prepare for phased implementation during 2026/27, including contributing to shared evidence, aligning organisational activity with the governance model, and participating in the development of the systemwide learning and outcomes framework.
d) Invite each partner sector (including VCSE) to set out how they will organise themselves to participate in and enable neighbourhood working within the shared system framework in their places (e.g., coordination arrangements, named leads, routes into local partnerships).

1. Background

1.1 Norfolk & Waveney partners have committed to strengthening neighbourhood working as a key enabling approach within the ICS strategy, NHS 10-Year Health Plan, local authority transformation programmes and VCSE partnership priorities. Current arrangements, shaped by historical commissioning boundaries and organisational processes, do not fully respond to the complexity of need or persistent inequalities experienced across communities.

1.2 Through the ICS Conference, Executive Management Team, partnership discussions and System Neighbourhood Steering Group, partners have developed a shared ambition to organise health and care, prevention and support around residents, within their local communities and neighbourhoods. The plan reflects this shared ambition and provides the enabling framework to move from aspiration to coordinated system delivery.

2. Emerging Neighbourhood Plan

2.1 The emerging Neighbourhood Plan sets out how partners across Norfolk and Waveney will organise, govern and develop neighbourhood working in a more joined-up, community-focused and preventative way. It responds to clear feedback from staff, partners and communities that the system needs to shift from complex, service-driven arrangements to more locally rooted, relational models based on trust, shared understanding and working alongside residents on what matters to them. Neighbourhoods in this plan are shaped around real communities and natural patterns of population and identity, rather than organisational boundaries. Because population need does not follow organisational lines, the solutions cannot be bound by them either. A credible neighbourhood health service must therefore be designed around the realities of people's lives, not the structures of our institutions.

2.2 A central part of this approach is developing a shared evidence base for each neighbourhood. This includes quantitative data, community voice, local insight, lived experience and social care intelligence. Neighbourhood Profiles will be "living documents", updated regularly as new insight emerges. They will give all partners a fuller, more grounded picture of need, strengths and priorities, and support more open conversations about where to focus resources fairly.

2.3 The plan also describes the shared capabilities neighbourhood teams will need, without prescribing a rigid structure. These include accessible, relationship-centred roles rooted in communities; the ability to "pull in" the right professionals as needed rather than rely on traditional referral routes; and multi-agency working that brings together primary care, community health, mental health, social care, public health, housing providers and VCSE partners. This allows each neighbourhood to build an integrated offer that fits its identity, maturity and community strengths.

2.4 Prevention is at the heart of the model. The shared Prevent, Reduce and Delay approach brings together clinical prevention, social care insight, early help, public health action and community-based support. Neighbourhood teams will focus on helping people earlier, reducing avoidable escalation, and supporting those with complex or deteriorating needs in a more coordinated, relational and consistent way. This includes recognising and responding to the wider factors that shape people's lives, such as housing, income, social connection and caring pressures.

2.5 The plan sets out a practical governance approach built around three environments:

- A **Strategic Enabling Environment**, providing sponsorship, alignment of resources and clear expectations.
- A **Sense-Making Environment**, bringing partners together to share insight, review neighbourhood profiles and build a shared understanding of what the evidence is telling us.
- An **Enabling and Delivery Environment**, focusing on coordinated local delivery, problem-solving and supporting neighbourhood teams to test and learn.

2.6 This governance is designed to be proportionate, transparent and supportive, helping neighbourhoods mature at different paces without losing shared direction.

2.7 A systemwide learning and metrics approach underpins the work. Rather than focusing on performance management, the plan emphasises learning, collaboration and transparency. It uses rapid learning cycles and a blend of data, lived experience and operational insight. Measures will focus on population outcomes, partnership behaviours, shared planning and the ability to adapt based on what neighbourhoods are learning.

2.8 Further place-specific implementation plans are already being developed across the system, and this work will continue to build through 2026. This will lead to clear, joint neighbourhood health plans agreed across partners, supported by shared evidence, practical outputs and consistent ways of working.

2.9 The system is still awaiting the national joint guidance from NHS England and the Local Government Association, which will set out what must be included in neighbourhood plans. The proposal within this report is that partners continue developing the Norfolk and Waveney approach rather than pausing progress. Once the national guidance is published, the work will be reviewed and adapted so the plan fully meets the required standards and incorporates any new expectations.

Officer Contact

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

Officer name: Ali Gurney
Telephone no.:
Email: alison.gurney@norfolk.gov.uk

Officer name: Amanda Sear
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Norfolk and Waveney — Developing Thriving Neighbourhoods

System Neighbourhood Approach

1. Purpose: w*here communities lead, partners come together, and relationships shape better outcomes, grounded in shared learning*

This document sets how we will organise and operate neighbourhood working across Norfolk & Waveney.

This framework sets out a shared, system-wide approach for building consistent, collaborative and outcomes-focused neighbourhood working across Norfolk and Waveney. It provides a common foundation for how we will design, implement and mature neighbourhood models together over time.

At its heart is a change in how we work: moving from transactional, activity-driven arrangements to neighbourhood ecosystems grounded in relationships, trust, shared purpose and meaningful community insight. This is as much a cultural shift as it is structural. It asks organisations to work relationally, make decisions closer to communities, and value the knowledge held by residents, our workforce and local networks.

This document describes both the shared foundations required for neighbourhood working and the longer-term ambition for how neighbourhood approaches will mature over time. Although neighbourhoods and partnerships will progress from different starting points, all areas are expected to accelerate delivery against this framework. Local variation explains the route, not the pace. Every neighbourhood must demonstrate clear, measurable progress towards the shared system ambition.

It brings together the collective ambition expressed across our ICS, through for a including our Place-based structures, conversations with our workforce, ICS Conference, Executive Management Teams, Chief Executives' discussions and the System Neighbourhood Group.

Neighbourhoods will be organised around real communities and natural population patterns rather than historical organisational boundaries. Boundaries will function as helpful reference points, not fixed lines that dictate delivery. This approach ensures local flexibility, enabling local partnerships to shape priorities, team arrangements and ways of working within their neighbourhoods that reflect local identity, lived experience, assets and need.

This document also sets expectations for how we will learn together and build transparent decision-making, governance and shared use of insight. It outlines principles for how using a different approach to qualitative and quantitative insight will drive collective continuous learning and improvement and shape equitable resource alignment. By working from a shared, transparent evidence base - combining data, community insight and lived experience - partners can align resources proportionately to need, consistent with Marmot's principle that equity requires ***more for those who need more*** and continually adjust this alignment as new insight and learning emerge.

Clarity on terminology is important - this document explicitly does not prescribe separate Integrated Neighbourhood Teams (for instance ‘health’ and ‘non-health’), as doing so risks reinforcing organisational boundaries and unintentionally narrowing who is seen as part of neighbourhood working. Instead, the system will use a simple, shared definition of Integrated Neighbourhood Teams as the ***collective capability to support people to live their best lives*** drawn from primary care, community health, mental health, adult social care, public health, district councils, the VCSE (Voluntary, Community and Social Enterprise) organisations — including community groups, charities, social enterprises and faith-based organisations — and local assets — brought together around residents and what matters to them.

To maintain consistency and avoid confusion or re-badging of existing activity, the system will also to the nationally defined requirements such as the National Neighbourhood Health Plan. That core offer describes what neighbourhoods should be able to deliver for residents, rather than prescribing fixed team structures or organisational labels. Anchoring to the core offer in this way supports genuine integration, alignment, and consistent interpretation, and enables partners across the system to collaborate in designing team and the system’s agreed outcomes with a clear line of sight to community needs and the system’s agreed outcomes.

The national neighbourhood guidance for 2025/26 establishes a shared minimum foundation for neighbourhood working, providing a consistent baseline across the system while allowing scope for further development as neighbourhoods mature.

2. **Case for Change**

Improving health and wellbeing in Norfolk and Waveney requires a broader perspective than traditional service delivery. Neighbourhood working provides a practical and relational way to understand, with residents, the social, economic and environmental factors shaping their lives. It brings together health, care, local government, the voluntary and community sector and communities themselves as equal partners to reduce inequalities and improve outcomes.

Our approach is fundamentally about collaborating *with* communities—listening to what matters to people, recognising strengths within their lives and neighbourhoods, and responding to the interconnected factors such as housing, work, income, connection, safety and environment that influence outcomes. Neighbourhood realities are complex: non-linear, relational and context-specific. Traditional systems often treat problems as complicated and protocol-driven. We will adopt Human Learning Systems principles—iterating, learning alongside residents and adapting support to real life.

Neighbourhoods will be shaped by real communities of place and identity, not administrative boundaries. Boundaries will function as working assumptions that guide shared understanding rather than rigid lines of responsibility. This flexibility ensures neighbourhood planning reflects local experience, demand, assets and inequalities.

Importantly, neighbourhood working is not a structural reorganisation; it is a way of working. It describes the behaviours, relationships and decision-making that put communities at the centre. Structures and teams may support this, but they are not the purpose.

Neighbourhood profiles will draw on the strongest available insight, blending quantitative data with social care intelligence, resident voice, local narratives and information about community strengths. Profiles will be transparent about limitations and evolve as learning emerges. They will provide a shared basis for setting priorities, allocating resources proportionately and organising integrated team arrangements.

Delivering this shift requires commissioning and service models that enable flexibility, stewardship and collective responsibility. Commissioning will focus increasingly on creating the conditions for integrated working and supporting partners to take joint ownership of resources, risk and outcomes. Delivery models will empower teams to work across organisational boundaries, respond to complexity and support people to start, live, age and die well—with particular emphasis on groups experiencing the greatest disadvantage, supported by digital innovation and a skilled workforce.

Neighbourhood approaches align with the ambition of the NHS 10 Year Health Plan and the transformation priorities of our ICS partners. They recognise that improving population health requires coordinated action across all sectors and that while everyone needs some support, some people need more. By aligning collective effort around neighbourhoods, we can build fairer, more connected and more sustainable communities.

Across Norfolk and Waveney, partners recognise a generational opportunity to redesign how care, support and prevention are organised. Current arrangements—shaped by historic commissioning, organisational boundaries and transactional processes—no longer meet the complexity of people's lives or the scale of persisting inequalities. Neighbourhood working offers a practical, relational and preventative response.

This requires cultural as well as structural change. Partners have emphasised the need to leave behind siloed decision-making, rigid rules and organisational protectionism, and instead embrace shared accountability, shared risk and subsidiarity. These shifts underpin the neighbourhood model and create the conditions for trust, innovation and joint problem-solving at local level.

Neighbourhood maturity varies across the system. Some areas already demonstrate effective integrated working rooted in strong relationships; others are earlier in their development. This diversity will be acknowledged and supported so that neighbourhoods can mature in a way that brings all partners with them.

To ensure consistent interpretation of the shared minimum foundation, the system will develop a collective view of current neighbourhood maturity aligned to this approach and national guidance. This will support local partnership planning, sequencing and prioritisation—identifying where further alignment, clarity or systemic

enablement is required. This assessment is intended to guide improvement rather than function as a compliance exercise.

3. Engagement

Engagement is central to credible and effective neighbourhood working. Partners, communities and staff have been clear that neighbourhood development must be shaped *with* people rather than *for* them, and that the process must be accessible, inclusive and grounded in real experience. The system will work with local partnerships to bring existing engagement activity into a coherent and transparent approach that enables meaningful contribution and shared ownership.

The approach will recognise the complexity of engaging a diverse population and will prioritise plain language, accessible communication and inclusive methods that amplify the voices of communities historically excluded from engagement. It will reflect the experiences of people living with the greatest disadvantage, ensuring decisions are shaped by those who rely most on integrated neighbourhood support.

Local partnerships will lead engagement locally, drawing on the collective identity of neighbourhoods and using forums that already exist within communities. This will avoid duplication, reduce burden and build on trust already in place. The system will support local partnerships with clear expectations and shared engagement principles that ensure consistency while allowing local variation, with discussions powered by data and guided by insight so that priorities are set from evidence.

Building confidence between partners is essential to success, and independent facilitation will support the provision of neutral and safe spaces for partners and communities to contribute openly.

Transparency will be a constant. A ‘you said, we did’ approach will demonstrate how feedback shapes decisions and where constraints limit what is possible. To reinforce this commitment to openness and shared learning, the system will establish a shared, publicly visible learning log capturing neighbourhood-level test-and-learn insights, caveats and adaptations - ensuring communities can see how learning informs decisions.

The engagement model will evolve as neighbourhoods mature, supporting the cultural shift towards shared accountability, collective problem-solving and relational ways of working.

Learning from engagement will directly inform the development and refinement of neighbourhood profiles by integrating community voice, lived experience, local narratives and insight about community strengths. This visibility will illuminate hidden or underused resources and provide partners — including those with more limited access to system-wide intelligence — with a clearer view of assets within their area.

4. Neighbourhood Profiles

A shared understanding of our population is essential to shaping neighbourhood priorities, organising integrated teams, and directing resources where they will have the greatest impact. The Norfolk and Suffolk Integrated Needs Assessment provide a strong evidence base, but this must be combined with lived experience, community strengths, and social care intelligence to create a rounded picture of local need.

Neighbourhood profiles are developed by integrating a wide range of data sources and modelling approaches, drawing on both system-wide and local insights. This work is complemented by additional analytical projects undertaken by system partners. To ensure fairness and transparency, all available data will be integrated where possible, with clear caveats and assumptions stated.

Neighbourhood profiles are living documents, updated on a defined cadence with community voice and operational learning (e.g., quarterly). Where appropriate, neighbourhood profiles will be aligned with the Joint Strategic Needs Assessment (JSNA) and other relevant system-wide evidence sources to maximise consistency, reuse of data and shared understanding. As the role of the JSNA evolves, profiles will continue to draw on the strongest available insight across local partnerships, ensuring they remain transparent, coherent and grounded in what matters to communities**.**

Once data sources and modelling methods are agreed, all partners will work from a shared, consistent evidence base—ensuring that comparisons are meaningful, decisions are grounded in robust and comparable information, and profiles are continually refined through ongoing learning and insight.

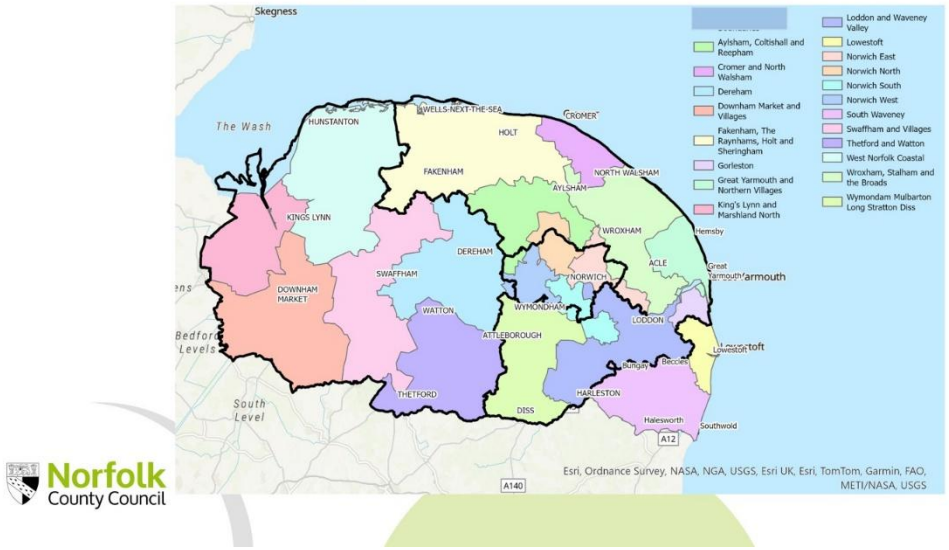
Profiles will be updated as new insights and partner contributions become available, supporting ongoing improvement and collaboration across the system.

The framework adopts a whole-population perspective recognising the interplay between physical, mental and social factors. While life expectancy in Norfolk and Waveney remains above national averages, significant inequalities persist—driven by preventable illness, deprivation, long-term conditions and wider determinants such as housing, employment, transport, financial security and social connection.

Neighbourhood working enables a more coordinated and initiative-taking response. Profiles will translate analysis into practical local insight by integrating demographics, disease burden, social care demand, local assets, community narratives and lived experience. Profiles will include transparent caveats about data limitations, modelling assumptions and representativeness, and will be updated as new insight emerges.

Data use will follow shared principles: common baselines, meaningful benchmarks and proportionate neighbourhood-level targets that reflect maturity. Data will be comparable and transparent, with assumptions documented and methods agreed to enable shared accountability for improvement rather than disputes about methodology.

N&W Natural Neighbourhoods



	Natural Neighbourhoods Resident Populations
Aylsham, Coltishall and Reepham	23,499
Cromer and North Walsham	34,985
Dereham	56,694
Downham Market and Villages	43,523
Fakenham, The Raynhams, Holt and Sheringham	47,015
Gorleston	47,006
Great Yarmouth and Northern Villages	62,813
King's Lynn and Marshland North	74,220
Loddon and Waveney Valley	30,463
Lowestoft	84,094
Norwich East	73,414
Norwich North	77,676
Norwich South	85,349
Norwich West	75,886
South Waveney	38,453
Swaffham and Villages	23,275
Attleborough, Thetford and Watton	71,275
West Norfolk Coastal	34,883
Wroxham, Stalham and the Broads	39,590
Wymondam Mulbarton Long Stratton Diss	61,434
Grand Total	1,085,547

Our neighbourhood footprints have been based on natural neighbourhoods as far as possible — the places where people live their daily lives, build relationships, access services and form identity. Because of this, they do not always align with existing organisational boundaries such as ICS footprints, district and borough council areas, school and community geographies or Primary Care Network (PCN) boundaries.

This divergence is intentional. Neighbourhood working is fundamentally about commissioning and delivering for population outcomes rather than working within inherited administrative lines. The patterns that most strongly define people's health — cohorts of residents, patterns of disadvantage, transport access, disease prevalence, housing conditions, social networks and the wider determinants — cut

across every formal boundary the system currently uses. Aligning neighbourhoods with the realities of people's lives, rather than institutional structures, is essential if we are to create a neighbourhood health service that genuinely improves outcomes.

This outcomes-driven approach is underpinned by proportionate universalism, as defined by the Marmot Review. While often associated with deprivation, the principle applies more broadly to any factor that increases or compounds inequality — including ageing, disability, rurality, transport constraints, long-term conditions, caring pressures, digital exclusion, social isolation and housing quality. A universal neighbourhood offer must therefore provide consistency for everyone, while scaling the intensity and depth of support according to need.

Importantly, everyone needs to move up the ladder - improving outcomes only for the most disadvantaged narrows the bottom but does not flatten the gradient. A neighbourhood health service must therefore lift the whole population, while applying deeper, more coordinated action in the places and populations facing the greatest barriers.

Taken together, these principles will strengthen and guide the use of natural neighbourhoods as the foundation for a coherent, equitable and outcome-driven neighbourhood model across Norfolk and Waveney.

5. Focus areas for neighbourhood teams

Neighbourhood working takes a broad view of what enables people to live well, recognising that outcomes are shaped as much by social and economic factors as by clinical care. Within this wider ambition, neighbourhood teams will initially focus on population groups where coordinated, multi-agency support can have the greatest impact on resident outcomes and the sustainability of the wider system:

a) **People with highly complex needs**
This group often experiences overlapping physical, mental health, housing and social challenges and relies on support from multiple services. They are a shared system priority because uncoordinated or reactive support leads to poorer outcomes and avoidable escalation into crisis services. Providing coordinated, relational and initiative-taking support can significantly improve people's quality of life, reduce unnecessary demand on acute and emergency pathways, and create the conditions to reinvest in preventative, neighbourhood-based approaches.

b) **People at risk of deteriorating health or wellbeing**
These people are often less complex but living with multi-morbidity that will impact more as their life progresses. Early intervention and preventative, community-anchored support can reduce harm, build resilience and avoid future crises. This includes both clinical deterioration and deterioration linked to housing insecurity, financial stress, isolation, caring pressures or wider determinants.

Across both groups, neighbourhood teams will focus on areas of greatest inequality and multiple disadvantage, and on priority cohorts identified through local insight – for people with highly complex needs this will likely focus on those with overlapping physical and mental health issues, addictions, housing and anti-social behaviour; frailty; people with dementia; and end of life., those approaching end of life. For people at risk of deteriorating health of wellbeing, this will likely focus on diabetes, COPD, musculoskeletal conditions, risk of falls and mental health disorders. These pressures reinforce the importance of integrated, neighbourhood-rooted responses that bring together clinical care, social care, VCSE support, public health approaches and wider determinants.

Crucially, this focused sequencing is not the totality of neighbourhood working. Instead, it provides a practical starting point that will:

- ensure targeted support for those that would benefit from the support neighbourhood working will provide
- stabilise pressure points across the system
- allow resources to be used more flexibly and proportionately
- enable the release of funding and capacity needed to build out broader neighbourhood-based support, prevention and community-led approaches

As neighbourhoods mature and system pressures ease, the scope of neighbourhood working will expand across the wider determinants, community strengths and the full breadth of what helps people live well.

6. Prevent, Reduce and Delay — A Shared Approach

Prevent, Reduce, Delay carries a specific statutory and economic meaning within particular sectors of our ICS, but in this document the terms are used in their broader, whole-system sense, aligned with public health prevention, neighbourhood wellbeing and the relational ways of working at the heart of neighbourhood teams.

Neighbourhood teams will help prevent ill health and avoidable hardship, reduce the escalation of need, and delay deterioration by working relationally, drawing on strengths, and responding to what matters to local people. While clinical and public health interventions remain essential, prevention in neighbourhoods goes far beyond traditional service-led models. It encompasses:

- community resources and social connections
- social care insight and relational practice
- housing, income, employment and environmental factors
- support for carers and families
- accessible early help embedded in trusted local settings
- the everyday relationships that keep people well

This approach recognises that preventing deterioration and reducing escalation is not only a health priority but also a whole-system necessity. Strengthening community-based prevention helps people live well for longer, reduces pressure on statutory services, and creates the conditions for neighbourhood teams to grow wider support offers over time.

Prevent

Prevention begins with the conditions that enable people to thrive. Neighbourhood teams will collaborate with communities and partners to tackle the impact of wider determinants - housing insecurity, isolation, income pressures, employment, transport and local environments. Prevention includes health checks and screening alongside support from social landlords, voluntary and community organisations, trusted coordinator and connector roles and networks to identify emerging issues early

Neighbourhood profiles will highlight where prevention can have the greatest impact by combining population data with lived experience, social care intelligence, and insight into local strengths. By making these assets visible, they can be recognised and used to inform preventative approaches, rather than remaining hidden. Profiles will support all partners—regardless of their size or role—to contribute meaningfully to shared prevention outcomes. At the same time, this approach recognises that each partner must be able to work in ways that suit their unique circumstances, ensuring that collective ambition for prevention and individual ways of working are, compatible and mutually reinforcing

Reduce

Reduction focuses on timely, targeted support for people whose needs are beginning to escalate. This includes access to clinical care, mental health support, social care responses and community-based activities that build resilience. Neighbourhood teams will use quantitative metrics and qualitative insight to identify people who may benefit from multidisciplinary input—not solely because of a condition, but due to social context, caring responsibilities or isolation.

Partners will use data to agree locally which groups to prioritise so decisions reflect what matters to residents rather than organisational boundaries or historic pathways, aligning with proportional resource allocation based on need and equity.

Delay

Delaying deterioration relies on coordinated support that sustains independence, helps people manage long-term conditions and avoids preventable crises. This includes integrated clinical input, reablement, support for carers, wellbeing approaches, community groups, peer networks and targeted interventions such as falls prevention and medication optimisation - underpinned by relational continuity and trusted local contact that makes it easier to seek help early.

Neighbourhood teams will consider how existing resources across health, social care and the VCFSE can be aligned to support this shared purpose. As neighbourhoods

mature, partners will review how capacity is deployed and explore different ways of working that reduce duplication, share risk and respond flexibly to local need.

Making it practical

Implementing Prevent → Reduce → Delay requires cultural and behavioural change as much as changes to systems and processes. Partners will commit to shared learning, openness about what is working, and honesty about limitations. Neighbourhood teams will be supported to test-and-learn, using insight from engagement, profiles and population health data to adapt over time. Clear governance routes will ensure decisions are made at the right level, enabling neighbourhoods to respond quickly and collaboratively while aligning with system priorities.

7. Identifying Resources for Integrated Working

Delivering neighbourhood working requires a coordinated view of all the resources that help people live well. This spans clinical and social care capacity, community organisations, social landlords, local networks, peer support, and the skills and relationships that already exist within neighbourhoods.

Partners will use neighbourhood profiles as shared visibility tools. Profiles will illuminate existing assets, informal support, local networks and roles that may be hidden or underused — particularly for smaller non-statutory organisations. They will also bring together insight on social care demand, workforce capacity, lived experience and wider determinants, ensuring that resource decisions reflect the real conditions and strengths of each neighbourhood.

7a. Delivery Model — Core Components

Neighbourhood working is built on the principle that teams form around what matters to residents, not around fixed organisational structures. As neighbourhood teams mature, the specific roles, skills and ways of working they adopt will be shaped by local strengths, insight, community identity and test-and-learn activity - rather than by historic service boundaries or predefined team lists.

Engagement has, however, highlighted a set of core components that support effective, relational and preventative neighbourhood working. These components describe the capabilities neighbourhood teams need, rather than prescribing which organisations must provide them. They offer a shared starting point that neighbourhood partnerships can adapt, combine and develop over time.

Early neighbourhood working may involve partial or priority-focused forms of integration while relationships and shared ways of working develop. These stages are expected and legitimate. The emphasis on integrated neighbourhood teams as collective capability is intended to support alignment and avoid re-badging, rather than to imply that fully holistic integration must be achieved immediately.

Community-Connected Coordinators and Specialist Support

Neighbourhood teams will build on relational, accessible coordinating roles—such as Local Area Coordinators and Care Coordinators—that work alongside residents to identify strengths, navigate options and access community-based solutions. These roles build trust, provide continuity, and offer support in ways that are responsive to people's real-world contexts, modelling the behaviours that underpin neighbourhood working.

Teams will also draw on dedicated specialists who can be brought in as needed to provide targeted, relationship-led support, ensuring residents receive joined-up, timely help without unnecessary hand-offs or organisational barriers.

Multi-agency capability drawn from the wider system

Our neighbourhood teams must have in place the infrastructure — including shared systems, shared information flows, agreed operating arrangements and aligned decision-making — that enables partners to work effectively as a single integrated team around the neighbourhood. This will allow capability to be brought together from across primary care, community health, mental health, adult social care, public health, district and borough councils, VCSE organisations, housing providers, social landlords and other partners. The specific blend of capability will vary by neighbourhood, reflecting local identity, community assets, workforce patterns and maturity. What matters is collective capacity, not organisational membership.

Flexible deployment and "pull" rather than "refer"

A central feature of the delivery model is the ability to draw on specialist input when needed — not through rigid referral routes, but by "pulling in" expertise to wrap support around a resident. This reduces hand-offs, prevents escalation and provides a more coherent and responsive experience for people and families.

Local adaptation over prescription

Neighbourhoods differ in their history, relationships, assets and starting points. The delivery model therefore provides guiding components, not fixed requirements. Each neighbourhood partnership will determine how these components are best delivered locally, adapting roles, structures and sequencing to reflect community needs and operational realities.

Partners will also identify resources within their own organisations that can be deployed differently to support neighbourhood priorities — reviewing where capability sits, how teams are structured and how skills can be aligned to neighbourhood-level work, focusing on relational, preventative and integrated approaches rather than transactional models.

To make this shift practical, partners will work collectively on shared accountability and risk, transparent resource mapping, clarity of decision-making, proportionate sequencing and support for test-and-learn activity. Existing neighbourhood arrangements — both emerging and mature — will not be disrupted; they will provide continuity and shared learning. System support will consolidate engagement,

evaluation and facilitation into a coherent process, ensuring partners have access to consistent guidance, shared learning, and neutral spaces to explore issues together.

Transparency will be essential. Understanding how resources flow across neighbourhoods, where gaps exist and how decisions are made will help build trust and support equitable outcomes. Partners will continue to align resources with need, recognising that everyone needs something — with some people needing more.

8. Building on What Exists and Recognising Different Starting Points

Neighbourhood working will grow from the strengths, relationships and arrangements already present across Norfolk and Waveney. Many local areas have been building collaborative approaches for several years; others are earlier in developing shared purpose, governance and ways of working. Variation is natural. The system framework is not about enforcing a single model but about setting consistent expectations while allowing each neighbourhood to progress at a pace that fits its context, capacity and maturity.

Maturity is shaped by culture and relationships as much as structures. Where trust, shared purpose and relational practice are strong, neighbourhoods can deepen integration more quickly. Where relationships are newer or previous arrangements have created uncertainty, additional support and time will be needed to build confidence and clarity.

Neighbourhood profiles will offer a shared foundation by blending quantitative data, social care intelligence, resident insight, community strengths and local narratives. Profiles will highlight opportunities and gaps - helping neighbourhoods understand strengths, needs and starting points, and providing visibility for partners who are smaller and may lack access to wider system insight.

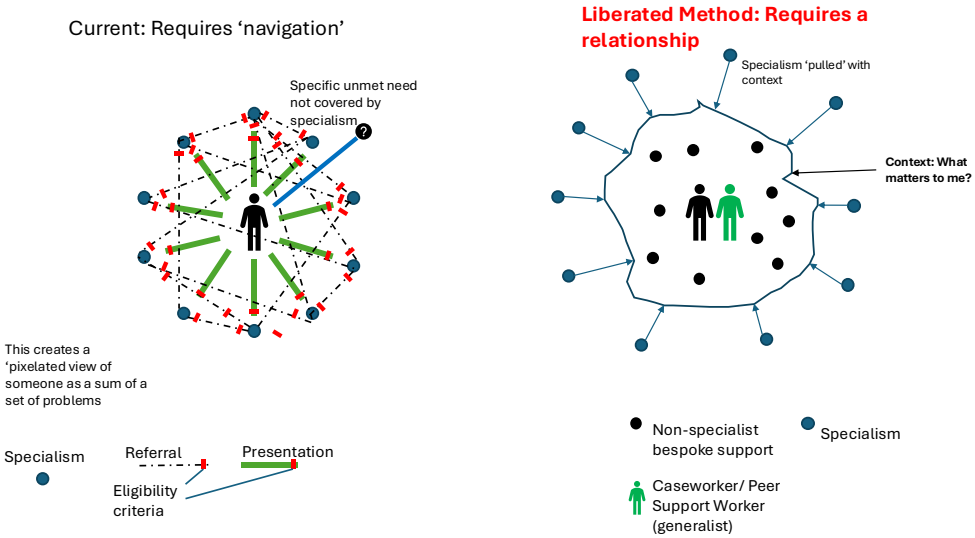
System support will grow capability through a coordinated and consistent approach: independent facilitation to create safe and neutral spaces, shared learning across neighbourhoods and consolidated engagement and evaluation. The intention is to reduce duplication, promote common understanding and enable partners to learn from one another while adapting to local context.

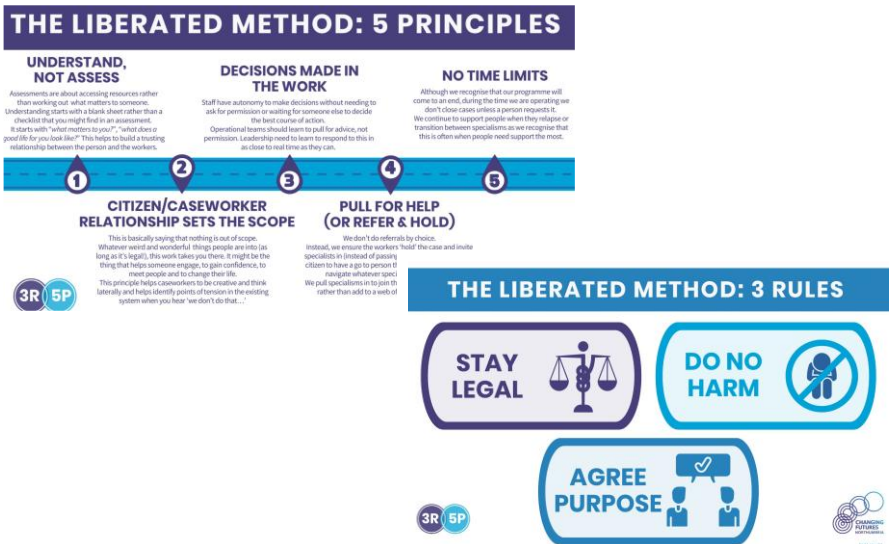
Different starting points mean different trajectories. The system will avoid rigid, stepped or time-bound expectations and will instead work with local partnerships to agree proportionate pathways that reflect maturity, resource availability and community priorities. Where minimum expectations must apply - clarity of shared priorities, visibility of community strengths, involvement of VCSE partners, transparent decision-making and commitment to prevention - these will provide coherence while preserving flexibility.

By acknowledging variation and tailoring support, the system will create the conditions for neighbourhoods to mature over time, fostering trust, strengthening relationships and building confidence. Neighbourhood working will be grown collaboratively from the strengths and realities within each community rather than imposed from above.

8a. Principles for Building Integrated Neighbourhood Teams

How neighbourhood teams work is as important as their structures. We will seek to implement a liberated method. The figures below show the 'traditional' system which require residents to navigate through procedures and referral systems, compared to **a 'liberated' model** where bespoke support is wrapped around the resident and specialists are 'pulled' in. It also shows the principles and rules for the liberated method.





The liberated model requires building a culture that promotes teams to:

- Recognise the uniqueness of every resident we serve
- Relational practice central to the approach. Form a relationship and let the solutions drop out
- Co-produce a bespoke solution with the resident that meets the resident's needs as they define them
- Strengths/asset based practice

- Empower the front-line practitioner to act in the context that they find themselves
- Do not assess for eligibility
- Do not refer on. Hold the case and broker support in.
- Recognise that it is the interaction of multiple variables in the system rather than individual programmes and services that create outcomes for residents
- Create healthier systems where relationships and collaboration between system actors is easy and power is shared

Learning principles to support the liberated model include:

- Treat each phase as a live test of change (particularly during early stages of testing), generating learning through stories, data, and feedback
- Use evidence from multiple sources (quantitative, qualitative) to adapt the approach in real time
- Share learning openly across phases to inform scale-up

9. Governance Basics

Effective governance is essential to developing neighbourhood working in ways that are consistent, credible and rooted in shared purpose. Governance must enable collaborative decision making, transparent use of data, mutual accountability and relational practice—while remaining proportionate, flexible and responsive to local context.

The system will adopt a governance model built around three complementary environments, each with clear purpose, membership and decision roles that together create coherence across Norfolk and Waveney while allowing neighbourhood flexibility:

1. **Strategic Enabling Environment** — Provides system level sponsorship: sets expectations, enables flexibility, aligns resources with priorities and creates the conditions for shared accountability. Holds system principles; aligns commissioning, finance and workforce; supports risk sharing and transparent resource flows; clarifies which decisions are system level; and ensures decisions build confidence without undermining local collaboration. Representation will be intentionally small and include local government, health, VCFSE and independent facilitation where required.
2. **Sense Making Environment** — Acts as the learning, evaluation and insight function. Brings multi agency expertise together to synthesise population insight, neighbourhood profiles and engagement feedback; make assumptions and caveats transparent; identify emerging practice and challenges; guide local prioritisation and sequencing; and ensure lived experience sits alongside quantitative data. It creates comparability without imposing uniformity.
3. **Enabling and Delivery Environment** — Operates at local partnerships and neighbourhood level to coordinate delivery and unblock issues. Supports

honest, ground level problem solving; helps neighbourhood teams design, test and adapt; maintains clarity on decision levels (neighbourhood, local partnerships or system); enables flexibility to reflect natural communities; and builds mutual accountability through shared goals rather than organisational KPIs.

Responsibility for establishing the shared minimum foundations for neighbourhood working sits across all governance layers, rather than with neighbourhoods or local partnerships alone. Strategic, sense-making and delivery environments each play a role in ensuring that expectations are clear, sequencing is realistic and the conditions for delivery are in place.

In this context, system-level governance focuses on alignment, enablement and removal of barriers; sense-making focuses on developing a shared understanding of maturity and variation; and local partnership governance focuses on translating this understanding into proportionate plans that reflect local context and readiness.

Across all environments, governance will follow core principles: clarity of decisions; transparency; relational practice; proportionality; shared accountability; equity and inclusion; flexible boundaries; consistency with local flexibility; alignment with neighbourhood profiles; and a learning orientation rather than compliance assurance.

Where gaps in foundational delivery are identified, these will be treated as signals for system alignment and support, rather than as failures of individual neighbourhoods or partnerships.

At local-partnership level, governance must be ruthlessly focused on achieving meaningful outcomes for local populations. Decision-making should be driven by clear, measurable improvements in health and wellbeing, ensuring that resources are directed where they will have the greatest impact. At system and strategic levels, it is essential to develop a shared understanding of which outcomes are necessary to enable the movement of resources and investment into neighbourhood health. This requires clarity on sequencing—identifying which outcomes must be achieved first, and what support is needed to enable progress. Only by aligning priorities and understanding the interdependencies between outcomes can the system invest effectively and sustainably in neighbourhood health.

Preparatory work will include aligning organisational structures to neighbourhood priorities, embedding data transparency and shared metrics, ensuring local-partnership based forums have capability and mandate, strengthening collaboration with the VCSE and social landlords, and building confidence through early test-and-learn cycles. Governance will evolve as neighbourhoods mature, while core principles remain stable.

10. Learning and Metrics for Monitoring and Evaluating Success

We will use rapid learning cycles (Plan–Do–Study–Act), blend quantitative and qualitative evidence, publish learning via the shared log, and link learning directly to commissioning and resource decisions.

Neighbourhood working is intended to strengthen prevention, collaboration and outcomes for residents. To understand whether this shift is happening, the system will adopt an approach to metrics that supports continuous learning, transparency and shared accountability—rather than reinforcing organisational silos or compliance-driven reporting.

This metrics framework will sit alongside neighbourhood profiles, population insight and the governance arrangements above. It will blend quantitative data, resident voice, social care intelligence and community narratives to create a rounded picture of progress and will evolve as neighbourhoods mature, shaped by learning from early implementation.

Principles include: collective accountability (not organisational ownership); transparency of data and assumptions; comparability without uniformity; minimal burden (align to existing datasets); equity and lived experience; prevention and relational practice; and continuous learning.

Progress will be monitored through four interconnected measure types: (1) neighbourhood impact measures (population health, equity, experience); (2) collaboration and relationship measures (shared planning, joint resource use, multi-agency case discussion, VCSE involvement, workforce confidence); (3) learning and adaptation measures (use of insight, rapid-cycle learning, experience-based design); and (4) transparency and resource measures (investment visibility, asset use, decision routes, data quality and usability).

Baselines, fair benchmarks and proportionate targets will be jointly developed with local partnerships, drawing on neighbourhood profiles and existing datasets, with transparent documentation of assumptions and caveats so that insight supports shared understanding, maturity-appropriate expectations and collective learning rather than competitive ranking or performance management.

To reduce burden, neighbourhoods will align with existing datasets and dashboards wherever possible; no new reporting will be introduced without removing an equivalent burden. The metrics approach will be piloted with early adopter neighbourhoods and refined based on learning. Next steps include agreeing shared principles, co-designing initial dashboards, aligning financial and commissioning arrangements, testing the framework and iterating indicators.

Report to Norfolk and Waveney Integrated Care Partnership

Item No: 7

Report title: Community Mental Health: Summit and Mindful Norfolk

Date of meeting: 04 March 2026

Sponsor: Cllr Kim Carsok, Cabinet Member for Health and Leisure, South Norfolk District Council
Cllr Natasha Harpley, Deputy Leader and Cabinet Member for Housing and Communities, Broadland District Council
Cllr Tristan Ashby, Executive Member for Health and Communities, Breckland District Council

Reason for the Report
To seek endorsement and resource commitments to maintain momentum around our locality led, system work on mental wellbeing.

Report summary
Good mental health is a key aspect of our resident's health and wellbeing. In Norfolk there is a vast array of system wide and locally commissioned support services and initiatives at local community levels which seek to empower and up-skill community members to support each other in identify and addressing mental wellness.

In May 2025, the system held a mental wellbeing conference at Carrow Road in Norwich. The event, sponsored by the Lord Lieutenant's office and introduced by DL Michael Gurney, attracted a wide range of statutory and voluntary sector agencies and community members, with over 180 attendees. The feedback demonstrated a highly successful and impactful event, based upon challenging and thought provoking sessions led by those with lived experience and front line practitioners, and a commitment to a number of pledges going forwards.

The event also saw the launch of Mindful Norfolk by Cllr Fran Whymark as a locality and community led movement to build the skills and resilience in residents and businesses in being able to identify, champion and support good mental wellbeing. To continue with momentum around this event and its success, the ICP is asked to consider endorsing and how it resources a further event in 2026, and to consider how a Mindful Norfolk movement can be supported through commissioning intentions going forwards. This report has been considered and endorsed by the Living and Working Conditions Group, one of the three pillars of the Health Inequalities governance structure.

Recommendations
The ICP is asked to:

a) Establish the Norfolk and Waveney Mental Health Summit as an Annual Event, building on the success and impact of the inaugural summit with each agency offering support and resources to enable this to take place.
b) To sponsor and actively support the County-wide implementation of Mindful Norfolk via Health and Wellbeing Partnerships, giving consideration as to how this community intervention can form part of commissioning intentions going forwards. The programme will strengthen early intervention, reduce stigma, and enhance local capacity to support mental health at a grassroots level through training local residents as wellbeing champions.

1. Background

1.1 "*Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health is a basic human right. And it is crucial to personal, community and socio-economic development*." (World Health Organization, 2022)

1.2 During 2024 and 2025, a number of system leadership meetings were held, convened by Deputy Lord Lieutenant (DL) Michael Gurney. These sessions were held to explore opportunities and initiatives which could be developed and supported to improve the mental wellbeing of our communities and residents in Norfolk. They explored a number of potential projects, which included the success of Mindful Towns and Villages that had been rolled out into several rural communities in Breckland, South Norfolk and Broadland, along with a number of similar community projects such as Safe and Habitable Homes in Norwich, PostiviTea in North Norfolk and Lily Proactive Intervention Programme in Kings Lynn and West Norfolk. These have all been developed and delivered by local Health and Wellbeing Partnerships (HWPs).

1.3 The sessions also commissioned the organising of a system wide summit, to continue to explore mental wellbeing amongst a much wider group of stakeholders and to help socialise mental wellbeing as being an objective of every agency in the health and care system.

2. Mental Health Summit 2025

2.1 The Mental Health Summit, held in May 2025, was organised by District Councils, Norfolk County Council (NCC) and Norfolk and Suffolk Foundation Trust (NSFT). The session attracted over 180 participants of a range of agencies, professions, management grades and community groups. A full report of the summit is included in appendix 1.

2.2 The summit was designed to be led by those with lived experience, enabling speakers to tell their stories and to use this as an opportunity for reflective practice in breakout sessions. The impact of the emotional stories

courageously told by presenters was key to the events success and the learning each delegate took. The sessions held during the summit were:

- **Workshop 1:** ***Community Connections – Supporting Families***
- **Workshop 2:** ***From Crisis to Calm***

2.3 Each delegate was asked to make a pledge based on what they had heard and discussed during the sessions. The pledges were collated and themed as follows:

i. **Connecting with Your Community** – Strengthening local relationships and support networks.
ii. **Promoting Positive Mental Wellbeing** – Encouraging proactive approaches to mental health.
iii. **Expanding Mental Health Training** – Increasing access to and uptake of relevant training opportunities.
iv. **Normalising Conversations and Reducing Stigma** – Creating safe spaces for open dialogue about mental health.
v. **Understanding GDPR to Empower Personalised Care** – Using data responsibly to support the development of effective personal care plans.
vi. **Driving System Change Through Sector Collaboration** – Building strategic partnerships to innovate, influence, and transform mental health support across sectors.
vii. **Engaging with People with Lived Experience** – Ensuring services are shaped by those who use them.

3. Mindful Norfolk

3.1 The Mental Health Summit provided the opportunity to launch the Mindful Norfolk movement. This movement builds upon the successful Mindful Towns and Villages (MTV) initiative delivered by Breckland, Broadland and South Norfolk Councils respectively, and many other community level mindfulness projects sponsored and enabled by HWPs across the county.

3.2 Through MTV, residents and local businesses within a community are offered the opportunity to complete low level, mental health awareness training in order to become Wellbeing Champions who have the knowledge and confidence to check in on their neighbours, colleagues and friends to provide support and signpost to other services. This early intervention model enables champions to engage with residents and divert them to suitable support before they need already overwhelmed statutory services. Once a town or village has gained a minimum number of champions, they can gain Mindful Status and take on a role of shaping community support that meets their own needs.

3.3 So far, across all three districts, there have been 1,001 adult wellbeing champions trained and 48 Mindful Towns and Villages recognised. Broadland and South Norfolk have developed the project further by co-producing a Youth Champion course with young people and relevant organisations. So far 161 Youth Wellbeing Champions have been trained. A further 4 community volunteers have also been trained to deliver the Mental Health Awareness course themselves as part of a new initiative to ‘train the trainer’ in localities and thus build resilience to the programme. Breckland have in turn been

expanding their priorities to incorporate Compassionate Communities and Age Friendly Communities by offering courses based upon relevant themes such as Grief and Bereavement, Pet Loss and Hearing Loss Awareness.

3.4 By becoming a Mindful Town or Village, those locations have been emboldened to apply the principles as they see fit. A 'chatty café' has been set up in Long Stratton and other locations. Many places, such as Hellesdon have allocated a 'Time to Talk' bench to encourage connection and Narborough and others now host a Pop Up Pantry to promote health and wellbeing as well as conversation.

3.5 Across HWPs, there are a number of projects with similar purposes of improving the mental wellbeing and resilience of residents. Examples of these include PitStop by MensCraft, All to Play For by Active Norfolk and 12th Man. Like Mindful Towns and Villages, these projects are based on short term funding via HWPs.

3.6 Mindful Norfolk provides an opportunity to bring consistency, shared branding and a common specification to a diverse range of community initiatives supporting mental wellbeing. Whilst each project is highly impactful in its own right in its local place, understanding how the system level impact replicates these low-cost supportive measures across the whole county is difficult and therefore hard to make a case for ongoing support. A small and multi-agency working group has been developing a common brand and specification to provide an umbrella to community mental wellbeing investment in this area, without being overly prescriptive as to the specific target cohorts or the operating model of any local initiative, to enable tailored support and flexibility in meeting local needs.

3.7 The specification and brand work is included in appendix 2. Application of Mindful Norfolk in any local context, whilst governed by a common specification and brand, must:

- continue to be identify and meet local needs,
- ensure an operating model cognisant of local context and signposting to available services,
- follow the principles of proportionate universalism.

Officer Contact

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IN TRAN communication for all

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Norfolk and Waveney Mental Health Summit 2025

Strategic Reflections and Recommendations

1. Purpose

This report presents the key themes, insights, and recommendations arising from the Norfolk and Waveney Mental Health Summit 2025. It is intended to inform strategic planning, policy development, and service transformation across the local health and care system.

2. Introduction and Background

The Norfolk and Waveney Mental Health Summit 2025 convened over 180 delegates from across the health, care, local government, education, and voluntary sectors. The event was convened by the Lord Lieutenant's office and aimed to foster collaboration, amplify lived experiences, and co-produce practical solutions to improve mental health outcomes for the residents of Norfolk and Waveney. The summit focus was community health and wellbeing rather than acute mental health.

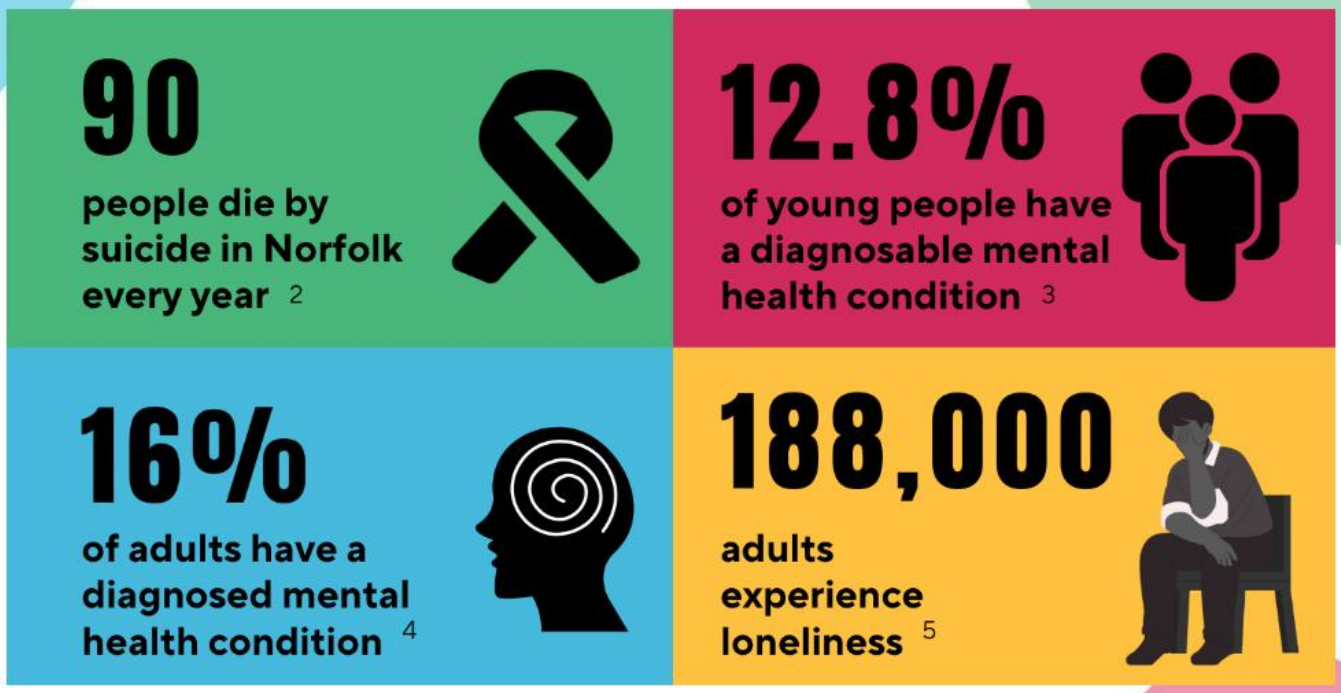
The Summit featured a keynote presentation from the founder of a local mental health charity and two interactive workshops. Individuals with lived experience of mental health services shared their personal journeys, offering powerful insights into the real-world impact of service provision. The organisers extend their sincere gratitude to these contributors.

3. Mental Health in Norfolk and Waveney – Key Challenges

> "Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health is a basic human right. And it is crucial to personal, community and socio-economic development." (World Health Organization, 2022) [1]

Norfolk and Waveney faces significant mental health challenges, including those identified overleaf.

[1] World Health Organization. (2022). *Mental health: Strengthening our response*. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response



4. Key Themes

During the Norfolk and Waveney Mental Health Summit, delegates participated in two focused workshops designed to explore key challenges and opportunities in mental health care and community integration. Each session facilitated the identification of systemic barriers, the exchange of diverse perspectives, and the co-creation of practical, forward-looking solutions.

Workshop 1: *Community Connections – Supporting Families*

This session focused on the role of community-based support in strengthening family resilience and improving mental health outcomes. It explored the current landscape of services available to families and identified gaps and missed opportunities for a more integrated, coordinated approach. The workshop followed a powerful and deeply personal presentation from Trevor Stevens, who shared the story of his daughter Tobi, who tragically died by suicide in 2020 at the age of 19. Trevor's testimony underscored the critical importance of involving families as active partners in the care and treatment

[2] **Norfolk Office of Data & Analytics.** (2022). *Infographic: Norfolk Suicide Audit 2022*. Norfolk Insight. Retrieved from https://www.norfolkinsight.org.uk/wp-content/uploads/2022/08/Infographic_Norfolk_Suicide_Audit_2022.pdf

[3] **Norfolk Office of Data & Analytics.** (2023). *Mental Health: Public Health Outcomes for Norfolk and Waveney*. Norfolk Insight. Retrieved from https://www.norfolkinsight.org.uk/wp-content/uploads/2023/12/Mental_Health_Public_Health_outcomes_for_Norfolk_and_Waveney_accessible.pdf

[4] **Norfolk Office of Data & Analytics.** (2023). *Mental Health: Public Health Outcomes for Norfolk and Waveney*. Norfolk Insight. Retrieved from https://www.norfolkinsight.org.uk/wp-content/uploads/2023/12/Mental_Health_Public_Health_outcomes_for_Norfolk_and_Waveney_accessible.pdf

[5] **Norfolk Office of Data & Analytics.** (2025). *Accessible Infographic: Norfolk JSNA – Social Isolation and Loneliness*. Norfolk Insight. Retrieved from https://www.norfolkinsight.org.uk/wp-content/uploads/2025/01/Accessible_Infographic_Norfolk_JSNA_Social_Isolation_and_Loneliness.pdf

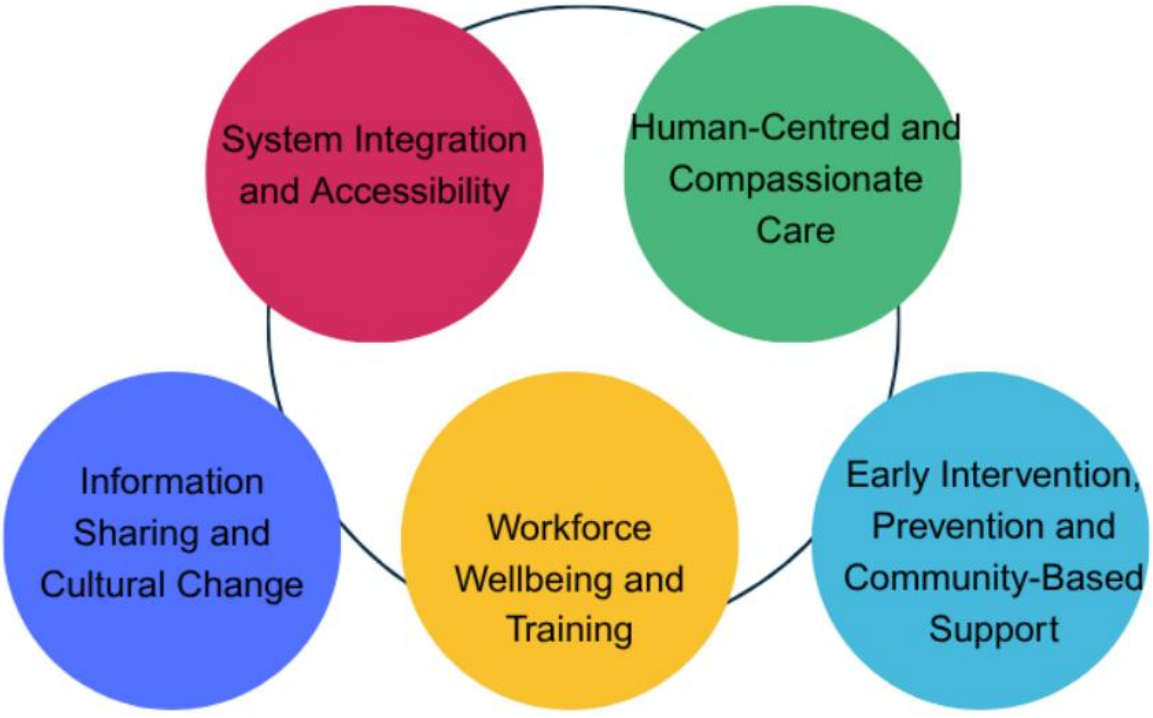
of young people experiencing mental health challenges. His message highlighted how family engagement can be a vital, and potentially life-saving, component of mental health support.

Workshop 2: *From Crisis to Calm*

This session examined the practical support available to individuals navigating mental health crises, with a particular focus on lived experience and service accessibility. Delegates heard from two speakers who shared their personal journeys through local mental health and social care systems.

- Anna (represented by her Case Worker), a former mental health professional, spoke candidly about her experiences of trauma, including domestic abuse, and her struggles with alcoholism and hoarding. Her story illustrated the complexity of needs that individuals may present with, and the importance of trauma-informed, holistic support.
- Hollie shared her family's experience of engaging with multiple services following her husband's suicide attempt and the sudden loss of their four-month-old son. Her account highlighted both the strengths and shortcomings of current crisis response systems, and the emotional toll of navigating fragmented services during times of profound distress.

Insights shared by delegates have been systematically reviewed and the following overarching themes identified:



5. Thematic Insights and Strategic Implications

The following section provides an in-depth exploration of the five key themes that emerged from the summit workshops, accompanied by suggested actions to support system-wide improvement.

Drawing on the collective insights and reflections of summit delegates, this analysis is intended to inform future policy development, drive service transformation, and enable long-term strategic planning across the local health and care system.

The feedback received offers a balanced view of current strengths and opportunities for enhancement, providing a valuable foundation for shaping the system's strategic direction and fostering collaborative progress.

System Integration and accessibility

Delegate feedback and insights

- Services are hard to navigate; there is a need for a centralised mental health services directory and better promotion of services to improve access.
- Services remain siloed. True integration requires shared systems, communication, and co-location.
- Short-term commissioning and rigid processes hinder innovation and responsiveness.

Future planning

- **Develop a Centralised Mental Health Directory**: Create a user-friendly, regularly updated platform (digital and physical) listing all available services, including VCSE organisations and community groups.
- **Promote existing services** through social media and other campaigns
- **Encourage Co-location of Services**: Pilot integrated care hubs where NHS, social care, and community services operate from shared spaces. Explore integration of associated services such as Domestic Abuse, Housing, Children's Services etc
- **Review Commissioning Models**: Shift from short-term, target-driven funding to long-term investment in prevention and community resilience.

Human-Centered and Compassionate Care

Delegate feedback and insights

- Emphasis on vulnerability, empathy, and treating individuals as people, not cases. There is a need to raise awareness around being non-judgemental and recognising unconscious bias.

- A “Think Family” approach is essential. Families and trusted networks should be involved in care planning. Residents should be supported to proactively identify a trusted individual who can act as their advocate in the event that they do not have the capacity to make decisions independently in the future.

Future planning

- **Embed the “Think Family” Approach**: Empower those working in healthcare with these tools to ‘Think Family’
- **Empower Lived Experience Voices**: Co-produce services with individuals who have lived experience, ensuring relevance and empathy in design. Work with service-users to have a greater understanding of barriers to access.
- **Embed equity and inclusion training** to address unconscious bias and promote non-judgemental care

Early Intervention, Prevention and Community-Based Support

Delegate feedback and insights

- Crisis services are overwhelmed. Investment in early support and community-based interventions is critical.
- Support should be available before crisis point, not just during.
- There is a need to further develop provision for Children and Young People including parental support.

Future planning

- **Promote the Mindful Norfolk approach**: Scale up the Wellbeing Champion programme to reach schools, workplaces, and community hubs. Implement Children and Young People programme to include parental support.
- **Invest in Local Projects**: Recognise the value of grassroots initiatives, taking a ‘test and learn approach’ where we have seen excellent practice, recognising that a ‘one size fits all’ approach isn’t always appropriate.
- **Strengthen and promote Early Help Pathways**: Ensure that holistic support is available before crisis point, with clear routes into services from any community touchpoint. Through the Help Hub and Social Prescribing model, recognise that a huge number of factors influence somebody’s Mental Health.
- **Develop practical support and information** for those who are bereaved or have other needs using support from VCSE

Workforce Wellbeing and Training

Delegate feedback and insights

- Staff burnout and desensitisation are widespread. Support for professionals is essential.
- Frontline workers across a range of services need trauma-informed training and confidence to have difficult conversations.
- Training needs to be available for staff working in mental health services and other frontline workers

Future planning

- **Mandatory Trauma-Informed Training**: Provide all frontline staff with training in trauma awareness, active listening, and mental health first aid.
- **Support Staff Wellbeing**: Introduce reflective practice sessions, wellbeing check-ins, and peer support networks for staff working in mental health services

Information Sharing and Cultural Change

Delegate feedback and insights

- GDPR is often misinterpreted, creating barriers to effective support. A cultural shift is needed to balance privacy with the need to protect the safety of individuals.
- Solutions must be shaped by those with lived experience to ensure relevance and impact.
- System partners are encouraged to have open communication and trust across services and with families.

Future planning

- **Co-produce personal action plans:** Encourage clinicians and mental health professionals to work collaboratively with individuals to identify a 'Trusted Person' who can be contacted if there are concerns about potential self-harm. Additionally, promote proactive reflection among all residents—while they are well—on who they consider part of their trusted support network.
- **Promote a "Presumption to Share" Model:** Encourage early conversations about confidentiality and support networks, with opt-out options for individuals.
- **Clarify GDPR Guidance**: Provide training and policy updates to help professionals understand when and how to share information safely and ethically.

- **Develop data sharing processes** to allow risk factors and a person's history to be shared and trigger alert systems
- **Promote Positive Mental Health Messaging**: Shift public campaigns from crisis-focused to wellbeing-focused, using Mindful Norfolk's grassroots reach to spread awareness
- **Develop sector networking events**

6. Commitment Pledges

As part of the Summit, delegates were invited to submit a personal commitment pledge—an action they would take following the event to make a meaningful difference within their community. These pledges reflect a shared commitment to improving mental health and wellbeing across Norfolk and Waveney. The pledges made by delegates aligned with the following key themes:

1. **Connecting with Your Community** – Strengthening local relationships and support networks.
2. **Promoting Positive Mental Wellbeing** – Encouraging proactive approaches to mental health.
3. **Expanding Mental Health Training** – Increasing access to and uptake of relevant training opportunities.
4. **Normalising Conversations and Reducing Stigma** – Creating safe spaces for open dialogue about mental health.
5. **Understanding GDPR to Empower Personalised Care** – Using data responsibly to support the development of effective personal care plans.
6. **Driving System Change Through Industry Collaboration** – Building strategic partnerships to innovate, influence, and transform mental health support across sectors.
7. **Engaging with People with Lived Experience** – Ensuring services are shaped by those who use them.

Following the conference, we engaged with delegates to review progress against the commitment pledges made during the event. We are pleased to report that the majority have successfully fulfilled their pledges, reflecting strong engagement and a clear dedication to driving positive change.

Through this follow-up process, several barriers were identified that have affected progress for some individuals. In response, we have provided targeted support—sharing relevant resources and facilitating connections with key partners—to help delegates navigate these challenges and continue advancing their commitments.

This section highlights the tangible actions and initiatives undertaken by individuals and teams, illustrating how strategic intent has been translated into meaningful outcomes and measurable impact across the system.

Connecting with Your Community

Example pledges

- *"To prioritise people, not processes"*
- *"To continue to talk within my community, to help to make it a safe place for people to open up and be honest"*
- *"To continue to put mental wellbeing at forefront of our organisation."*

Commitment in action

- Meaningful conversations with friends and people in the community
- Signposting voluntary opportunities
- Volunteering and completing volunteer training
- Joining a working group to improve access to services across Norfolk and Waveney
- Setting up a mid-week evening drop in session for an existing wellbeing hub

Promoting Positive Mental Wellbeing

Example pledges

- *"To talk positively about mental health and ask others how they were feeling about it and present more positivity."*
- *"I pledge to be mindful to make time for the conversations around good mental health."*
- *"To promote positive mental health-every day is a mental health day"*

Commitment in action

- Talking positively about mental health
- Running a pilot adult colouring book project
- Sharing information with staff on how to commit to self-care, engage in physical activity and speak openly.

Expanding Mental Health Training

Example pledges

- *"To become a Wellbeing Champion"*
- *"I pledge to interact and network with more organisations than ever to raise awareness of MH services available whilst also educating the public on basic MH training"*
- *"Provide mental health first aid training to all staff"*

Commitment in action

- Training whole teams in Mental Health awareness
- Looking at flexible working arrangements and staff terms and conditions to promote improved health and wellbeing of staff
- Staff trained in how to make onward referrals to organisations for Mental Health services
- Promoting Wellbeing Champion training

Normalising Conversations and Reducing Stigma

Example pledges

- *"Not to shy away from the important conversations as it may just save someone"*
- *"In my organisation I will make sure I talk about mental health in terms of good mental health and poor mental health. To make these conversations a normal part of daily life."*
- *"How can I support change regarding mental health discussions"*

Commitment in action

- Speaking with colleagues and listening
- Applying reflections from the summing into interactions with family, friends and co-workers
- Conversations around mental health are now reported to be normalised in some teams who also reflect on both good and poor mental health
- Linking with Mental Health days and providing information leaflets to customers

Understanding GDPR to Empower Personalised Care

Example pledges

- *"To break through the issue of 'confidentiality' when people are at risk of harm"*
- *"To change my contract with clients to include permission to contact a family member or secure person in their life if the client is at risk of injuring themselves."*
- *"To support our clients to add more of their personal resources to their care plans, risk assessments and confidentiality agreements."*

Commitment in action

- Development of Common Sense Confidentiality policy which sets out the importance of communicating with families and carers where it relates to a risk to safety.
- Asking clients for permission to contact a secure person if they are at risk.
- Making a concerted effort to hear the client voice

Driving System Change Through Industry Collaboration

Example pledges

- *"To continue to knit conversations together across professionals and providers to keep us all moving in the same direction around prevention and proactive Mental Health support"*
- *"To continue working with partner organisations to encourage action, to make things better and understand the best way to support people."*
- *"Collaboration across services, to work towards clearer access to support everyone in their wellbeing"*

Commitment in action

- Building accessibility and inclusivity into plans for mobilisation of a new Integrated Neighborhood Team working across a highly deprived population area.
- Commissioning training sessions on Restorative Practice Approach and presenting to system leaders to promote collaborative problem solving
- Workshops held for care home staff, social workers, bed managers and Community Mental Health Teams to give detail on services to reduce readmission and empower staff in relapse prevention.
- Raising awareness of services with community groups
- Workstream developed for service provider to achieve Triangle of Care status

Engaging with People with Lived Experience

Example pledges

- *"I will walk a mile with families of neurodivergent children and provide stability in their lives."*
- *"Engage people with lived experience of mental health struggles into delivering training to address needs of organisations"*
- *"To ensure user and carer experience is embedded in our work"*

Commitment in action

- Co-developed training package, working with long term unemployed participants who have experience of mental health struggles
- Commissioned service has various workstreams in progress to involve service users, carers and wider communities in the shaping of services through surveys, community engagement and service user and carer forums.

Delegates identified a range of barriers that have impacted their ability to fully deliver on their commitment pledges. These included personal circumstances and competing professional demands,

which have limited capacity. A significant structural challenge remains the uneven accessibility of training and funding, often restricted to specific areas or functions within the system. Furthermore, the absence of commissioned funding for certain services continues to threaten their sustainability and hinder progress.

Persistent systemic issues—such as cultural stigma, long waiting times, and limited engagement responses—were also highlighted as ongoing barriers. In some cases, initial pledges did not align with the needs of the local population; however, more suitable alternatives were identified to better reflect community priorities. Despite these challenges, delegates remain committed to fulfilling their pledges, actively leveraging available tools and resources to drive meaningful and inclusive change.

7. Conclusion

The Summit highlighted both the scale of the mental health challenge and the collective will to address it. The insights and recommendations presented here provide a foundation for system-wide transformation. Stakeholders are encouraged to adopt and champion these proposals to ensure a more integrated, compassionate, and effective mental health system for Norfolk and Waveney.

MINDFUL NORFOLK

A County-wide Approach to Community Mental Health Awareness

Purpose

- To create a network of trained community volunteers across Norfolk who can:
  - Co-design approaches that promote mental wellbeing and remove barriers to support
  - Hold safe, empathetic conversations with confidence
  - Recognise when someone needs help and respond appropriately.
  - Signpost residents to services, enabling early intervention

MINDFUL NORFOLK

Objectives

•Foster community-led resilience and wellbeing through local action
•Reduce stigma and normalise conversations around mental health
•Improve access to mental health resources and early support
• Strengthen informal support networks to provide timely help
• Increase mental health awareness and confidence in communities

MINDFUL NORFOLK

Community Champions

Champions will be recruited from the local community

- Volunteer groups
- Town and Parish Councils
- Small and medium sized businesses (for benefit of own workforce and wider community)
- Schools, faith groups
- VCSE organisations
- Keen individuals/residents

- The role of a community champion is not a substitute for professional help

Beyond the Training

- Champions are supported through a community of practice (virtual and/or face to face)
- Champions are encouraged to:
  - Advocate for achieving Mindful Town or Village status in their area
  - Facilitate mental wellbeing activities (e.g. walking groups, creative workshops)
  - Promote local awareness campaigns
  - Hold "Time to Talk" events
  - Organise Peer support groups

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Target Populations

Who champions will support

Each district can adapt to their local needs and strategy

Emerging Norfolk Mental Health Needs Assessment may be a useful tool to support this

- Example priority groups for
  - Older adults
  - Farmers and rural workers
  - Young people
  - Carers
  - People with long term conditions
  - Socially isolated individuals

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Training Requirements

- Training will be delivered by an approved provider
- Core skills should include:
  - Active listening
  - Empathy
  - Confidence to hold difficult conversations
- Core knowledge should include:
  - Identifying signs that indicate support may be needed
  - Signposting and referral pathways
  - Safeguarding and confidentiality
- Courses will be tailored to local volunteer needs

MINDFUL NORFOLK

Branding

- Use of “Mindful Norfolk” logos and signage
- The Mindful badge will have a consistent meaning and visual identity across Norfolk, improving brand recognition and the profile of the scheme
- While maintaining a Norfolk-wide standard, the programme will allow flexibility and local nuance.
- Options of dual branding for existing programmes (TBC)

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Partnerships and Promotion

- Partnership Opportunities:
  - NHS (e.g. Patient Participation Groups)
  - Voluntary sector
  - Schools
  - Housing providers
  - Integration/interface with local mental health services, social prescribing
  - Any district specific offerings/partnerships

- Promotion:
  - Promotion through local media, social media and council channels

MINDFUL NORFOLK

Delivery

- Mindful Norfolk will be delivered through a partnership approach, involving local authorities, voluntary sector organisations and training providers
- Delivery will be community based, using existing networks and venues to maximise accessibility
- The delivery will reflect the unique needs and context of each community.
- Adaptations will be guided by local issues, resources and partnerships.

MINDFUL NORFOLK

Governance

- A steering group of district councils will oversee strategic direction
- The group will meet to review progress, address challenges and ensure alignment to local boards and priorities
- The group will agree an approach for reporting outcomes
- The group will report to the Norfolk Living and Working Conditions Group, local programmes will report to and engage with Health and Wellbeing partnerships

MINDFUL NORFOLK

Baseline Mindful Norfolk Offer

- Promotion of free wellbeing training
- A minimum of 6 courses Approx 72 champions trained per council area (a guide only)
- Each District commits to 3 hours per week in officer time to co-ordinate and promote training offer (in kind contribution)
- Face to face training providers supported with a small budget to provide refreshments, hire rooms and promotion. Ensure joint advertising/promotion
- Communities are encouraged and enabled to develop and support their own vision of ‘Mindful’

- **Total funding required for one year = approx. £2-3,000 per council (plus officer time in kind)**

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Opportunities for District-Level Enhancement

- Districts can strengthen the Mindful Norfolk scheme by investing additional resources and activities, including:
- **Public Health Mental Health Training and Resource Hub (from early 2026)**
  - Access free training offers to enhance Champion role, supported by resource library and access to E-learning modules.
- **Commission additional training**
  - Expand capacity and introduce new training opportunities.
- **Commit additional officer time**
  - Promote the scheme to communities, businesses, and partners.
  - Provide extra support and benefits to Champions.
  - Drive co-production and quality improvement.
- **Engage in Norfolk-wide network events**
  - Share learning and good practice.
- **Partner with local influencers and trusted figures**
  - To boost engagement and visibility

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Success measures

- Annual impact report
  - Comprehensive report to demonstrate outcomes and learning
- Key Metrics
  - Quantitative: Volunteers trained, courses delivered
  - Qualitative: Participant testimonials, case studies of impact and feedback from communities
  - Geographical coverage: Reach across Norfolk
  - Comms Engagement: Social media metrics
- Ripple effects mapping
  - To identify indirect benefits and wider community benefit (may require additional investment)

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Indicative Costs: Based on Established Schemes

- Delivery in Breckland
  - Funding: £15,000 per annum from Breckland Council funding
  - The delivery uses a combination of Officer time for day-to-day co-ordination and management time for strategic input.
  - Combined Officer time of 2 days per week

- Delivery in Broadland and South Norfolk
  - Funding approximately £37,000 (including staff)

- Delivery of Mindful Norfolk
  - The minimum Mindful Norfolk programme is estimated to cost between £2-3,000 plus a minimum of 3 hours officer time per week.*

** It will be interesting to understand through evaluation the added value from minimum through the variation in funding levels across Districts*

MINDFUL NORFOLK

Current training providers

- Norfolk and Waveney Mind
- YANA
- Swaffham and Litcham Home Hospice
- Lorna Vyse – Childhood Bereavement Specialist
- Advocacy After Fatal Domestic Abuse
- How 2 Thrive Coaching
- South Norfolk and Boadland in house delivery
- Transpire Training's free webinars as CPD Mindful Impact | Transpire Training

- Anglian training- not yet used but could be an opportunity for people to explore. Mental Health | Anglian Training

Opportunity to share tools/processes

Checklist

TO BE COMPLETED FOR EACH ORGANISED TRAINING

TRAINING LOGISTICS

- [ ] Choose provider
- [ ] Choose location/venue
- [ ] Confirm date & venue with provider
- [ ] Apply for a PO for the venue hire
- [ ] Update booking form
- [ ] Start marketing
- [ ] Add bookings to a spreadsheet
- [ ] Send confirmation details
- [ ] Check minimum numbers
- [ ] Send reminder email
- [ ] Create a register

WHO TO CONTACT

- [ ] Parish clerk
- [ ] Parish/town councillors
- [ ] District councillors
- [ ] Villages halls
- [ ] Existing community groups
- [ ] Libraries
- [ ] Doctors surgeries
- [ ] Small businesses (e.g. hairdressers, cafes,)
- [ ] Post in Facebook community groups

POST TRAINING

- [ ] Update attendance and statistics to database(s)
- [ ] Send post course resources
- [ ] Collect feedback
- [ ] Update booking form
- [ ] Pay invoices

ONGOING TASKS

MONTHLY

- [ ] Project meetings
- [ ] Promote the project (articles, magazines, social media, email connections, existing groups etc)
- [ ] Develop supporting community activity (as appropriate)
  - Community engagement
  - Source or supply funding/ resources
  - Comms

QUARTERLY

- [ ] Send newsletter to existing champions
- [ ] Plan out future training
- [ ] Request/collate qualitative feedback
- [ ] Evaluate the project progress
- [ ] Recognition of Mindful Towns and Villages
  - Certificate presentation/photo with ward member / portfolio holder
  - Press release

Funding Options

- Sponsorship opportunities from business
- Activists / Philanthropy
- External Funding
- Commissioners
- HWPs Funding

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