Norfolk and Waveney Integrated Care System

Part 1: Joint Forward Plan 2025/2026-2029/2030

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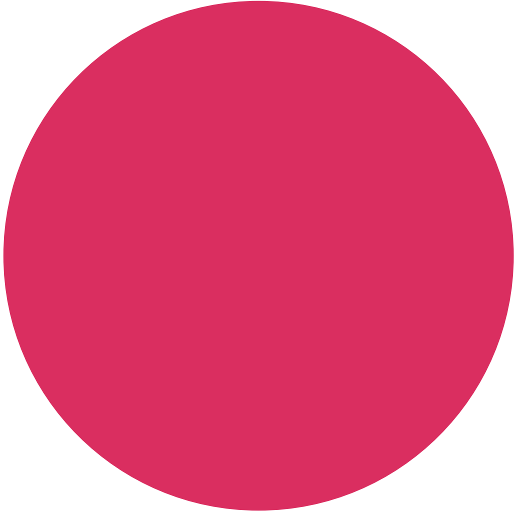


Foreword

Foreword

Our mission is clear: to help the people of Norfolk and Waveney to lead longer, healthier and happier lives. This is our third Joint Forward Plan, setting-out the actions we will take over the next five years to help us work towards our mission.

It is worth just taking a moment to look back over the past year. We have always said that our success should be judged on whether we are making a real difference to people's lives, and over the past year we have had some real successes. For example:

We have made huge investments in buildings and equipment:

- We have opened three community diagnostic centres, increasing the number of scans and tests we can do, and speeding-up the diagnosis and treatment of cancer and other conditions.
- The Willow Therapy Unit has welcomed its first patients and is helping people who don't need to be in hospital, but do need some support before they can go home.
- The new Rivers Centre wards at Hellesdon Hospital are providing in-patient care in a state-of-the-art facilities.
- The Government also confirmed that the Queen Elizabeth and James Paget Hospitals will be rebuilt and we have continued to work hard on our plans for this.

We have developed and invested in new services, for example:

- The new NHS Talking Therapies service is providing tailored support to people experiencing anxiety and depression as close to their home or place of work as possible, thanks to a doubling of the number of locations it is operating from.
- Dental care is one of our biggest challenges and this year we have seen a significant increase in the number of people being seen by our Urgent Treatment Service, with 2,500 people now being treated every month, following a £1.6m investment.
- And our Unscheduled Care Coordination Hub (UCCH) has had an impressive first year, helping over 10,000 patients and preventing more than 7,500 unnecessary ambulance dispatches.

Our progress has been recognised: Our Integrated Care System progressed out of national support and has been removed from the Recovery Support Programme (RSP), formerly known as "special measures". This is testament to our work as a system and the hard work of staff.

We are making a difference and there are many more examples of where we have made progress described in the plan. While this is of course positive, we know we have a lot to do as a system to ensure we are consistently providing the right the level of care.

The next year will have its own challenges, there's more we need and will be doing to improve the quality of and access to care. The financial position will be very challenging and there will be a significant amount of change to the organisation and structure of the NHS.

Our refreshed plan sets-out our ambitions for the future and the actions we will take to improve people's health, wellbeing and care from birth through to later life. By working together, we can create a healthier Norfolk and Waveney.

Hein van den Wildenberg, Acting Chair, NHS Norfolk and Waveney ICB

Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB

Norfolk Health & Wellbeing Board opinion on the JFP

We would like to acknowledge the work that has happened to deliver this light touch refresh of the Joint Forward Plan (JFP) 2025/2026 for Norfolk and Waveney and that the JFP continues to underpin our Integrated Care System (ICS) ambitions to help the people of Norfolk and Waveney to live longer, healthier, and happier lives. We also note that the refresh continues to align to the four themes of our combined Norfolk Joint Health and Wellbeing Strategy and Norfolk and Waveney Integrated Care Strategy.

We understand that this light touch approach follows the Guidance issued for 2025/2026 and sets an expectation that ICB's and Trusts perform a limited refresh of existing plans before April 2025, given the anticipated publication of the 10-year health plan in the spring of 2025. After that, there will be a more extensive revision of JFPs aligned to wider reform of nationally co-ordinated NHS planning resources.

The Norfolk Health and Wellbeing Board continue to fully support and endorse the refreshed ambitions of the Norfolk and Waveney JFP. As part of the ICS, members of the Health and Wellbeing Board and the Integrated Care Partnership look forward to working collaboratively to fulfil the ambitions and outcomes contained within the JFP and sharing our expertise, as partners, to help achieve them.

Councillor Fran Whymark
Chair of Norfolk Health and Wellbeing Board and Norfolk and Waveney Integrated Care Partnership

Suffolk Health & Wellbeing Board opinion on the JFP

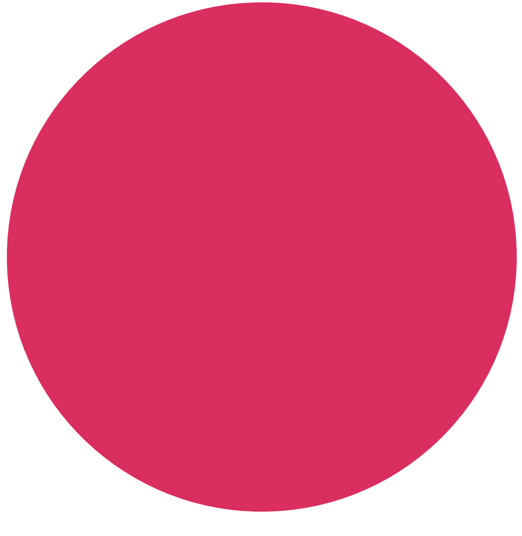
Suffolk Health and Wellbeing Board endorses the SNEE/N&W Joint Forward Plan. The Board received information of the updates to the Joint Forward Plan in March 2025 and recognises the plan takes account of the Suffolk Health and Wellbeing Strategy which was informed by the Joint Strategic Needs Assessment. The Joint Forward Plan aligns smoothly with the Health and Wellbeing Board's strategic priorities including Healthy Ageing which is outlined in their Ageing Well Strategic Framework.

The Board welcomes the alignment of priorities across the organisations, including the focus on Population Health Management and Health Inequalities among others. It's evident to see the positive steps taken to improve the key performance indicators to ensure that individuals are receiving the best quality care and services available. Furthermore, Members of the HWB were pleased to see that the plans had been produced in collaboration with a wide range of key stakeholders from across the Suffolk system.

The Board welcomes the approach within the Joint Forward Plan to provide a coherent and robust set of immediate and longer-term priorities, centred on the eight ambitions for improvement developed with system partners. The level of integration across the system is welcomed. Members also commented on the positive language in the plan with regard to ageing well and referred to the importance of inspiring public trust and confidence, noting that communication is crucial and the benefit of having simple metrics to demonstrate progress.

The Board also recognises the level of engagement that has been undertaken in producing the JFP, the degree of co-production that has been employed to bring this report and the opportunity the JFP provides for shared learning across organisations.

Councillor Steve Wiles
Chair of the Suffolk Health & Wellbeing Board and Cabinet Member for Public Health and Public Protection



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Executive Summary

Introduction

The 2025/2026 to 2029/2030 Norfolk and Waveney Joint Forward Plan is our rolling plan for the next five years setting out what we will do, and where and how we are going to improve health and care services for our local population, their families and carers. Our local communities are at the heart of our plan, and people have previously told us that they want to feel safe when they use local services, they do not want to be passed between different organisations, so they have to re-tell their story each time, and they expect services to be accessible, tailored to their needs and of good quality.

Our third JFP is a light touch refresh of the second version which was published in June 2024, within the context that the 10-Year Health Plan is expected in 2025. The plan has been refreshed to ensure it remains 'live' and addresses current needs, and is a shared plan, developed with and supported by the partners in our local system. The plan is split into two parts:

Part one draws together our public health data and learning from engagement with the people who use our services to set out the case for why we need to make changes to the way we provide services. This informed our eight ambitions for improvement and the objectives that underpin them. Within all the objectives we have been clear about what people will see improve and by when, and how partners in our ICS will work together on our commitment to making a difference to peoples' lives.

Part two provides a summary of how we will meet our legal duties, and these have been reviewed and updated. Taken together, these parts form the Norfolk and Waveney Joint Forward Plan.

We will deliver our plan through collaboration with our partners and local communities. Where services are being developed, this will involve the people that plan, provide and use our services, using a range of methods to help people participate. District, city and borough councils and the Voluntary, Community, & Social Enterprise (VCSE) sector are key partners in their local areas within Places and Health and Wellbeing Partnerships. How all parts of the system will work together to deliver this plan is equally as important as what we are going to do. There is an emerging and critical role for neighbourhood health services that deliver more care at home or closer to home.

The Life Course infographic (Figure 3) shows whether certain aspects of health in Norfolk and Waveney are getting better or are declining. This plan aims to address a number of these challenges through our ambitions and objectives. There are known challenges across Norfolk and Waveney as our population is ageing and there are inequalities that must be addressed. Where people live can also be a major factor affecting both the length and quality of peoples' lives.

Our eight ambitions for improvement

1. Population Health Management, Reducing Inequalities and Supporting Prevention

2. Primary Care Resilience and Transformation

3. Improving services for Babies, Children and Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS)

4. Transforming Mental Health services

5. Transforming care in later life

6. Improving Urgent and Emergency Care

7. Elective Recovery and Improvement

8. Improving Productivity and Efficiency

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Our eight ambitions are unchanged this year, but Ambition 8 has been updated to reflect a system-wide approach to productivity and financial improvement, retaining digital and workforce as key elements within that. Expected outcomes and milestones for delivering each of the 21 objectives have been refreshed.

Prevention and self-care
The eight ambitions are of equal importance, with prevention, self-care and early intervention being integral to them all. The public health data highlights where we have room to improve, and the key message is that outcomes can improve if preventative action is taken now.

This plan continues to signal a clear shift towards prevention through education and direct intervention, looking ahead and being proactive about what can be done now and enabling and supporting those people in our local population identified as most at risk. At the same time, we will ensure we tackle some of our most pressing system challenges, such as reducing waiting times for treatment, developing the availability of dental provision, our primary care workforce and ensuring people receive the right care in the right place at the right time. This is within the context of significant financial challenges.

Alignment with partners' plans and other strategies
This plan is aligned to the Norfolk and the Suffolk Joint Health and Wellbeing Strategies and key ICS strategies in areas including Population Health Management, Health Inequalities, Clinical, Research and Innovation, Quality, Digital, Workforce and Estates. Ensuring all our strategies are aligned and complement each other will better enable us to make the improvements we are committed to. The three acute hospitals have a joint acute clinical strategy, and more information can be found on this in section 6. Both the Queen Elizabeth Hospital and the James Paget Hospital are part of the New Hospital Programme which brings an opportunity to re-size and re-configure service delivery in partnership with others. On 1 April 2025 the ICBs in the East of England become the commissioners for an additional 11 specialised services, which brings an opportunity to join up pathways of care. There is more about this in section 4.

Affordability
The ambitions and objectives in the JFP are consistent with the current medium term financial planning for our system, but our financial position as a system across our NHS partners is extremely challenging and there will be some difficult choices to make. We must live within our means and so we must ensure we enhance productivity and efficiency within everything we do. By designing and transforming services to ensure the best value for money, we will be more able to provide high quality, responsive and sustainable services for our population in the future. This will not be easy, and we will need to be agile with our change programme, balancing this with the requirements for existing commitments and significant future developments such as our new Hospital build programmes and the Electronic Patient Record.

1.0 Scope of the JFP

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1.0 Scope of the Joint Foward Plan

1.1 Introducing the JFP

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

The JFP describes how we will deliver national NHS commitments such as recovering core services after the COVID-19 pandemic and improving productivity, as well as transforming care across our eight areas of ambition. The JFP also describes how we will meet our key legal duties, and these are set out in Part 2. A number of these are also referred to within the JFP in relevant sections because they will help support our improvement and the delivery of our eight Ambitions which we set out in this plan.

This plan is predominantly about improvements in NHS services but has been developed in collaboration with partners where services are provided together.

1.0 Scope of the Joint Foward Plan

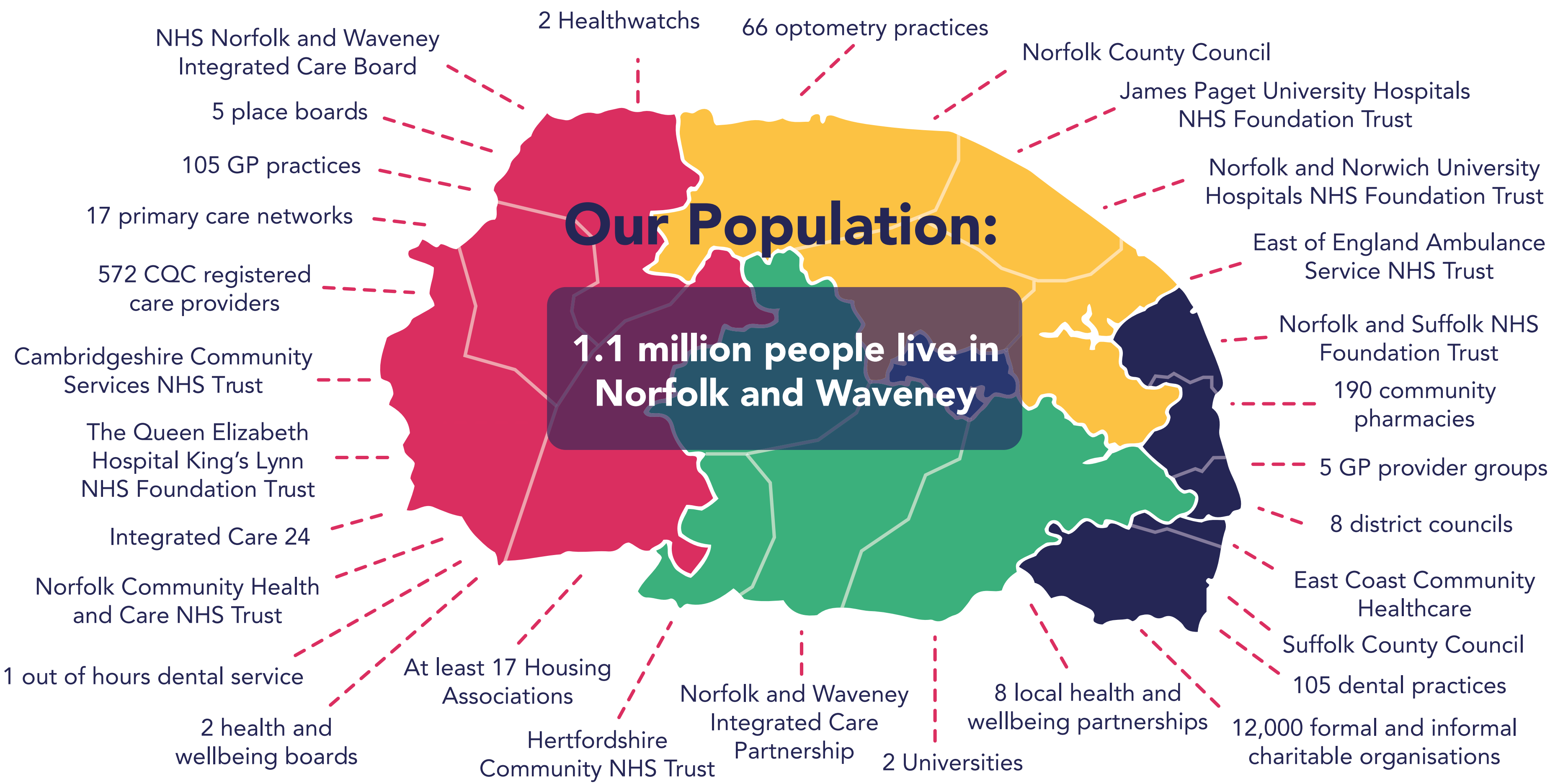

Figure 1 - Stakeholder map

1.2 Building on progress made in 2024/2025

This is our third JFP, and we refresh it each year so we have a rolling five-year programme of improvement. The plan incrementally builds on progress made in previous years with the expectation that Objectives within the Ambitions are delivered and become business as usual and we move to the next area of focus.

The eight Ambitions and the 21 underpinning Objectives are tracked according to what has been completed, is in progress and delayed. The format of the bi-annual report follows the structure of the eight Ambitions. Progress against the plan is monitored through the Commissioning and Performance Committee and is available on the ICS website. The latest progress report can be found here.

In the October 2024 report we shared several outcomes that improve experience for patients. For example, fewer patients have fallen due to the intervention of the Unscheduled Community Care Hub, a flowchart for anti-depressant prescriptions has been introduced in primary care to ensure we are not over-prescribing, and patients are regularly reviewed and offered alternatives e.g. access to NHS Talking Therapies.

There was some excellent engagement, for example with Community Voices in the Targeted Lung Checks prevention programme which is supporting uptake, with schools in the Partnership for Inclusion of Neurodiversity (PINS) pilot and Healthwatch Norfolk have supported feedback sessions on the use of the NHS App.

There is strong leadership within the system, for example the adoption and dissemination of both the Health Inequalities (HI) Framework for Action and the Population Health Management (PHM) Strategy. Support from the Integrated Care Partnership has been excellent.

Some of the challenges were and still are around capacity, for example within primary care to deliver prevention workstreams, specifically the hypertension objective (1d). Similarly, the capacity of care home and primary care staff to be fully engaged in the Transforming Care in Later Life Ambition may impact on the ability to record frailty scores.

The elective recovery Ambition 7 and Ambition 8 Improving Productivity and Performance remain challenging to deliver, which reflects the local and national position, and work in these areas continues in 2025/2026.

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

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

1.4 Link to the core purposes of an ICS

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

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

These core purposes have very good alignment with the Norfolk and Suffolk strategies referred to above. The JFP addresses these through the development of eight areas of ambition, enabled by working differently together and through some key strategic infrastructure which is explained in section 6.0. Our eight ambitions are set out below:

1. Population Health Management, Reducing Inequalities and Supporting Prevention

2. Primary Care Resilience and Transformation

3. Improving services for Babies, Children and Young People and developing our Local Maternity and Neonatal System (LMNS)

4. Transforming Mental Health Services

5. Transforming Care in Later Life

6. Improving Urgent and Emergency Care

7. Elective Recovery and Improvement

8. Improving Productivity and Efficiency

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

The ambitions are at the centre of our JFP and are set out within section 4.0.

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Case Study

Working across our system to improve medicines safety

Hayley is a pharmacist within the Medicines Optimisation team based at Norfolk and Waveney ICB. She specialises in the quality and safety of medicines use, and recently led a project that involved working across organisations to implement a change in how some patients use their medicines for epilepsy.

In November 2023, the Medicines and Healthcare products Regulatory Agency (MHRA) published guidance concerning developmental risks to unborn babies when certain medicines were taken during pregnancy. To ensure that these risks were reduced, new ways to start, monitor and review these medicines was required to be put in place, within a few months.

To comply with the guidance, a working group was quickly established with representation from hospitals (including NSFT – the mental health trust), community services, general practice, sexual health clinics and community pharmacy. A workshop was also organised to gather thoughts from clinician experts in the field.

Working together, a prescribing guideline document was produced to ensure the requirements of the alert was met. The group is now well established and has worked to ensure some of the difficulties in actioning this alert have been resolved in a timely manner. In June 2024, a further alert was released relating to another medicine but due to the previous expertise with the working group, an action plan was developed quickly.

Hayley says "previously when working on this type of projects, it has been led by a single organisation, and it has been difficult to change practice; often taking months and sometimes years to implement change. By working across the system, we were able to utilise the expertise of our healthcare professionals, but also develop this change at speed because everyone understood the importance of doing so.

Not only has this particular project improved patient safety, but is has also strengthened working relationships across our services. We continue to meet regularly and plan to change the current format into a regular medicines safety group to share knowledge and learning."

2.0 Framework for Change

2.0 Framework for Change

2.1 Five-point approach to developing our JFP

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

1. **Why** we are doing this – using our ICS Integrated Care Strategy and the Suffolk Health and Wellbeing Strategy we have set out the needs of our population using evidence, data and public engagement to compile an overall case for change to improve the health and outcomes for the people of Norfolk and Waveney. This is section 3.0.

2. **What** are our ambitions for improvement– these are our eight ambitions, with initial objectives identified. This is section 4.0.

3. **When** we expect to deliver – we have created a summary roadmap that illustrates when there will be activity happening on each ambition. This is in section 5.0. Within each objective there are detailed trajectories and milestones for implementation.

4. **How** we are going to work together differently to deliver this – these are the seven ways of working that we have agreed and are set out in section 6.0. This is a really important journey for us to go on as a system, these are our enablers, and we have some key areas to focus on – these are equally as vital as the ambitions and objectives themselves.

5. **Commitment** to achievable, measurable and impactful improvements – this is how we will know we are achieving our objectives in our first JFP. Our objectives are consistent with the Medium-Term Financial Plan, recognising capacity constraints and competing priorities. This is section 7.0.

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

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Case Study

North Norfolk Frailty Project

Frailty has been identified as a priority for North Norfolk due to a very high rate of frailty and associated risk of falls and A&E attendances from the population demographic. We were keen to look at ways to support patients to reduce their frailty risks.

From June 2024 North Norfolk patients aged 50+ who have attended A&E with a fall but not been admitted are offered a call from their District Council as part of the North Norfolk frailty pathway. Calls aim to identify frailty early and provide support to reduce, delay or prevent frailty. Types of support range from home adaptations, equipment and social prescribing to financial and housing advice. Where a health need is identified, this is passed to our Integrated Care Co-ordinators within General Practice.

Partners from Norfolk and Norwich Hospital, North Norfolk District Council, Broadland District Council, Norfolk County Council, Norfolk Community Health Care, and primary care developed the work in partnership.

Between June and December 2024, 799 patients were identified, with 248 onward referrals. Future plans for the programme include expanding eligibility criteria and shifting to anticipatory interventions.

3.0 Why we are doing this – the case for change

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3.0 Why we are doing this – the case for change

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

Prevention - 3 levels

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

For more information – Prevention | local government Association

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

NHS England > What are Health Care Inequalities?

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

For more information NHS England Population Health and the Population Health Management Programme

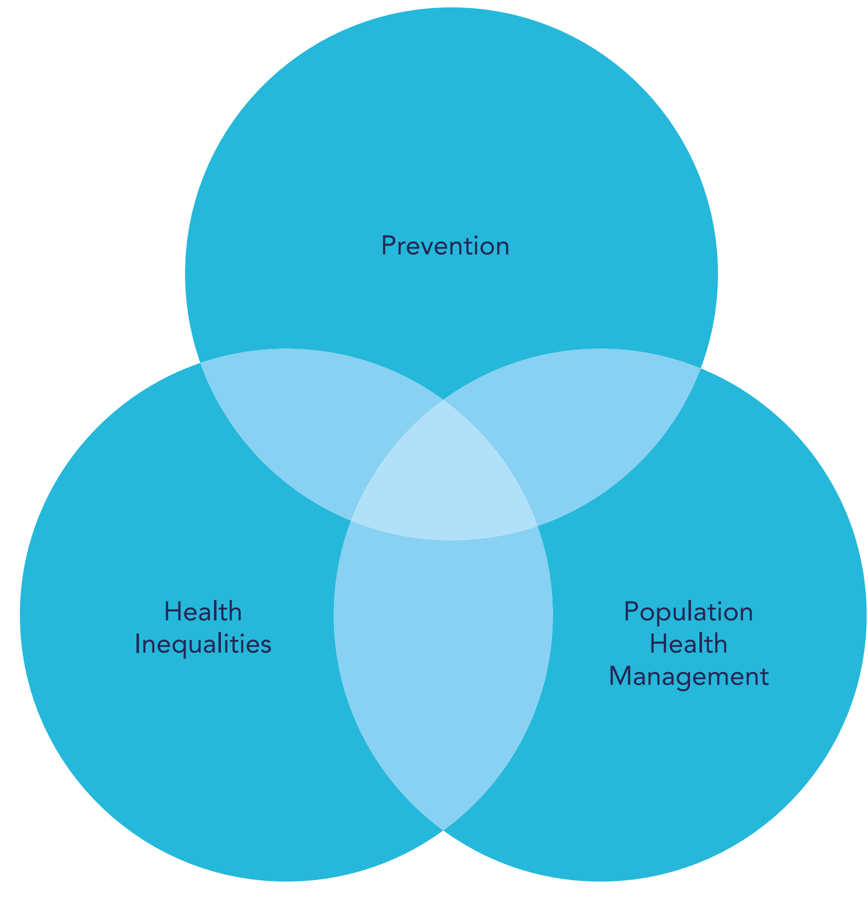

Figure 2 - PHM, Health Inequalities and Prevention

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3.1 Summary of health need for Norfolk and Waveney population

In this section we present a summary of our local population and our associated health needs using a population health management approach, which has been led by our public health team. It makes a compelling case for focusing on the ambitions we have chosen, and particularly what we can do now on prevention, to improve our health and wellbeing for the future. Let's look at some of the key facts about Norfolk and Waveney (note: numbers are rounded):

In 2023 there were **8,300** births and **12,600** deaths

In December 2024 there were **1,099,900** people registered with a General Practice in Norfolk and Waveney.

During 2023, patients attended **7,181,000** appointments with General Practice (this means that on average, each person across Norfolk and Waveney attended about 7 appointments), and **76.7%** of people have a positive experience of their GP practice

In June 2023 **83,000** children had visited a NHS dentist in the previous 12 months and **327,000** adults visited an NHS dentist in the previous two years

During 2023/2024

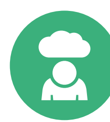
66,500 people in Norfolk and Waveney were in contact with Mental Health, Learning Difficulties or Autism services and **19,000** of these were under 18. This is over 6% of the total population and over 9% of the population under 18

A&E departments saw **294,000** attendances with **109,150** Norfolk and Waveney patients admitted as an emergency.

There were **1,152,000** hospital outpatient appointments and **200,460** hospital operations – of which **135,275** were operations for people on the waiting list

166,800 people in Norfolk and Waveney live in the 20% most deprived communities in England (known as the Core20 population)

In terms of physical health, in 2023/2024 the number of people diagnosed with long term health conditions (LTCs) include **191,900** with high blood pressure, **79,700** with diabetes, **40,500** with heart disease, **32,000** with atrial fibrillation or a common abnormal heart rhythm, **25,300** with Chronic Obstructive Pulmonary Disease (COPD) which is a lung condition that causes breathing difficulties and **82,600** with asthma.



In terms of mental health, **11,200** people are diagnosed with dementia, **10,700** people are diagnosed with a serious mental illness and **9,600** are diagnosed with depression anually

In 2022/2023 across Norfolk and Waveney there were **7,313** cancers diagnosed

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We know there are opportunities for longer term prevention. For example, there are estimated to be:

more than **100,000** smokers, more than **560,000** people overweight or obese and more than **190,000** who do not exercise

more than **87,000** people with high blood pressure that has not yet been diagnosed and managed

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

3.2 The growing population – our older population

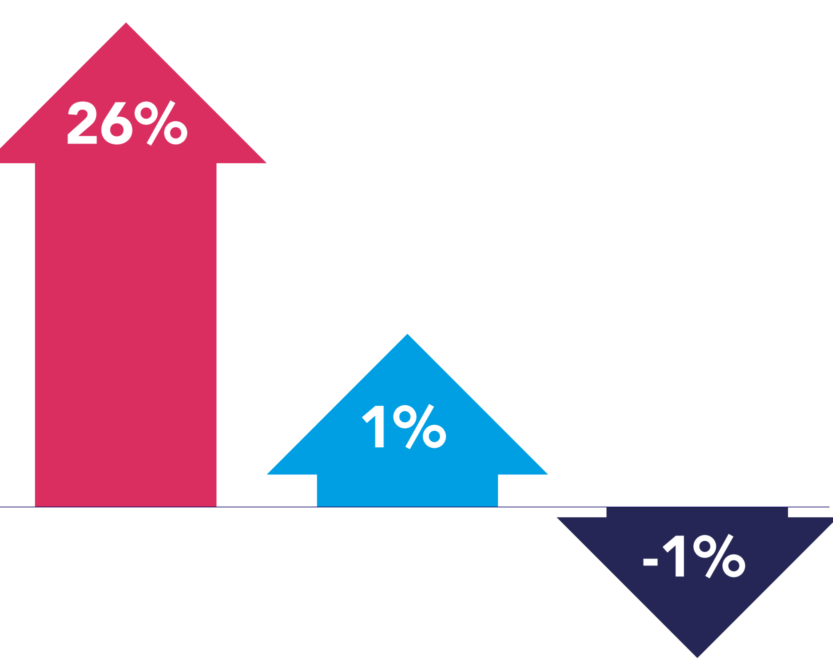
Norfolk and Waveney generally has an older population, projected to increase at a greater rate than the England average. This creates a key challenge for our health and care system and is why we have an ambition of transforming care in later life.

From 2020 to 2040 there will be an estimated:

26% increase in people aged over 65, mostly in those aged 75+

1% increase in people of working age

1% decrease in children and young people under the age of 16



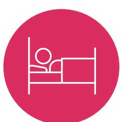
The greater increase in those in later life compared to those of working age by 2040 means that there will be fewer people of working age for every person under 16 or of retirement age, which has implications for our workforce.

Over the next five years the population is expected to grow by more than 29,000 people, and the majority will be those aged 65+. We anticipate this to continue, and by 2040 the population is likely to have increased by about 78,000 people, this is about the same as half of the current population of Norwich.

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

The demand for appointments with a GP is likely to have increased by more than a **1,000 per day**

The number of people going to A&E is likely to have increased by about **900 per month**



The number of people who have to stay in hospital having arrived as an emergency is likely to have increased by about **500 per month**

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

3.3 We can make a change

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

Preventing LTCs improves outcomes for people and reduces costs. While the impacts of health behaviour change might take longer to take effect, we can see impacts over a shorter time frame by improving other aspects of the health and care system like urgent and emergency care, mental health services, and services for families and babies, children and young people and people in later life which are all ambitions in our JFP.

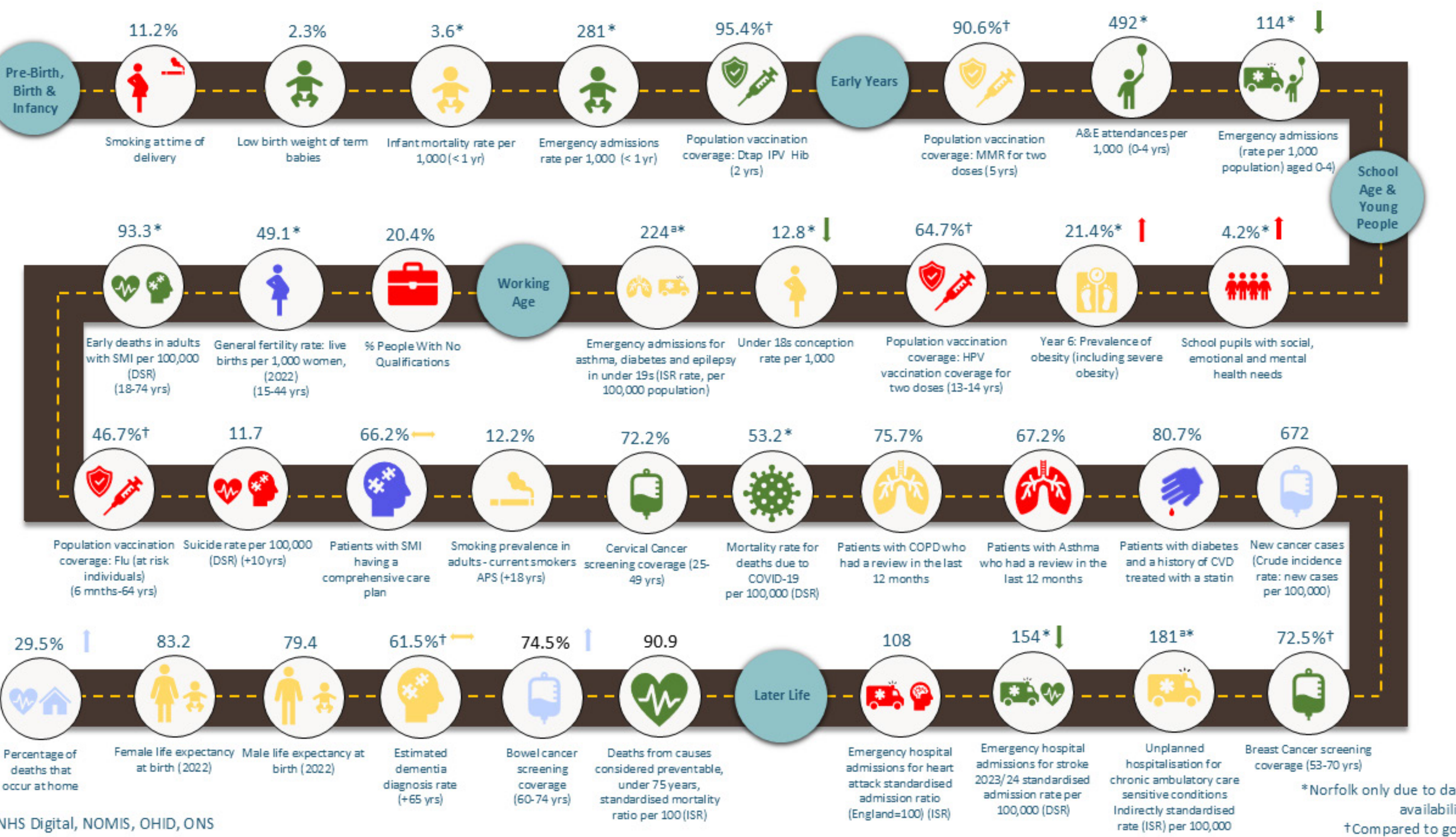
However, there are some poor outcomes or associated factors for people at different stages along their life course (Figure 3) and we want to tackle those. For example, a higher proportion of pregnant females smoke. When developing our ambitions and objectives we have carefully considered what this outcomes life course is telling us and focused on where we need to make improvements based on the evidence.

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

Outcomes along the life course for people in Norfolk and Waveney
Source: Insight and Analytics at Norfolk County Council

Arrows represent the trend (if available)
Green arrows represent getting better
Yellow arrows represent staying the same
Red arrows represent getting worse
Icon colours show how the indicator compared to the national average (if available)

Worse **No significant difference** **Better**



ª NHS OF measures are indirectly standardised to the 2012 England population structure: the ratio of actual local counts to expected (the 2012 England age rates applied to local age populations) is multiplied to the original 2012 England rate.

Figure 3 – Outcomes along the life course for people in Norfolk and Waveney

3.4 Health Inequalities

Aside from the conditions that people die from, the amount of disability or illness that people have varies according to where you live – that is a fact. In Norfolk and Waveney many health outcomes for people are as good or better than in England overall as a comparison, and males and females generally live longer lives in Norfolk and Waveney than the England average.

However, there are stark inequalities in outcomes for people in the 20% most deprived communities (known as "Core20"), that then accumulate over the life course. These result in poorer health outcomes and ultimately a shorter life expectancy.

The State of Norfolk and Waveney report 2022 shows that the 167,000 people of Norfolk and Waveney that live in some of the 20% most deprived communities in England are more likely to:

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

(Core20 and CORE20PLUS5 are explained in more detail in the legal duty to reduce health inequalities in Part 2 of the JFP, and through this link: NHS England » Core20PLUS5 – an approach to reducing healthcare inequalities).

The Core20 populations in Norfolk and Waveney are shown on the map in Figure 4 and we know that the health outcomes for the populations in our most deprived communities could be improved further. This is one of our objectives in Ambition one, Population Health Management, Reducing Inequalities and Supporting Prevention.

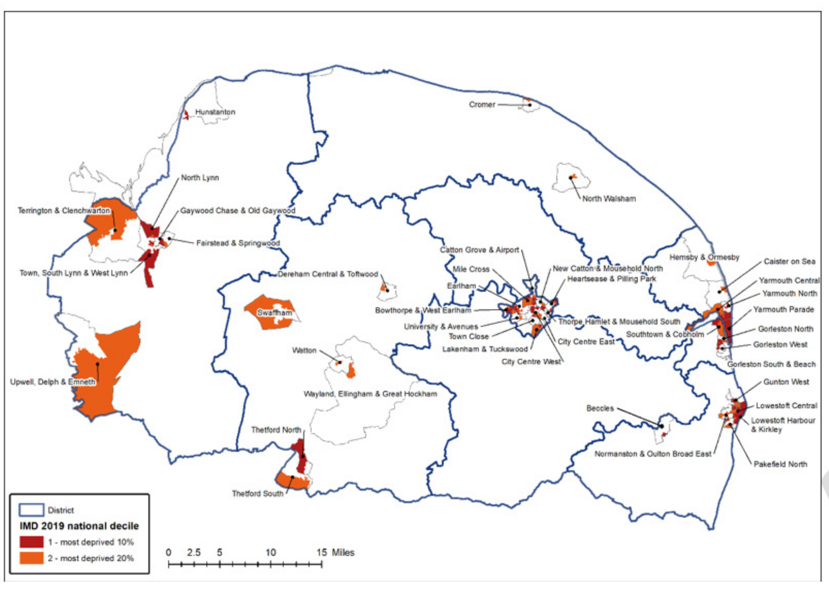


Figure 4 – "Core20" communities across Norfolk and Waveney where some or all of the residents live in the 20% most deprived areas in England according to IMD2019

Other population groups in addition to those that live in the most deprived communities are also more likely to have poor health outcomes and to die early. For example, children and young people with learning difficulties or autism and those that are looked after are more likely to experience mental health issues. According to the Norfolk Joint Strategic Needs Assessment undertaken in 2022 there is a predicted population of over 16,500 adults in Norfolk who have a learning disability, and who have an average lifespan that is over 10 years shorter than the wider population.

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

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For example, Figure 5 compares the least deprived communities with the most deprived "Core20" communities:

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

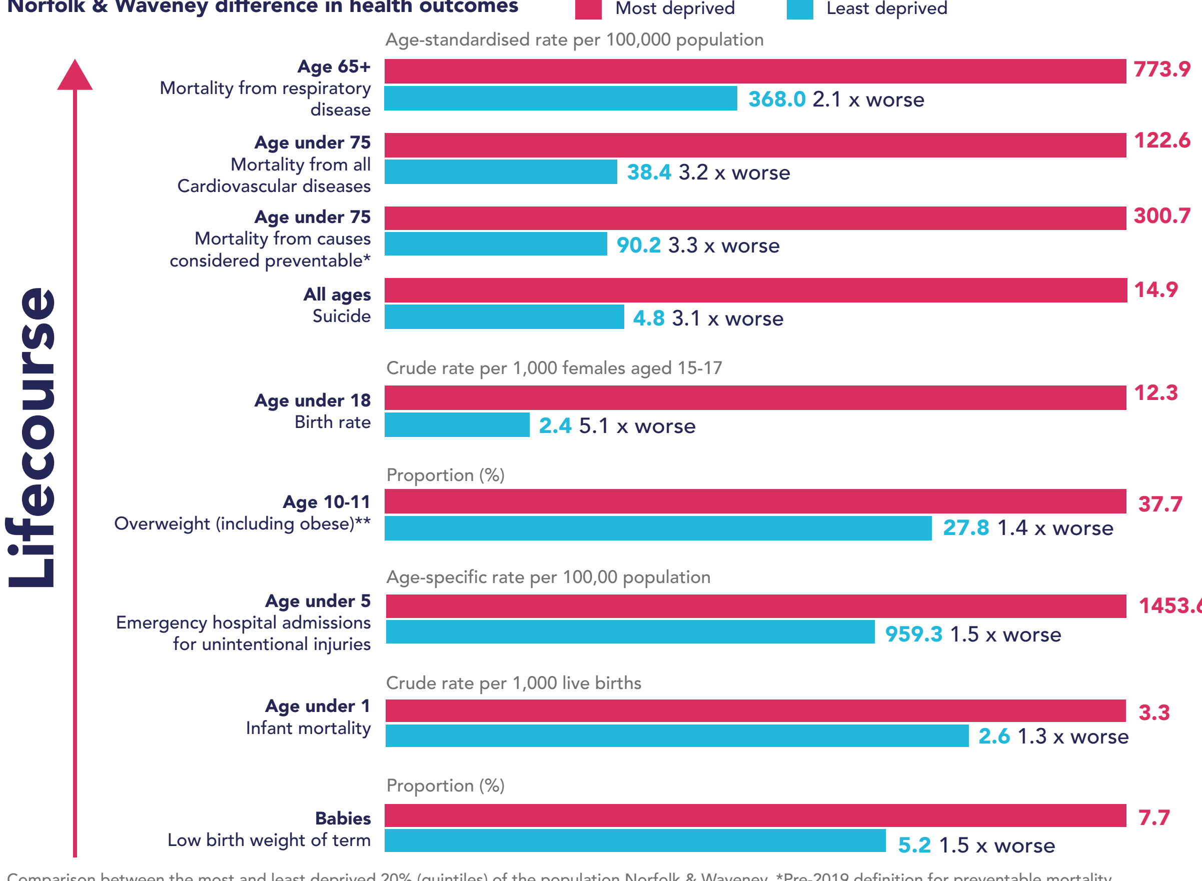


Figure 5 - Inequalities in health outcomes between the least deprived and the most deprived Core20 communities in Norfolk and Waveney

The accumulation of inequalities over the life course for those in the more deprived Core20 communities has an impact on the number of years a person is likely to live.

Across Norfolk and Waveney in 2020-2021 the gap in life expectancy between the most deprived Core20 communities and the least deprived communities was 6 years and 9 months for males and 5 years and 4 months for females.

This gap is due to more deaths in the Core20 communities from heart attacks, strokes, cancer, respiratory disease and COVID-19 (Figure 6).

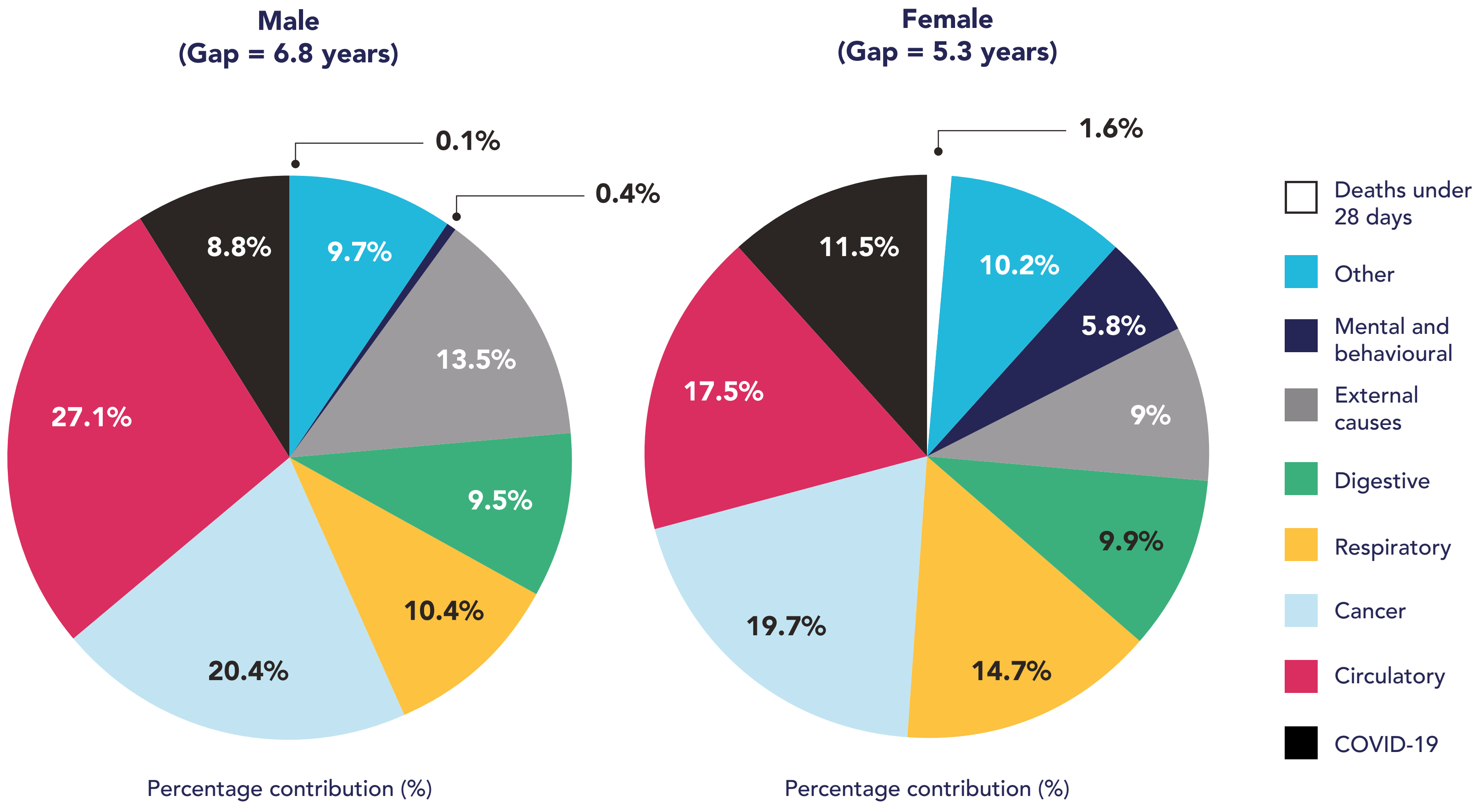


Figure 6 Breakdown of the life expectancy gap between the most and least deprived quintiles of NHS Norfolk and Waveney by cause of death, 2020 to 2021 (https://analytics.phe.gov.uk/apps/segment-tool/)

3.5 Opportunities to improve outcomes

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

Across Norfolk and Waveney just over half of all cancers are diagnosed early and while overall screening uptake is good (and this helps with earlier diagnosis), people from the Core20 most deprived communities are less likely to be screened for cancer. For example, there are 46 GP practices in Norfolk and Waveney where the proportion of people screened for bowel cancer is less than the Norfolk and Waveney average. If all these practices screened at least the Norfolk and Waveney average then an additional 3,600 people would be screened for cancer. For the Core20 most deprived GP practices this is an additional 1,400 people, which is more than a third of the total.

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

There are also opportunities to improve outcomes for people with respiratory and circulatory conditions through changing health behaviours and reducing unwarranted variation in clinical care. For example, Norfolk and Waveney has a higher prevalence of COPD than England (2.3% vs. 1.9%) and a similar proportion of COPD patients that receive a 12-month review (75%), but there is variation across Norfolk and Waveney from practices with 47% of patients with a 12-month review to practices with over 96% of patients with a review. For circulatory conditions, the Cardiovascular Disease (CVD) prevent work shows that if we were to detect and better manage 17,000 hidden cases of high blood pressure then we would save more than 100 heart attacks and more than 150 strokes over the next three years.

Due to inequality in health behaviours, the opportunities for improving outcomes are likely to be greater in the Core20 most deprived communities. As deprivation increases the proportion of people with risky health behaviour also increases. Over the long term if we are to reduce inequality in life expectancy due to cancer, circulatory and respiratory conditions, then we will have to address health behaviours such as smoking, physical activity, obesity and diet.

Opportunities to improve outcomes are not only limited to physical health conditions as there are also opportunities to improve outcomes for those with severe mental illness. For example, of the people with severe mental illness only 66% have a comprehensive care plan compared to the England average of 72%. Across the Norfolk and Waveney GP practices this ranges from under 14% of patients to 100% of patients. By at least matching the England average across Norfolk and Waveney, more than 1,300 extra people would have a comprehensive care plan with potential risk of self-harm reduced.

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

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

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

There are opportunities through:

- Primary prevention, intervening before health effects occur. For example, by changing health behaviours and vaccination.
- Secondary prevention, intervening to reduce the impact of disease that has already occurred. For example, regular patient reviews and by managing conditions appropriately.

- Tertiary prevention, intervening through surgery or similar. For example, coronary artery bypass grafting, to prolong life in some people with stable congenital heart defects that have been present from birth.

Since the first version of the Joint Forward Plan was produced the Norfolk & Waveney Population Health Management Strategy has been published. This identifies smoking and smoking in pregnancy, serious mental illness, cardiovascular disease, diabetes and respiratory conditions, early cancer diagnosis and children & young people as priorities for the system, based on joined up local data and information.

An East of England level Specialised Commissioning Inequalities review has been undertaken to inform the initial areas of focus, now that these services have been delegated to ICBs. This has identified common areas with our ICB priorities namely cancer, cardiovascular disease, mental health and neonatal / paediatric services. There is more detail about specialised services in section 4.0.

The Norfolk and Waveney Health Inequalities Strategic Framework for Action has also been developed as a ten-year plan aimed at addressing health disparities by uniting partners under a common vision to improve health outcomes for all residents.

The shift from reactive to proactive care, or sickness to prevention, will be an iterative process. However early signs show that progress is being made. Bowel and breast cancer screening coverage has improved in the last two years and COPD reviews are now similar to the England average rather than significantly below. Some outcomes are also improving, for example there are now fewer hospital admissions for stroke, which shows an improving trend, making the ICS significantly better than the England average.

3.6 Public engagement on the JFP so far

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

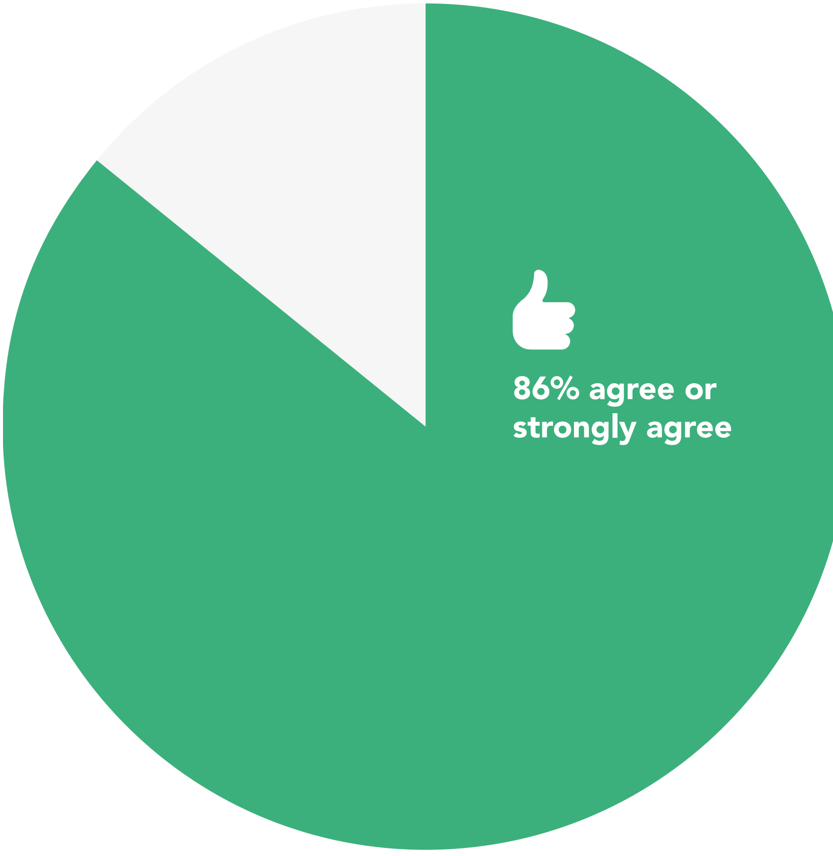
- Transforming Mental Health services
- Improving Urgent and Emergency Care
- Elective Recovery and Improvement
- Primary Care Resilience and Transformation
- Improving Productivity and Efficiency

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

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

Our online survey received 700 responses in total.

505 people out of 585 who responded (just over 86%) strongly agree or agree that we have chosen the right priorities.

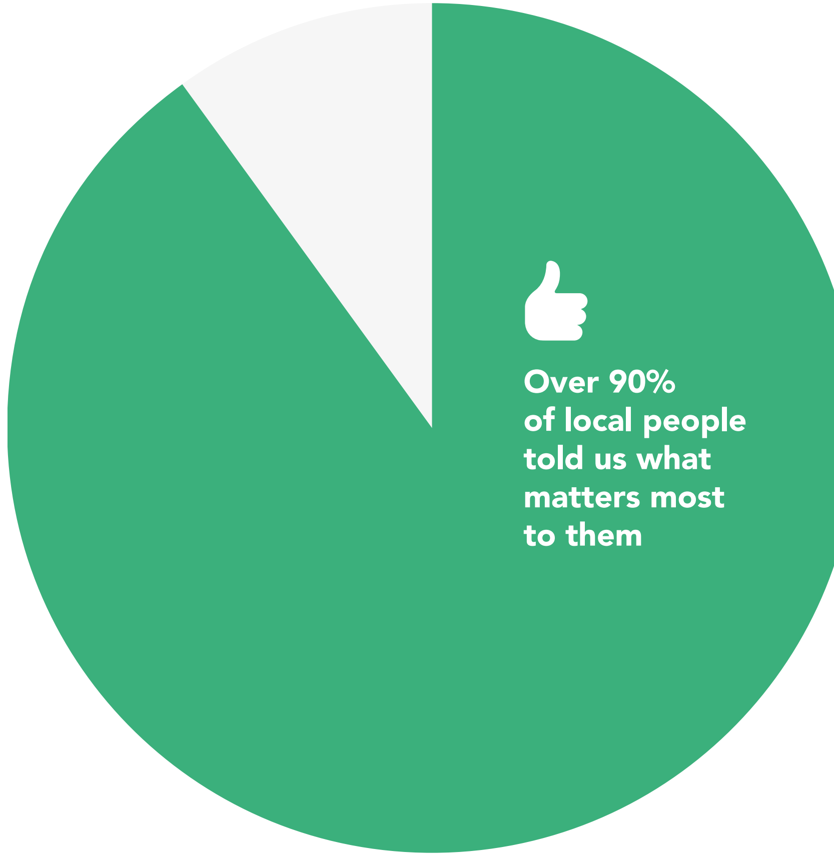


249 people also left free text comments

For example:

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

537 people out of 592 who completed surveys (just over 90%) responded to What matters most to you?



Many of the points were made again, but other issues raised include:

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

You can read the full report, including examples of the comments people made, on our dedicated webpage: Joint Forward Plan

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

Case Study

Norwich Integrated Anticipatory Care Team (INTERACT)

INTERACT is a multi-agency team providing holistic support for people whose housing or home environment is negatively impacting their health or wellbeing. It helps people achieve their goal(s) including:

- Moving to a more suitable home.
- Managing their home or garden, through cleaning, decluttering, and adaptations.
- Increasing income and reducing isolation.

Developed by Norwich Place Board and hosted at City Hall, the integrated service involves Age UK Norwich, Norfolk Citizen's Advice, Norwich City Council and Norfolk County Council. Working in an integrated way has brought challenges around data sharing and systems access, but also the huge benefits of a wide range of skills, resources, and networks to support people in a personalised way. Volunteers from Menscraft are now supporting INTERACT clients with garden clearances in allied partnership project.

INTERACT has received over 900 referrals from partners since it began in April 2022, around 80% of whom were aged 50+. Evidence demonstrates people's improved satisfaction with their accommodation, physical and mental health and reduced pressures on statutory services.

INTERACT has improved understanding about the housing issues facing older people and identified a gap around hoarding support, leading to the development of Safe Habitable Homes.

4.0 Our Ambitions for improvement

4.0 **Our Ambitions for improvement**

We have two timescales, the immediate priorities that are aligned with NHS planning requirements nationally and the next tranche of delegation of specialised services, and medium-term local improvements within our eight Ambitions, coupled with work to develop new models of care.

4.1 2025/2026 immediate priorities

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

Each year the NHS is asked to produce an operational plan detailing the activity levels, performance standards, workforce numbers and financial plans for the next 12 months. Each of these elements are triangulated to ensure consistency, for example that an increase in activity is supported by an increase in staffing, which in turn is included in the financial projections. These plans are developed together as a system, working in partnership to achieve the required aims and ambitions in the Operational Planning Guidance for 2025/2026.

The overall operational plan priority for 2025/2026 is to improve access to timely care for patients, increasing productivity and living within allocated budgets. There are many links through to the ambitions of the JFP such as:

- Improving the flow of **urgent and emergency care** patients in to and out of our services. We have said that we will work in a more collaborative way, to support community teams to respond to urgent care needs which are not life threatening but need a rapid response, which will improve how quickly emergency ambulances can respond to our most unwell patients. This in turn will reduce the length of stay in hospital, bed occupancy, and enable the emergency department to see at least 78% of patients within 4 hours; allowing ambulances to be released from waiting outside hospitals and respond to calls in the community. This is Ambition 6.
- Continue to reduce the number of people waiting for **diagnostics and elective care**. During the year the plan is to improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with all our local hospitals expected to deliver a 5% improvement against a November 2024 baseline. This and future reductions in 18 week waiting times will be achieved by working more closely together, supporting direct GP access to nationally recommended cancer diagnostic tests and utilising capacity within new system resources such as our new community diagnostic centres. This will help to improve our diagnostic performance and our 62-day cancer standard which we are being asked to improve to 75% by March 2026. This is Ambition 7.
- **Increase the amount of dental activity** by continuing to implement the key proposals set out in the national Dental Recovery Plan published in February 2024, working to deliver the additional unscheduled care appointments that are part of the 2025/2026 Operational Planning requirements. This is Ambition 2.
- Continue to **address health inequalities and shift towards prevention**. For adults this is maternity continuity of care, severe mental health checks, respiratory conditions, early cancer diagnosis and case finding and treating high blood pressure. We have identified Population Health Management priorities at a system level to address health inequalities and meet the Core20PLUS5 approach for adults and children. For adults, we have JFP objectives that focus on smoking, especially smoking in pregnancy, serious mental illness, cardiovascular disease, and early cancer diagnosis and for children and young people, asthma, epilepsy mental health and oral health. These are part of Ambitions 1, 2, 3 and 4.

- **Improve mental health and learning disability care** to reduce length of stay in acute mental health beds, increase the number of children and young people accessing services, and reduce the reliance on inpatient care for people with a learning disability and autism so they are receiving services in the community or through other ways. Ambitions 3 and 4 include objectives that are about providing alternative therapies and services, and earlier interventions provided in community settings.
- **Deliver within our financial resources and improve our productivity**, with a particular focus on reducing our spend on agency staff, reducing waste and maximising productivity. We will ensure that we continually review opportunities for improvement. This is the focus of Ambition 8.

Specialised Services

From April 2025 the ICB will receive another 11 'specialised services', legally taking on the delegated responsibility for these from NHS England. Services being delegated in 2025/2026 include specialised Mental Health and Learning Disability and Autism. The rationale for the delegation is to enable population based, end-to-end commissioning of services with decisions made closer to communities, and care provision is better joined up for the benefit of the local population of all ages.

Specialised Services support people with a range of complex conditions. They often relate to care given to people with rare cancers, genetic disorders or complex medical or surgical situations. They are provided by a relatively small number of hospitals to a small number of patients. Some of these services are provided locally at our hospitals in Norfolk but some are in specialist hospitals such as Great Ormond Street, Papworth or Moorfields for example.

The ICB became responsible for commissioning pharmaceutical, ophthalmic and dentistry services in 2023, and for 59 specialised services in 2024, with some screening and immunisation services expected to follow in future years. This is following the NHS England Roadmap for integrating specialised services within integrated care systems (2022). The six ICBs and partners are developing a work plan and longer-term strategy for the eastern region which is consistent with the JFP's that each ICB has published. Cardiac and cardiovascular, cancer and renal services have been identified as priority areas for review. Clinical input into the re-design of services within the existing available budgets with input from specialised provider collaboratives will be key and form part of the plans for improvement in 2025/2026.

4.2 Our medium-term ambitions for improvement

New Models of Care

Since the second JFP was published, Lord Darzi's report on the state of the National Health Service in England (Independent investigation of the NHS in England, September 2024) showed that NHS services are stretched to breaking point and that radical change is needed as incremental improvement will not resolve the challenges. In response, the government is developing a 10-year plan for health and care, based on three 'big shifts' they want to see in health and care, moving from:

- Hospital to Community Services: The biggest improvements to health and care will come from prioritising services outside of hospital. That means greater investment in the primary and community services that support people before they need hospital treatment.
- Treating sickness to preventing it: political focus on public health strategies that keep people healthy and prevent illness in the first place.
- Analogue to digital: Using digital technology to improve patient experience and outcomes and help deliver the ambition of moving care closer to home.

More locally, across the East of England, the NHS delivers health care to over 6.4 million people, covering a large and diverse urban and rural geography. Despite this diversity, NHS services face similar challenges of limited capacity to support an ageing population that is rapidly growing, high rates of multi-morbidity, rising demand, significant health inequalities, preventable long-term conditions, a need to better manage and co-ordinate care for improved patient outcomes and a workforce that needs to adapt to meet the future care needs of the people it serves. Collectively, these challenges are creating unsustainable healthcare costs.

There is increasing demand on healthcare services from a growing population, with increasing (national annual rate of 6.1%) prevalence of multimorbidity who need support to live well, for longer. Therefore, a different model of care is needed that provides an alternative, safe and sustainable option.

This transformative approach shifts from traditional acute care to a community-based model that enhances accessibility, patient satisfaction, and operational efficiency. Our priority is to empower people by placing access to care directly in their hands, offering user-friendly digital platforms and personalised support to navigate their healthcare journey with ease.

This regional approach, owned by all ICBs, sets out a new care model covering four areas of delivery and implementation:

1. **Digital Enablement:** Utilises electronic health records (EHRs) and telemedicine to enhance patient care, streamline data sharing, and reduce costs. Digital tools will improve efficiency, accessibility, personalised care, and patient outcomes, while also allowing patients to manage appointments and access health records online.

2. **Health Optimisation:** Focuses on prevention, early detection, and management of chronic conditions. It targets high-risk populations with personalised interventions to improve health outcomes and reduce healthcare utilisation.

3. **Acute Illness Management:** Integrates multi-disciplinary teams (MDTs), case managers, and a virtual hospital infrastructure to streamline patient care, reduce delays, and ensure seamless transitions. This model emphasises community-based acute care and reduces unnecessary hospital admissions.

4. **Advanced Illness Care:** Enhances quality of life for individuals in their last two years by providing personalised support, managing end-of-life care, and reducing hospital admissions through better community care.

We are working to develop our new local model of care to tackle the local, regional and national challenges. We have started to draft the framework that sets out our system approach to efficiency, productivity and transformation over the next five years. Alongside our other strategies and plans, this work will:

- Set out the overall vision for how the system will function and the key services that will be delivered.

- List the priorities for transformation (including Prevention and Anticipatory Care, the Neighbourhood Health Service, Acute Collaboration, End of Life Care, Ageing Well and Long-Term Conditions Management).

- Describe our ambition for these areas:

  - We will use expertise (nationally and worldwide) to help us create the very best models for our community
  - We will embed a culture of innovation and continuous quality improvement to evolve services, but we will also future proof and protect services from regular, disruptive systemic change.
  - We will start from a 2030 blank page (building up from demand, capacity and need), and then work back to fit in our current assets, existing plans and strategies and plan to fill the gaps.
  - We will balance making the necessary short-term changes and efficiencies, with the new models in mind and the aim to achieve a high performing but lower cost system.

- Describe the structures that will deliver the new models and what fundamentally will be delivered at each level of:

  - System.
  - Place.
  - Neighbourhood Health Service via our Integrated Neighbourhood Teams.

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The emerging transformation priorities are detailed below:

1

Person-centred, preventative and proactive care

Addressing health inequalities through five data-driven Population Health priority areas:

1. Smoking and smoking in pregnancy
2. Serious mental illness
3. Cardiovascular disease, diabetes and respiratory
4. Early cancer diagnosis
5. Children and young people

2

Neighbourhood Health Service

- Developed from the Community Services Review (CSR) and now a national priority
- Designed to deliver five Strategic Impacts across physical & mental healthcare in N&W - no one organisation can deliver these on their own:

1. Proactive and personalised support from integrated teams
2. Enabling healthy communities
3. Delivering more specialist care in the community
4. Meeting local and emergency care needs
5. Transforming Care in the Last Year of Life

3

Physical and mental health in secondary care

New Hospitals Programme
- Future Paget
- New QEH

Acute Clinical Strategy Priorities
- Develop person-centred services
- Integration, more care delivered out of Hospital
- Deliver care within the shortest waiting times
- Intervene early to manage poor health
- Provide reliable and sustainable services
- Reduce Health Inequalities

Mental Health Clinical Transformation Priorities
- Children, Families & Young People
- Community Mental Health
- Improve the response to people experiencing crisis
- Inpatient Care

Figure 7 – New Model of Care: Three Norfolk & Waveney Priorities for Transformation

Eight Ambitions

For our third year and until the 10-Year Plan for Health is published, we have retained our focus on the eight Ambitions. These are evidence based and consistent with what we heard from our public engagement, planning ahead to make improvements and to get ahead of the curve with prevention. We have also looked at our local population across the course of an entire lifetime, from conception to end of life, to examine outcomes to inform where improvements could be made.

Our eight ambitions are described in more detail in this section, but this is not the only work we are doing. This JFP does not describe 'business as usual must-do's'. If we were to do this, our JFP would simply be too large and complex to be useful as a delivery plan.

As system partners we all want to use this plan because it identifies common ambitions that we can all support and will help us to drive forward improvements together. This is why we have purposely selected and made a commitment to a few achievable, measurable and impactful improvements, presented in this section as objectives, linked to each of the eight ambitions.

These objectives have been developed in response to what our data tells us, and they require a collaborative system-wide approach to successfully deliver them. As we move from having plans and strategies into delivery, most of the objectives are more specific projects with defined and measurable outcomes in the shorter term.

A summary of the eight ambitions and 21 underpinning objectives is set out in Figure 8.

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Joint Forward Plan eight Ambitions and underpinning objectives

Ambition	Ambition Objective
1	**PHM, Reducing Inequalities & Supporting Prevention**
1a	Development and delivery of two strategic programmes: The Norfolk and Waveney Health Inequalities (HI) Strategic Framework for Action; and the Norfolk and Waveney Population Health Management (PHM) Strategy
1b	Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people
1c	Early Cancer Diagnosis – Lung Cancer Screening (formerly called the Targeted Lung Health Check or TLHC Programme)
1d	Cardiovascular Disease (CVD) Prevention – develop a programme of population health management interventions targeting High Blood Pressure and Cholesterol
2	**Primary Care Resilience & Transformation**
2a	Developing our vision for providing accessible enhanced primary care services, improving patient outcomes and experience
2b	Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.
3	**Improving Services for Babies, Children, Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS)**
3a	Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach
3b	Continued development of our Local Maternity and Neonatal System (LMNS), including the Three-Year Maternity Delivery Plan
3c	Implementation of asthma and epilepsy recommendations for Children and Young People
3d	Develop an improved and appropriate offer for Children's Neurodiversity
4	**Transforming Mental Health Services**
4a	We will work together to increase awareness of mental health; enable our population to develop skills and knowledge to support wellbeing and improve mental health; and deliver a refreshed suicide prevention strategy. This will prompt early intervention and prevention for people of all ages, including those who experience inequalities or challenges to their mental health and wellbeing.
4b	Mobilise an adult mental health collaborative and a children and young people's collaborative so that partners work as one to deliver better health outcomes for our people and communities
4c	Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'Integrated Front Door' so all requests for advice, guidance and help are accepted, and the appropriate level of support is given to ensure that needs are met.
4d	We will see the whole person for who they are, developing pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on dual diagnosis and Complex Emotional Needs (CEN).
5	**Transforming Care In later life**
5a	To have health, carer and support services that are fit for our ageing population - supporting people as they age, to lead longer, healthier, happier lives
6	**Improving Urgent and Emergency Care (UEC)**
6a	Improve urgent care to improve emergency response times across all organisations
6b	Expand virtual ward services
6c	Reduce length of stay (LoS) in hospitals
7	**Elective Recovery & Improvement**
7a	Effectively utilise capacity across all Health System Partners
7b	Implement digital technology to enable elective recovery
8	**Improving Productivity and Efficiency**
8a	To deliver our Medium-Term Financial Plan

Figure 8 – summary of the eight ambitions and 21 underpinning objectives

Case Study

Wellbeing hubs putting mental health front and centre of the community

Wellbeing hubs across Norfolk and Waveney are breaking down barriers and putting mental health front and centre of the community.

Dr Ardyn Ross, Mental Health Clinical Lead for NHS Norfolk and Waveney said: "Having community wellbeing hubs where people can drop in, without an appointment, to discuss their health and wellbeing and any issues that are affecting their mental health is invaluable in removing the stigma around mental health. After all we all have mental health – sometimes it's good and sometimes we need support with it to stay well."

The fifth NHS-funded hub – REST Aylsham opened in July 2024 – joining REST Norwich and Kings Lynn and Steam House Café Gorleston and Kings Lynn.

The wellbeing hubs may be branded differently but they all have one thing in common – they're a safe space for people to get support for their mental health and wellbeing in their community. This includes people experiencing significant mental distress.

With a focus on wellness, not illness, there's always a warm welcome and supportive staff to offer help, advice or a listening ear.

The Steam House Café in Gorleston – run by Access Community Trust, has been a lifesaver for Lynn White. She says: "I have a mental health problem and the staff here are absolutely brilliant. I come every day and they listen, and they are so kind and helpful. If you come in and just want to chat, you can.

"If it wasn't for this place, I'm not sure I would have coped with my health. I have dissociative disorder and I do have bad attacks and they know what to do if I have one. It's so relaxed and a perfect place to come."

Ambition 1: Population Health Management (PHM), Reducing Inequalities and Supporting Prevention

Ambition 1: Population Health Management (PHM), Reducing Inequalities and Supporting Prevention

Mark Burgis
Executive Director of Patients and Communities

Suzanne Meredith
Associate Director Population Health Management
Deputy Director of Public Health, Norfolk County Council

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

Our objectives

Delivery of two strategic programmes:

- The Norfolk and Waveney **Health Inequalities** Strategic Framework for Action.
- The Norfolk and Waveney **Population Health Management** Strategy.

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

b) Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people

c) Early Cancer Diagnosis – Targeted Lung Health Check Programme

d) Cardiovascular disease (CVD) Prevention

These three programmes are consistent with the priorities identified in the PHM strategy.

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

Why we chose these objectives
We are aiming to reduce the differences in outcomes we currently experience. We have identified initial Population Health Management priorities at a system level to address health inequalities and meet the CORE20PLUS5 priorities, which will have the greatest impact and where we know there are opportunities to improve. These are smoking, especially smoking in pregnancy, serious mental illness (SMI), cardiovascular disease, diabetes and respiratory, early cancer diagnosis and children and young people. We will also be seeking to prioritise prevention activities, particularly relating to smoking, alcohol, diet and physical activity and uptake of cancer screening and immunisations.

Objective 1a: Delivery of two strategic programmes: The Norfolk and Waveney Health Inequalities (HI) Strategic Framework for Action and the Norfolk and Waveney Population Health Management (PHM) Strategy

What are we going to do?
We have developed a Health Inequalities Strategic Framework for Action and a Population Health Management Strategy, and we will continue to deliver these two strategic programmes.

Our data and insights ensure we are clear on our priorities for targeting resources and that we are working on agreed priorities for Health Inequalities and PHM together, across the Integrated Care System.

Deliver a Health Inequalities strategic framework for Action, as a first step towards a whole system approach to reducing inequalities across our Integrated Care System (ICS), with all partners. The framework is focused around three key building blocks (including the wider factors that impact on health and well-being such as housing and the environment we live in, lifestyle and inequalities in healthcare access, experience and outcomes) and at the same time to create a strong foundation in the form of conditions for success. The Framework is overseen by the Integrated Care Partnership and several leadership groups have been established to develop and implement actions plans for our key areas (our building blocks) of focus.

Deliver a Population Health Management strategy, to proactively use joined up data and to put in place targeted support to deliver improvements in health and wellbeing. The strategy identifies five initial PHM priorities and includes plans for how we will be using data, building a PHM cycle of improvement into our work. Our approach to delivering the improvement will be at both system and at place / neighbourhood level.

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

How are we going to do it?
By working together and getting behind the priorities that have been collectively agreed by system partners and our local communities for Health Inequalities and PHM. We will be using joined up data to proactively identify prevention opportunities and groups of people who would benefit most from targeted health and care interventions.

We have a data hub in place to allow access to joined up data and the interpretation of that data and insight to support local teams to identify their own priorities. A Population Health and Inequalities dashboard is being developed to support the understanding of variation in outcomes and benchmark our system to identify areas for further focus. This approach is driven by the needs of local communities, and interventions designed to support them. This may also involve working across the ICS to plan new services or models of care in an integrated way across the ICS. Therefore, we need to have participation in the development process by the range of partners and stakeholders.

What action are we taking to address Health Inequalities as part of this work?
We have established strong ICS governance and programme management to implement the Health Inequalities Strategic Framework for Action. The Healthcare Inequalities Oversight Group is responsible for the delivery of the NHSE inclusion health framework, CORE20PLUS5 and NHS Anchor programmes of work, as well as our outreach and engagement with people and communities through a programme called Community Voices. We are undertaking a project to improve data quality in support of these programmes of work.

We are developing organisational improvement plans because of our 'Health Inequalities Commitment', with the ICB developing a plan that focuses on workforce and organisational development, processes and resources, leadership and governance and data, intelligence and voice.

The priorities in the PHM Strategy also focus on addressing the drivers for health inequalities across Norfolk and Waveney.

How are we going to afford to do this?
Resources may be needed to support ongoing projects, on an invest to save basis – each project to be considered on its own merits and evaluated.

What are the key dates for delivery?

Year 1: April 2025 – March 2026

Review as required, and continue with delivery plans and monitoring of achievement against objectives including:

- Improved ethnicity data collection in primary care.
- Development of an ICB organisational Improvement Plan, alongside ICS Health Inequalities Improvement Plan by September 2025.
- Development of an outcomes framework for Population Health and healthcare inequalities.
- Development of PHM data analytical tools to support PHM and address Healthcare Inequalities.

Year 2: April 2026 – March 2027

Continued focus on reducing Health Inequalities and opportunities for prevention, based on the data and insights in respect of outcomes and population experiences, extending our PHM approach.

Year 3: April 2027 – March 2028

A continued and targeted focus on prevention and reducing Health Inequalities and continued focus on using PHM to drive improvement across the system and inform where we focus our effort.

Year 4: April 2028 – March 2029

Review and refresh both strategic documents for the future, with refreshed objectives and trajectories.

Year 5: April 2029 – March 2030

Continued delivery of plans to address health inequalities and use data to deliver proactive interventions.

How will we know we are achieving our objective?

Delivery against the objectives in our published action plans.

Monitor progress using our Population Health and Inequalities dashboard of key measures.

Develop a programme of evaluation based on the best available data, evidence and insight to measure progress.

Objective 1b: Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people

What are we going to do?
Stopping smoking is a preventative approach to improving health for all, especially in pregnancy.

We will develop and provide specialist support that gives all pregnant women across Norfolk and Waveney the best help and advice to stop smoking at a time when they are likely to be motivated to quit, in line with the NHS Long Term Plan commitments.

Our vision reflects the nationally recommended model for stop smoking services for pregnant women and this will be provided through the development of a new midwifery led NHS-based service. Each hospital trust will have stop smoking advisers who will offer support based on what research tells us works best.

Delivery of midwifery-led stop smoking services will contribute to one of the priorities in the 10-year Health Plan that is to be published in the spring i.e. from sickness to prevention, by addressing smoking in pregnancy, which is an important underlying driver of ill-health and persistent inequalities in health.

How are we going to do it?

- The NHS working together with local authorities, service users and others through our Tobacco Dependency Working Group, Tobacco Control Alliances and the Health Improvement Transformation Group to plan how we can best make use of our shared resources and how support should be rolled out. These groups enable our smoking in pregnancy providers to come together with a range of ICS partners including public health experts, universities and researchers and the voluntary community and faith sector. This means we can take a collaborative approach to evaluating and improving quality of local support and learn from the latest evidence about what works.
- We are focusing on health inequalities to ensure that we understand access by population sub-groups (such as age, ethnicity and deprivation) and support equity of access. We will identify barriers and opportunities for improvement through an evaluation of the service one-year post implementation. This will align with Norfolk and Waveney's Health Inequalities Strategic Framework for Action and use the data improvement and monitoring dashboards to inform any targeted health inequalities improvement work, which will be developed and monitored through reporting to the Local Maternity and Neonatal System Board.

How are we going to afford to do this?
National NHS funding has been provided to help us roll out NHS tobacco support in Norfolk and Waveney.

We received national support to trial new approaches in 2024/2025 including provision of vapes and smoking in pregnancy incentive schemes. We are waiting to hear if any further national funds may be available to help continue this.

We are also working closely with local authority Public Health teams who are providing significant support to help with the delivery of NHS smoking in pregnancy services, including help with staff training, access to Nicotine Replacement Therapy and vapes and quit support for partners and other people living with service users.

What are the key dates for delivery?

Year 1: April 2025 – March 2026

- Ensure service user voice informs a review of how the services are working.
- Working with Public Health and other partners, to review longer-term support available in the community after the baby is born.
- Work with local authority and VCSE through partnerships at local community level to ensure good access to wider community support e.g. social prescribers and peer support groups.
- Explore opportunities for the use of technology to improve the support to pregnant smokers and their wider families.

Year 2: April 2026 – March 2027

Explore opportunities to enhance joined up working e.g. between tobacco advisors, antenatal teams and mental health support for women with perinatal mental health conditions.

Years 3 to 5: April 2027 – March 2030

This objective will be retired at the end of Year 3 as the maternity tobacco dependency service becomes fully established and will continue to be delivered as 'business as usual' and monitored along with other core maternity care, using the Maternity and Neonatal Safety Improvement Programme to ensure we continue to improve.

How will we know we are achieving our objective?
We will be able to measure a reduction in the percentage of women in Norfolk and Waveney who are smoking at time of delivery (SATOD).

Annual Office for Health Improvement and Disparities (OHID) data for Norfolk and Waveney for 2023/2024 showed that 11.2% of mothers were smoking at time of delivery.

Quarterly data provided by NHS Digital is available to help us track changes. Data from Quarter 2 of 2024/2025 indicates a reduction to 8.8%.

We aim to see annual SATOD rates reduce by March 2026 towards the regional and national average of 9% and to reduce further to 6% by the end of March 2028.

Ultimately, the national ambition, which we share for Norfolk and Waveney, is to become 'smoke-free' by 2030 – achieved when adult smoking prevalence falls to 5% or less.

Objective 1c: Early Cancer Diagnosis – Lung Cancer Screening (formerly called the Targeted Lung Health Check or TLHC programme)

Lung Cancer Screening is a programme designed to diagnose Lung Cancer early when treatment is more straight forward and patient outcomes are better. From April 2025, the name changes to Lung Cancer Screening to reflect the future move to a national screening programme.

What are we going to do?
Deliver a Lung Cancer Screening Programme designed to assess a patient's risk of Lung Cancer and to identify any signs of cancer at an early stage when it is much more treatable – ultimately saving lives.

The programme is being offered to people between the ages of 55 to 74 who are current or former smokers and at greater risk of lung cancer. We will initially prioritise patients in our most deprived, Core20 populations. The first phase of our expansion will focus in the more deprived GP practices in Kings Lynn and Norwich.

The programme will also incorporate smoking cessation support to encourage current smokers to quit as there is strong evidence that individuals who live in areas of high deprivation, with higher smoking rates, are likely to have particularly poor lung cancer outcomes.

How are we going to do it?

- As the programme is rolled out across Norfolk and Waveney, we will use a place-based local approach to support its promotion.
- Eligible individuals will be invited to a Lung Health Check appointment. At the Lung Heath Check a risk assessment will be undertaken which will identify if the patient is at a higher risk of Lung cancer. If the participant is at higher risk, they will be referred for a Low Dose CT scan, provided as close as possible to home. If the scan results come back with signs of anything of concern, the participant will be contacted with further information and referred for further tests and treatment. Most of the time no issue is found, but if a cancer or other issues with participant's breathing or lungs is found early, treatment could be simpler and more successful.

What action are we taking to address Health Inequalities as part of this work?
A project is underway with our Community Voices team to identify barriers that prevent access to the programme and encourage individuals from harder to engage populations to access their appointments. Learning from this project will be used to inform the approach during the expansion. A larger scale communication plan will raise awareness and encourage uptake.

Specific targeted interventions will be planned for groups where engagement in screening is difficult including prison, learning disability/autism, gypsy roma and traveller people and homeless populations.

How are we going to afford to do this?
The Lung Cancer Screening programme is funded by the National Cancer Action Team, and this is expected to continue until the system achieves 100% roll out to the baseline population in March 2029. After this it is expected that the programme will become part of the recently announced National Lung cancer screening programme.

What are the key dates for delivery?

Year 1: April 2025 – March 2026

- Finish delivering lung health checks to all individuals in Lowestoft who are in the initial target group for the programme.
- Subject to capacity, commence invites for patients who have reached the age of 55, and review the risk assessment of previously lower risk patients. Risk can change over time due to increased age and changes in an individual's life (e.g. start smoking again).
- Introduce a 'maintenance' service for Great Yarmouth and Gorleston to manage individuals who age in and move into the eligible cohort and to carry out re-risk assessment.
- Continue with follow up scans for individuals at high risk of lung cancer, every 24 months until they reach the age of 75.
- Commence roll-out to the remaining 'ever smoked' group across Norfolk and Waveney, focusing initially on areas of higher deprivation.

Years 2, 3 and 4: April 2026 – March 2029

- Continue expansion to the remaining 'ever smoked' populations in Norfolk and Waveney, including invitation of patients who reach the age of 55, and continue with 24 month follow up scanning.
- The national target is to cover the whole eligible baseline population of approximately 138,000 individuals by the end of 2028/2029.

Year 5: April 2029 – March 2030

- Support transition of the programme to a national screening programme.
- Continue to invite patients who age in and move into the cohort.
- Continue to provide Low Dose CT scanning to all high-risk patients at 24-month intervals until they age out of the programme.

How will we know we are achieving our objective?

The programme provides a range of management information monthly against our planned invites and conversion rates which is benchmarked against regional and national provision. We also provide quality assurance and audit data on a quarterly basis against the national quality standard. This includes our lung cancer diagnoses and other findings including other cancers.

	Baseline Position	**Q1**	**Q2**	**Q3**	**By Q4**
Uptake (%) of Lung Health Checks	36% at the start of the programme	45%	45%	45%	50%

(*) the national target for 2025/2026 is expected to increase to 55%, however the most recent uptake rate nationally is 47% to date, which is an increase of 2% in the previous 12 months.

Great Yarmouth and Waveney take-up is approximately 36% which is in line with expectation in populations with high levels of deprivation.

It is expected that uptake will increase when the project expands to the rest of Norfolk & Waveney.

Objective 1d: Cardiovascular Disease (CVD) Prevention – develop a programme of population health management interventions targeting High Blood Pressure and Cholesterol

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

What are we going to do?
We will provide all Norfolk and Waveney Primary Care Networks (PCNs) with real time data on their patients who have:

1) A diagnosis of CVD; or are at high risk of CVD, and

2) Risk-stratify these patients, to help Practices treat those at greatest need.

This will allow action to be taken early to prevent and reduce the negative outcomes of unmanaged CVD.

In tandem, we will be running a PHM project and contacting patients identified through a case finding tool, assisting Practices in promoting CVD prevention, and helping to reach those patients who most need intervention. There will also be some clinical input through a third-party provider to identified patients, enabling prescribing to take place.

We will seek to incorporate CVD Prevention into the New Models of Care objective following completion of the PHM project.

We will further seek to explore innovation solutions to CVD Prevention and seek to treat people earlier, out of hospital where appropriate for patients, to ensure quicker access to specialist help. Examples of this will be to increase promotion of pharmacist support for hypertension diagnosis, and technology to enable better monitoring of CVD conditions at home.

How are we going to do it?
We will be using a national audit tool called "CVD PREVENT" to benchmark our system. A digital tool will be utilised to risk-stratify and identify specific patients on practice systems.

Our PHM Team will engage with practices and will contact patients to seek to get them to discuss their care with a relevant health professional from a procured provider. Patients will also be directed to other services that can help with lifestyle changes that promote better cardiovascular health.

Local engagement will be a key component of the CVD prevention objective. Each place has different demographics and challenges, and VCSE partners. Their engagement will be key in supporting PCNs to achieve our targets.

We will scope how Primary and Community Care services could work together to prevent CVD. Given that this objective focuses on the desire to prevent CVD before community services input is required, the greater scope will be for Primary care working with other ICS VCSE partners.

We will evaluate our findings using the audit tool and as part of our Population Health management programme evaluation. As CVD PREVENT is updated on a Quarterly basis, progress can be monitored very closely.

What action are we taking to address Health Inequalities as part of this work?
Health Inequalities will be a key criterion utilised in clinical searches for identifying at-risk patients for the PHM project.

How are we going to afford to do this?
Current funding for CVD Prevention only covers the 2025/2026 PHM project. Beyond this, no new funding has been identified or allocated to support further activities which will limit progress.

What are the key dates for delivery?

Year 1: April 2025 – March 2026

Start the PHM element of the project. Provider organisation working with the ICB Protect NoW Team to contact and optimise patients.

Year 2: April 2026 – March 2027

Norfolk & Waveney metrics on CVDPREVENT to show positive impact of project, with increased rates of diagnosis of Hypertension, and better treatment to target percentages for Hypertension and Cholesterol management. Evaluation of the project.

Year 3: April 2027 – March 2028

Continual monitoring of system performance and incorporation of CVD Prevention into New Models of Care objectives.

Year 4: April 2028 – March 2029

Continued monitoring of progress.

Year 5: April 2029 – March 2030

Continued monitoring of progress.

How will we know we are achieving our objective?

In the short-term, our digital tool will enable us to track numbers of patient contacts, new prescriptions, and optimisation rates in real time.
In the longer term we would expect to see reduction in inequalities in terms of early mortality, reduction in admissions related to CVD related events.

Data will be available via CVD PREVENT to benchmark our system. Targets for treatment will follow national NHSE operational planning guidance which will be adopted once made available each year.

Ambition 2: Primary Care Resilience and Transformation

Ambition 2: Primary Care Resilience and Transformation

Sadie Parker
Director of Primary Care

"The aim is to integrate primary care services to match access with need across a wide range of services delivered by multi-professional teams. This will deliver more proactive care, preventing illness and improving outcomes, for local communities closer to home with a focus on those with the highest need."

Our objectives

a) Develop a framework and long-term plans to support.

b) Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.

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

The Primary Care Commissioning Committee monitors feedback received by the ICB together with results from patient surveys and other local intelligence. This process has highlighted timely access to services and ongoing joined up, holistic care remains a priority for our population.

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

Nationally, all primary care services are facing greater challenges than ever due to workforce shortages, alongside an increasingly complex workload. Norfolk and Waveney have an ageing workforce within general practice with approximately 30% of staff being over the age of 55. In the last 10 years, the number of dentists has declined in our area compared to the East of England region and the whole of England. This decline has a greater impact in Norfolk and Waveney due to higher levels of need, areas of deprivation and a higher number of residents in later life. Poor oral health is widely considered to be an important aspect of our general health and wellbeing and is largely preventable and can have a significant impact on quality of life, such as eating, speaking, discomfort and cause an increase in days lost from work and school. Our ambition aligns with The next steps for integrating primary care: Fuller stocktake report and the direction of travel supported by the findings published in the Darzi Report which together set out a framework for integrated care systems to work with primary care contractors to improve access, experience and outcomes for our patients and communities.

NHS England published the Delivery plan for recovering access to primary care which builds on actions designed to streamline access to care and advice. Our latest report against delivery was presented to the ICB Board meeting held in public during November 2024 and can be found here PCARP Update November 2024.

Objective 2a: Developing our vision for providing accessible enhanced primary care services, improving patient outcomes and experience

What are we going to do?
We will build on the vision and principles developed for **overarching vision for those receiving, delivering or planning primary care services** across Norfolk and Waveney by creating a framework which allows service development tailored to meet the needs of local communities.

The shared vision will underpin delivery of long-term plans (both those published and those in development) for all four pillars of primary care which are: community pharmacy, dentistry, general practice and optometry.

Long-term plans will be focused on supporting delivery against key areas, including:

- Those who need care understand how they can access what they need, when they need it within their local community.
- Those delivering care can respond to the ongoing challenges and demands they face, as part of a wider primary care group of services within their local communities.
- Those planning care do so in a way that enables everyone to play a meaningful role in accessing and providing sustainable services across primary care which is the front door of our NHS.

Long-term plans will reflect the transformation required to support the government's priorities of:

- Hospital to community.
- Analogue to digital.
- Sickness to prevention.

A **model of care framework** will be agreed to support partners who work locally at place level to consider and test new ways of organising and delivering primary care together to meet the needs of their local population. The framework will be designed to highlight interdependencies and commitments within other strategies, and map activities across all primary care long term plans to support detailed, locally owned plans for achieving better outcomes through an **integrated approach at neighbourhood level.** Joining things up and doing them together so we do them once is a key opportunity identified in the Neighbourhood Health Guidelines 2025/26.

We will build on **Pharmacy First Services** launched on 31st January 2024, the national initiative to enable community pharmacies to provide treatment, if required, **for seven common conditions** (sinusitis, sore throat, earache, infected insect bite, impetigo, shingles and uncomplicated urinary tract infections in women) as well as hypertension and contraception. With the new pharmacy contract due in 2025 we will closely monitor impact on existing pharmaceutical service, seeking to understand from stakeholders, local intelligence and available data the best strategic approach we can take to support and grow existing services.

How are we going to do it?

- We will use of available data to understand and prioritise population need.
- We will seek meaningful engagement with professionals and providers to understand the challenges they face and the enablers required to address them.
- We will listen to service users about access and experience.
- We will focus on the role of primary care in tackling health inequalities.
- We will identify opportunities for working at scale, workforce recruitment and retention, shared systems and processes and a collective approach to estates.

Integrated working across all providers at neighbourhood level will be key to planning how we move care, where appropriate, from hospitals to communities. Our strategic framework, and annual programmes of work will focus on the building blocks to enable communities to work with primary care, community and social care provides alongside council services, public health, voluntary and community and social enterprise (VCSE) sector groups.

A key pillar for primary care integration and improving access is the national Pharmacy First Scheme, introduced at the end of January 2024.

Our Community Pharmacy Integration roles will continue work to strengthen working relationships between community pharmacy and general practice. These roles help to streamline processes to provide a better experience for people accessing Pharmacy First, and other clinical services, at their local pharmacy as well as upskilling those signposting and referring into community pharmacy.

What action are we taking to address Health Inequalities as part this work?
The work going on within primary care provides a significant contribution to reducing Health Inequalities and improving the wider determinants of health. This primary care Ambition is embedded within the action plans that are delivering the ICS Health Inequalities Framework for Action, which is part of this JFP and also Ambition 1.

How are we going to afford to do this?
We will use existing funding allocations to commission services with flexibility to deliver against agreed priorities, including targeted support for identified population needs and working at scale.

What are the key dates for delivery?

Years 1 to 3: April 2025 – March 2028

- Publish/refresh long term plans for all four pillars in line with the new 10-year Health Plan for Health (expected spring 2025).
- Continue delivery against long term dental plan to improve access to dentistry services.
- Start delivery to achieve ambitions set out in long term plans for community pharmacy and general practice by April 2026.
- Agree and publish a long-term plan for optometry by March 2026.
- Start delivery against plan to achieve agreed optometry ambitions by April 2026.

Year 4: April 2028 – March 2029

These will depend on contracts for primary care contractors from April 2025 onwards and the new 10-year Health Plan.

Year 5: April 2029 – March 2030

As above.

This objective will be refreshed for Year 5 or sooner, and may be retired or replaced based on current priorities at that time.

How will we know we are achieving our objective?
Publication of a Strategic Framework for Primary Care.

Publication of long-term plans for community pharmacy and general practice.

Improve patient experience of access to general practice as measured by the ONS Health Insights Survey.
Implement Primary Care Improvement Plans in line with NSHE priorities and planning guidance for 2025/2026, including:

- Reduction in unwarranted variation.
- Increased activity for Pharmacy First, and clinical services.

Objective 2b: Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years

What are we going to do?
We are now well on the way to developing a follow-on Long Term Dental Plan and taking steps to make improvements, but there is much to do and this will take a number of years.

The Long-Term Plan will set out what we plan to prioritise and outline our aims and a more strategic piece of work over the next three years. This will enable us to develop a dental strategy, as part of the wider primary care strategy which is referenced in Objective 2a.

The Long-Term Plan has some key programmes of work:

1. Develop capacity in our dental teams through our workforce
2. Improve access for everyone, but with an initial priority on children and young people and those individuals and patient groups with greatest need
3. Promote good oral health, in our population overall but especially in children and young people

NHS England published the national Dental Recovery Plan in February 2024 setting out key proposals for implementation during 2024/2025. We are now in year 2 of this plan and will work to deliver the additional unscheduled care appointments that are part of the 2025/2026 operational planning requirements.

The Long-Term Plan and the national Dental Recovery Plan work will be co-ordinated and undertaken together where it makes sense to do so. We will develop measurable outputs and milestones to track the outcomes we want to achieve for our local population through these plans.

How are we going to do this?
By working with key stakeholders and system partners to develop solutions for securing access to NHS dental care for the whole population.

We will extend our two-year plan by another three years and publish a five-year dental strategy for Norfolk and Waveney.

- We will use all available data to understand and prioritise the immediate dental need. This may be a clinical need or a geographical need.
- We will seek interest from current dental providers to increase the number of appointments.
- We will monitor the impact these actions have to improve access to dentistry.

We will:

- Continue to engage with the profession and the ICB's 'Dental Development Group' to hear to the challenges faced by the profession and work collaboratively with system partners and key stakeholders to find solutions to improve access to dental care.
- Listen to our patients and hear about their lived experiences, to ensure our local population has access to oral health prevention advice, working with local authorities and the voluntary sector in Norfolk and Suffolk.
- Use our population health data, Dental Data Review, and ensure our approach is evidence based, balanced to meet the needs of residents, and reduces health inequalities.
- Identify steps to retain, grow and develop our local dental workforce to meet our patients' needs. We will work with our local providers to begin to build multi-skilled dental teams, including roles such as Dentists, Dental Nurses, Dental Hygienists and Dental Therapists.

What action are we taking to address Health Inequalities as part this work?
The ICS Health Inequalities Framework for Action is embedded within our Long-Term Plan. The priorities for the first two years are to focus on children and young people and in particular geographical areas within Norfolk and Waveney that have higher levels of deprivation.

How are we going to afford to do this?
We have a ring-fenced budget for 2025/2026.

What are the key dates for delivery?

Year 1: April 2025 – March 2026

Implement the first stage of the Long-Term Plan

Years 2 to 4 April 2026 – March 2029

Continue to implement the individual elements set out in the new long-term plan and wider primary care strategy with frequent monitoring of outcomes.

Year 5: April 2029 – March 2030

Develop plans and respond to provider landscape and population need.

Monitoring and evaluation will focus on:

- Improved access for our population to unscheduled care, and reduced impact on Emergency Departments and other system partners
- Improving access for our local population through management of health inequalities and for children and young people

How will we know we are achieving our objective?
Increased unscheduled care appointments in line with the 2025/2026 NHSE trajectory for Norfolk & Waveney

The number of new patients being seen and treated by an NHS dentist from April 2023 as a baseline.

Case Study

Working in the Voluntary, community and social enterprises (VCSE) sector there is so much to be gained. Meet Joe.

Joe Worsley is on a Health Leadership, Graduate Management Scheme with an interest in the charity sector and was pleased to take a flexi opportunity and work at Access Community Trust. Joe helped to develop and roll out their Customer Relationship Management system which hopes to measure the social value of the work that Access do.

The Access Community Trust's vision is to promote social inclusion for the community benefit by preventing people from becoming socially excluded, relieving the needs of those who are socially excluded and assisting them to integrate into society. Aimed at young people and adults they provide a range of services from house related support, learning, development, employment and providing support with mental health and wellbeing. With social enterprises such as the STEAM house cafes offering a safe space for those in mental health crisis day and night.

Joe says "that it is important that Access can measure the social value of the work they do, so they can demonstrate the value their work provides the Community which often goes far beyond their initial remit. This will help to secure further government funding and enable them to self-evaluate where they need to further focus their efforts, continuing to reduce health inequalities by providing essential services to customers at risk of social exclusion.

The work of Access is vital as it supports complex customers who otherwise might fall through the gaps between health and social care and multiple providers. Access can support a customer's journey from sleeping rough to temporary accommodation, permanent accommodation, and employment.

Joe says, "this placement gave me a real insight into how much value the 'third sector' can bring and how much there is to be gained by integrating the Voluntary Sector and Social Enterprises such as Access, with all healthcare providers".

Ambition 3: Improving Services for Babies, Children, Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS)

Ambition 3: Improving Services for Babies, Children, Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS)

Sarah-Jane Smedmor
Executive Director Children & Families
Suffolk County Council

Sara Tough
Executive Director Children's Services
Norfolk County Council

Tricia D'Orsi
Executive Director of Nursing,
and LMNS SRO, N&W ICB

"Our collective Ambition is that all babies, children and young people will have the best start in life, achieved through person and family centred, high quality support to enable them to 'Flourish'. We will focus on collaborative working with system partners to promote the importance of a strong start in life for children and young people. We will prioritise the voices, needs and ambitions of children and young people so they can live their happiest, most rewarding lives and meet their potential."

Our objectives

- **a)** Successful implementation of Norfolk's Start for Life and Family Hubs approach.
- **b)** Continued development of our LMNS, including the 3-year Maternity Delivery Plan.
- **c)** Implementation of asthma and epilepsy recommendations, for Children and Young People.
- **d)** Develop an improved and appropriate offer for Children's Neurodiversity.

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

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

Objective 3a: Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach

What are we going to do?
Continue to implement, embed and sustain the national Family Hub (FH) and Start for Life (SfL) transformation programme across Norfolk.

This reinforces the whole family approach to provide a single access point to family support services that is integrated across health (physical and mental health), social care, VCSE organisations and education settings.

The emphasis will be on sustaining and better integrating holistic support for families in their local community through enhancing the seven existing family hub sites. Building on the success of the past three years, year four of delivery will focus on several key elements including evidencing the impact of the support offered to families, widening the support for families with special educational needs and/or disabilities, addressing health inequalities by targeting activities and support offers and further enhancing integrated neighbourhood approaches across health, education and social care to meet whole needs of families.

Virtual services will also be available through the family hubs approach.

How are we going to do it?
Through improved data sharing arrangements and a more joined up approach to 'whole family' needs, whatever part of the system families' access.

Through FH sites and the FH network, co-located teams will be working alongside each other to provide support.

Through prioritising prevention and early intervention by providing holistic advice and guidance to families at the earliest opportunity when families engage with Family Hubs. This will also include the signposting to self-care resources, and the opportunity to link with others, including peer support workers for mutual support.

What action are we taking to address Health Inequalities as part of this work?
A significant focus of the FH and SfL programme over the past three years has been addressing health inequalities. In year four of the programme, we intend to continue to expand this offer by focussing on under-represented groups across several of our workstreams and particularly the parent carer panel. A significant focus will be placed on a 'hyper-local' approach to delivery of support with integrated neighbourhood approaches to ensure support is delivered closer to home reducing inequalities in access and the postcode lottery of service provision historically.

How are we going to afford to do this?
A fourth year of funding from the Department of Health and Social Care and Department for Education has been announced which will be in place until March 2026. Alongside this, evidence of meeting additional minimum requirements will be expected of local services.

The funding required to develop and implement the family hub and start for life approach in Norfolk is secured through a grant to the host agency, Norfolk County Council. There continues to be an added requirement for Partners (resource expertise) across the system, including within the health system, to collaborate to ensure the most effective support is in place to benefit families.

What are the key dates for delivery?

Year 1: April 2025 – March 2026

- Development of clear communications to ensure families and children understand what support is available to them and how they can access services when they need them, closer to home.
- Strengthening the network of support surrounding children and families to enable faster recognition of needs and a joined-up approach to meeting them – with a focus on developing a "think family approach" across the system.
- Increase accessibility of support, including proactive outreach to those families currently facing inequalities in access.
- Joining-up pathways and service offers within local communities to ensure families' experience of accessing services is smoother and more aligned.
- Further development of our workforce to ensure all partners, including peer supporters, can respond to the needs of families, no matter their professional background, with an ambition to only tell their story once.

Years 2, 3 and 4: April 2026 – March 2029

To be defined by local plans developed with system partners and include sustaining the transformation programme beyond the extended funding period.

Year 5: April 2029 – March 2030

The objective will be retired as it will become business as usual.

How will we know we are achieving our objective?

The programme team is currently working with the DfE/DHSC to ensure impact associated with the first three years of this transformation programme can be showcased and sustained into year four.

At a local level a performance measurement dashboard has been developed to track the identified KPIs across the programme and for each individual work strand and this will continue to be refined throughout the next 12 months, for example:

1. Feedback from families on Start for Life and Family Hubs offer (e.g. inclusive, 90% accessible, co-ordinated approach, greater connection through services, easier to navigate access services).
2. 90% access integrated referral pathways tell story once and 90% of families access the advice, information and guidance they need feedback from parent and carer panel feedback.
3. More Practitioners across agencies work in a whole family approach (data single view – data sharing agreements).
4. Families receiving help to manage financial challenges (measured through Department of Work & Pensions advisors embedded in Family Hubs).
5. Families accessing non funded services.
6. Parents accessing Start for Life and Family Hub services have improved understanding of the contribution to child's wellbeing, achievement and school attendance. Measured increase in number of families receiving support and increase in school attendance.
7. Families with SEND receive early support reducing escalation measured through reduction in Education Health and Care Plan (EHCP) and needing access alternative provision.
8. Improved health and development outcomes for babies and children with focus on most deprived 20% of Norfolk population (measured by aligned public health outcomes).

Objective 3b: Continued development of our Local Maternity and Neonatal System (LMNS), including the Three-Year Maternity Delivery Plan

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

NHS England published a three year delivery plan for maternity and neonatal services in Spring 2023. It sets out four themes that underpin how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. 2025/2026 is the third and final year of the delivery plan and is cross referenced in the 2025/2026 Operational Planning guidance.

There is a Norfolk and Waveney action plan that sets out how we will deliver the themes within the delivery plan, and this is reported to the Commissioning and Performance Committee. These are embedded into the work of the LMNS through programme delivery in transformation, quality and safety, strategy and business as usual. Good progress has been made on filling maternity workforce vacancies as part of the delivery plan, reducing from 9% to 0.5% over the past two years.

The JFP talks about the importance of enabling functions and digital is a key enabler for this Objective. Go-Live of the Electronic Patient Record (EPR) will support health care professionals and women and their families when they move location and are in touch with different parts of the health care system. This will align with the analogue to digital aim of the 10-year Health Plan that we expect to see published in the Spring.

How are we going to do it?
Beyond the three-year delivery plan there are transformational ideas emerging from the fledgling Speciality Clinical Network (SCN) for Perinatal care. This is looking at a shared vision for services and will test out service model options for new models of care / pathways, best practice and joint business planning across the three acute hospitals to begin with, and then with other partners outside the hospital setting. The SCN is taking a data led approach and both the LMNS and the SCN are committed to working together to transform services. This collaborative way of working is described more broadly in Section 6 of the JFP and SCNs are an enabler in the delivery of the Acute Clinical Strategy.

The LMNS will continue to oversee the quality and safety of maternity services. We will share learning and development, informed by the experiences of people using maternity services. This will include access to postnatal physiotherapy and a focus on reducing in smoking during pregnancy, which is an objective within Ambition 1. We will continue to work with the Family Hubs that are also part of this Ambition 3. We will ensure our Maternity and Neonatal Voices Partnerships (MNVPs) are representative of the population and the LMNS can evidence continued co-production with service users of service improvement.

What action are we taking to address Health Inequalities as part of this work?
Our LMNS equity and equality action plan Maternity Equity and Equality - Norfolk and Waveney ICS is a five year plan that will be monitored, reviewed and updated to ensure:

- Equity for mothers and babies from Black, Asian and Mixed Ethnic groups
- Those living in the most economically deprived areas
- Race equality for staff
- Development of co-produced equity and equality action plans to support the CORE20PLUS5 approach.

How are we going to afford to do this?
The Local Maternity and Neonatal System will work together to ensure best use of available funding including additional allocations from previous years.

What are the key dates for delivery?

Year 1: April 2025 – March 2026

- Continue to implement the Three-Year delivery Plan for maternity and neonatal services.
- Progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury.
- Commissioning review of LMNS services.
- System working with the Norfolk & Waveney Acute Hospitals Collaborative Speciality Clinical Network (SCN) for Perinatal Care.

Years 2 to 5: April 2026 – March 2030

- EPR Go Live for maternity.
- Service delivery in partnership with the acute SCN for Perinatal Care.

How will we know we are achieving our objective?

Implementation of the Three-Year delivery plan for maternity and neonatal services.

Objective 3c: Implementation of asthma and epilepsy recommendations, for Children and Young People

What are we going to do?
We will work alongside clinically led professional networks to implement the recommendations of two bundles of care:

1. Asthma
2. Epilepsy

Asthma: We are committed to enhancing asthma care for children and young people (CYP), with a particular emphasis on addressing disparities in the most deprived areas and ensuring the inclusion of health groups that are often underserved. Our approach will include exploring and implementing evidence-based strategies to improve service delivery and intervention outcomes. A key focus will be on improving inhaler technique through new equipment and education programmes, ensuring that CYP and their families are equipped with the knowledge and skills to use inhalers effectively and in turn, reduce the reliance on reliever medication.

Epilepsy: We will prioritise access to psychological support (subject to funding), to continue supporting the mental health and emotional needs of CYP with epilepsy, and their families. We will also work to increase awareness of epilepsy to reduce stigma, improve early recognition of symptoms, and promote understanding of the condition. We are committed to improving the support available to children with epilepsy and their families by expanding access to educational resources, coordinating care across healthcare and education systems, and offering practical guidance to empower families in managing the condition effectively. These efforts aim to ensure holistic, inclusive, and equitable care for all individuals affected by epilepsy, fostering improved health and quality-of-life outcomes.

This links to CORE20PLUS5 which is explained in section 3.4. Asthma and Epilepsy are two of the '5' focus clinical areas.

How are we going to do it?
We will expand the collaboration achieved in year one and work alongside Place based leads to drive forward plans using local teams and expertise.

We will continue to support children with asthma and epilepsy to access activities within their communities and remain well while doing so through delivery of better care across clinical and non-clinical services, including access to condition specific training.

We will continue to support improved independence to self-manage conditions and access to skilled advice and support to keep children out of hospital.

What action are we taking to address Health Inequalities as part of this work?
We are committed to addressing health inequalities for CYP in the most deprived quintiles and ethnic minority groups who often face barriers to care. We plan to develop strategies to ensure that services and interventions are tailored to meet the specific needs of these groups.

How are we going to afford to do this?
We will work with partners to understand the resource that is available and seek to align this to deliver the most effective outcomes.

What are the key dates for delivery?

Year 1: April 2025 – March 2026

- Seek to extend psychological support for CYP with epilepsy in the NNUH & QEHKL.
- Undertake a comprehensive review of the psychological support offer available for long-term conditions. Evaluate the effectiveness of current provision, identify gaps and ensure an equitable service.
- Seek to increase specialist nursing capacity across trusts.
- Seek to implement agreed care pathways across epilepsy services.

Years 2 and 3: April 2026 – March 2028

Seek to implement a sustainable psychological support offer for CYP with long-term conditions.

Year 4: April 2028 – March 2029

To be defined by local plans developed in collaboration with system partners. At this point the Objective may be business as usual.

Year 5: April 2029 – March 2030

To be defined by local plans developed in collaboration with system partners. At this point the Objective may be business as usual.

How will we know we are achieving our objective?

- Decreased hospital admissions for asthma for young people aged 10-18.
- Decreased hospital admissions for epilepsy for children and young people aged 0-19.
- Reduction in the use of reliever medications.
- 20% of CYP from deprived areas have asthma care plans in place.
- Link for indicators.

Objective 3d: Develop an improved and appropriate offer for Neurodiversity

What are we going to do?
Through a collaborative of system leads responsible for children's services, we will formally review and improve the clinical and non-clinical offer of support for our neurodivergent population.

This programme will:

- Improve data monitoring and intelligence.
- Improve pathways to support for assessment, and treatment.
- Identify and address skills gaps in the existing education, health and care workforce.
- Improve quality of clinical pathways.
- Improve access to evidenced based information and advice.
- Increase access to support for mental health needs.

How are we going to do it?
We will increase awareness of health inequalities for neurodivergent young people.

We will work with organisations that see patients to improve data monitoring and reporting for autistic young people accessing their services.

We will improve governance of this programme of transformation through the system collaborative for CYP.

We will develop a joint plan for action to reduce waiting times, integrating process improvements and innovative service delivery models.

We will test the delivery of whole-school approaches to support neurodiversity and expand if proven effective.

We will provide tools to self-manage conditions and access skilled, high-quality advice and support to reduce the need for specialist interventions.

We will work with parents and carers to ensure those with lived experience are involved in the co-production of improved services.

We will introduce a digital offer of support and training, enabling universal services to provide better support to children and young people.

We are committed to improving the quality of clinical pathways by incorporating the latest evidence-based research into treatment protocols and support strategies.

We will enhance training and upskilling initiatives for the education, health, and care workforce to embed high-quality, innovative practices into everyday service delivery.

We will co-produce services with parents, carers, and stakeholders, and evaluate the effectiveness of innovative practices, such as whole-school approaches to neurodiversity.

We will enhance data monitoring and intelligence to guide quality improvements and ensure strategies are informed by robust evidence.

What action are we taking to address Health Inequalities as part of this work?
We will actively raise awareness of the disparities in health outcomes for neurodivergent young people, ensuring these inequities are prioritised and addressed within the broader system.

Improving data monitoring and reporting: By collaborating with organisations that see and support neurodivergent young people, we aim to enhance data collection, monitoring, and reporting to identify and address gaps in service provision.

Engaging with Lived Experience: Working closely with parents and carers, we will co-produce solutions that reflect the lived experiences of neurodivergent young people and their families, ensuring interventions are equitable and meet their needs.

Improving Access to Support and Services: We will provide tools and resources to self-manage conditions, reduce reliance on specialist interventions, and increase access to high-quality advice and support.

Testing Whole-School Approaches: Pilot programmes in schools will address neurodiversity inclusivity at the community level, ensuring every child receives the necessary support regardless of background or location.

How are we going to afford to do this?

This Objective is funded within existing resources and supported through a process of prioritisation.

What are the key dates for delivery?

Year 1: April 2025 – March 2026

- Implement changes to commissioned pathways.
- Launch pre-diagnostic and training offer for families and Education settings.
- Evaluate Mental Health offer pilot.

Year 2: April 2026 – March 2027

Use evaluation and learning to develop the future service.

Years 3, 4 and 5: April 2027 – March 2030

To be defined by local plans developed in collaboration with system partners.

How will we know we are achieving our objective?

- Improved patient experience evidenced through feedback with families.
- A reduction in waits to specialist services.
- Increase in 'appropriate' referrals to services.
- Reduction in complaints regarding barriers to accessing care.
- Number of unique users of the digital library.

Outcomes

- Improved experiences for children and young people of health and care pathways.
- Improved attendance at school.
- Improved access to digital resources online and accepted referrals for sensory needs.
- Improved access to specialist advice and therapy through increased interventions.
- Improved access to assessments of need.
- Improved access to universal training for non-clinical professionals and parents/carers.

Case Study

Your Health Improved – Falls Prevention

This project relates to the Ageing Well agenda focused on preventing falls in Great Yarmouth. The Great Yarmouth Health and Wellbeing Partnership (GYHWP) were allocated funding as part of the Improved Better Care fund in 2022/2023. GYHWP partners identified a high rate of hospital admissions related to falls yet very little physical activity provision locally for residents from a preventative approach to reduce the risk of falling.

Your Health Norfolk were awarded funding equating to £24,500 to develop and deliver a series of exercise classes focusing on increasing functional fitness such as strength, mobility and balance using the communal rooms across the borough of Great Yarmouth.

A total of 216 residents aged between 50 and 85 attended the classes and over 85% of these participants showed improvements in the Sit-to-Stand, 4-Stage Balance and Short Falls Efficacy tests. Feedback from residents has been incredibly positive, the project has continued beyond its initial funding with two classes still being delivered at Shrublands Adult and Youth Centre with participants paying to attend. A further venue is currently being identified in the north of the borough with an additional £4000 awarded to subsidise places for new participants.

Ambition 4: Transforming Mental Health Services

Ambition 4: Transforming Mental Health Services

"Our aim is to ensure that people of all ages can access timely and responsive support for all their emotional wellbeing and mental health needs. Working together with partners across health, care, VCSE and our experts with lived experience, we will offer person centred care at an earlier stage, and provide services that are compassionate, holistic, and responsive guiding people towards better mental health".

Tricia D'Orsi
Executive Director of Nursing

Jossy Pike
Executive Director of Strategic Transformation

"We look forward to being equal partners in the implementation of the JFP, using lived experience insight to ensure better mental health outcomes for everyone. The JFP will be delivered alongside existing services and builds on current and ongoing improvement plans. We hope the JFP will lead to joined-up, timely, ongoing care and personalised support for the people in our communities. Including addressing mental health inequalities for people who have little or no support. We hope the JFP will mean more people, including unpaid carers and staff, are more connected to wellbeing support and the right care for them."

N&W ICS Mental Health Transformation Expert by Experience Reference Group, May 2023

Our objectives

a) We will work together to increase awareness of mental health; enable our population to develop skills and knowledge to support wellbeing and improve mental health; and deliver a refreshed suicide prevention strategy. This will prompt early intervention and prevention for people of all ages, including those who experience inequalities or challenges to their mental health and wellbeing.

b) Mobilise an adult mental health collaborative and a children and young people's collaborative so that partners work as one to deliver better health outcomes for our people and communities.

c) Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'integrated front door' so all requests for advice, guidance and help are accepted, and the appropriate level of support is given to ensure that needs are met.

d) We will see the whole person for who they are, developing pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on dual diagnosis and Complex Emotional Needs (CEN).

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

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

- They want to be empowered to access intervention and holistic wraparound care, which supports long-term recovery.
- They want to "experience person-centred care, and be treated as an individual, rather than as a diagnosis".
- They want choice in how care is delivered and a focus on "what matters to me", instead of "what's the matter with me".
- They want their diagnosis to be only one part of their health journey. Their other physical and/or mental health conditions, as well as life events, may impact on their current state, which needs to be considered.

Children and young people have developed a Mental Health Charter and have told us that what matters to them is that services will care, staff will support and be well supported themselves, the right help, right time, right way, treatment will be personalised to meet individual needs, communication will be effective and young people will have a voice.

Why we chose these objectives

Mental health conditions can have **a substantial effect on all areas of life, such as school or work performance, relationships with family and friends and the ability to participate in the community**. People with mental health conditions often experience human rights violations, discrimination, and stigma. Key vulnerable groups who may be affected by poor mental health include children, young people and families, people who experience long term conditions and men experiencing financial and economic constraints and/or relationship breakdown. Improving the offer of proactive and preventive support is a priority outcome for this ambition, where we aim to intervene quickly and broaden the range of specialist support offers to enhance recovery.

Objective 4a: We will work together to increase awareness of mental health; enable our population to develop skills and knowledge to support wellbeing and improve mental health; and deliver a refreshed suicide prevention strategy. This will prompt early intervention and prevention for people of all ages, including those who experience inequalities or challenges to their mental health and wellbeing.

What are we going to do?
There are three priority activities:

1. Develop a structure for mental health literacy, to enhance and expand skills and knowledge on emotional wellbeing and mental health.
2. Co-produce, implement and promote tools and capacity to support good mental wellbeing.
3. Co-develop a refreshed Norfolk and Waveney Suicide Prevention Strategy and action plan.

How are we going to do it?
Building on the targeted grant programme for vulnerable groups and the health promotion campaign 'Take 5', we will develop two complementary workstreams that will empower our people and communities to look after and improve their wellbeing:

A community mental health literacy workstream will be developed to inform our workforce, people and communities about wellbeing and mental health. This will promote activities to keep people well and enable them to access services if needed. Training and resources will be aimed at:

- Increasing skills to recognise and address wellbeing concerns.
- Enabling individuals to effectively manage their own wellbeing.
- Building capacity across the wider system, including in the VCSE sector to manage wellbeing within the community.

This will build on existing approaches focussed on children and young people.

Mental Health Literacy activity and related plans to improve population mental health resilience, are in progress. Activities are underway to establish a set of wellbeing measures to support this work, and this will provide our workforce, people and communities with the tools to increase and maintain wellbeing; focusing on a range of wellbeing initiatives such as a targeted sleep campaign to provide practical solutions in managing mental health and wellbeing.

These commitments work with existing prevention initiatives such as digital wellbeing tools, support for schools and families, Family Hubs, Community Wellbeing Hubs and NHS Talking Therapies.

The Suicide Prevention Partnership has co-produced a refreshed five-year Norfolk and Waveney Suicide Prevention strategy, with anticipated key themes for action around Self Harm, Bereavement and Primary Care pathways for people with depression – as informed by audits. We continue to raise awareness, deliver campaigns to reduce stigma, provide accessible training, and invest in community support for at-risk groups. There is commitment to continue monitoring outcomes through Suicide Prevention Audits, and real time surveillance on self-harm and suspected suicides.

What action are we taking to address Health Inequalities as part of this work?
The entire focus of this objective - improving mental health literacy, to enhance and expand skills and knowledge on emotional wellbeing and mental health; implementing and promoting tools and capacity to support good mental wellbeing; and contributing to delivery of the Norfolk and Waveney Suicide Prevention Strategy, is designed to address the health Inequalities experienced by communities across Norfolk and Waveney that are currently underserved, across all three objective deliverables.

How are we going to afford to do this?
We continue to explore opportunities to use existing resources to deliver this provision, which has impacted on timescales to date. We will seek to identify what can be achieved through improved partnership working at no/low cost and scope where additional resource would improve delivery.

What are the key dates for delivery?

Years 1 and 2: April 2025 – March 2027

- Plan implementation of Mental Health Literacy Programme.
- Begin implementation of the targeted workstreams in the action plan of the refreshed suicide prevention strategy.

Year 3: April 2027 – March 2028

- Implement the resilience framework and deliver initiatives i.e., impact of sleep and tools to improve sleep quality, and continue to deliver mental health literacy.

Year 4: April 2028 – March 2029

- Review the suicide prevention strategy.
- Evaluate the jointly funded suicide prevention programme.

Year 5: April 2029 – March 2030

- Implement actions based on evaluation of joint funded initiatives.
- Continuous improvement of the Mental Health Literacy programme.

How will we know we are achieving our objective?

There will be a measurable change in self-reported mental wellbeing – the number of people reporting high anxiety, low happiness and low worthwhile scores.

Rates of suicide and self-harm will decrease.

Objective 4b: Mobilise an adult mental health collaborative and a children and young people's collaborative so that partners work as one to deliver better health outcomes for our people and communities.

What are we going to do?

- Further integration into the wider Adult MH programme of work.
- Establish a Children and Young People (CYP) system.
- Collaborate and participate in the Suffolk Mental Health.
- Collaborate to help plan services for CYP in Waveney.

Adult Mental Health System Collaborative

Identify opportunities to work collaboratively, using available data, intelligence, and insights, which focus on improving mental health and wellbeing of adults and older people.

Children and Young People System Collaborative

Implement the Thrive model through close working between the Norfolk and Suffolk MH CYP collaboratives, which are on a county council footprint. Making the structural, operational, and cultural changes required to deliver community based multi-disciplinary teams, working across organisations, to ensure collective support to meet the emotional wellbeing, mental and physical health needs of the child or young person and their family.

How are we going to do it?

Embedding a new approach that:

- Focuses on early intervention and prevention – moving the resource and support further upstream, providing support to more people at an earlier stage and freeing up specialist support.
- Focuses on 'place' and the development of support within local communities – with less reliance on specialist settings, clinics, or institutions.
- Moves away from a focus on a clinical model to one which builds understanding and resilience of community-led early support, and which develops the skills and resources of people, families, and communities to help themselves.

What action are we taking to address Health Inequalities as part of this work?

We will review our pathways against the most recent evidence and guidance to improve quality and ensure that health inequalities are reduced by understanding gaps and barriers to access. We will work with under-represented groups to ensure equity of access.

How are we going to afford to do this?

We intend to make use of existing resources in a different way. For example, existing community-based teams would be upskilled to support people and families with early dementia, which will free up capacity within the specialist teams to support people with more complex needs and reducing the existing specialist waiting lists. This process will be repeated for other conditions and for children and young people too.

Through a collaborative approach, system partners working with children and young people will seek to align collective resource to reduce duplication, increase quality and value and strengthen services. A collective focus on early help and prevention will support a 'left shift'.

What are the key dates for delivery?

Year 1: April 2025 - March 2026

- Integration into the wider Adult MH programme of work and associated governance structure; reviewing the membership and ToR of the MH Strategic Oversight Board, and potentially the sub-groups that feed into it.
- Continued checking back with adults with mental health needs, and children, young people and families with emotional wellbeing, mental and physical health needs that the transformed services are meeting their needs.
- Following contractual considerations, consider movement towards a more provider-led collaborative/alliance approach across both Norfolk and Suffolk.
- Further develop the CYP System Collaborative to include associated priority areas including support for neurodiversity and Special Educational Needs and Disabilities.
- With partners, review CYP system governance to embed CYP System Collaborative approach in Norfolk and Suffolk.

Year 2: April 2026 – March 2027

- Continued integration of services within mental health and wider system pathways, so that people have their wellbeing and mental health needs met seamlessly.
- Embedding delivery of the adult mental health programme, through the Objectives in this Ambition.

This objective will be retired at the end of Year 2 and become business as usual within the Adult MH programme of work.

How will we know we are achieving our Objective?
Access to support is streamlined, responsive and coordinated for:

- Adults with mental health needs.
- Children or Young Person with emotional wellbeing, mental and physical health needs.

Services will be inclusive and responsive to all children and young people with a particular focus on support neurodivergent individuals and their families.

The impact will be measured by actively seeking feedback from our people and communities, families and carers, and workforce, before and after any change that is implemented.

We will see an increase in the numbers of children accessing mental health support at an earlier stage and a reduction in admissions to inpatient provision.

Objective 4c: Establish a Children and Young People (CYP)'s Emotional Wellbeing and Mental Health "Integrated Front Door" so all requests for advice, guidance and help are accepted, and the appropriate level of support is given to ensure that needs are met

What are we going to do?
We have launched an Integrated Front Door (IFD) to support Children and Young People (CYP) aged 0-25 years with an emotional wellbeing or mental health need to access the right support at the right time. This will be a 'needs led' single integrated access point for all emotional wellbeing and mental health enquiries and requests for support. Following consultation with CYP and families this new service will be called "Norfolk & Waveney access to mental health advice and support 0-25yrs". The aim is that children and young people and their families will have immediate guidance and/or timely support based on an understanding of need, to allow them to flourish.

It will provide:

- **Self-Care** support, through digital resources and tools, including guided self-help, with a 'request for support' process that automatically leads to suitable resources.
- **Improved access to advice and guidance** through a single telephone number, and offering timely, single session interventions where clinically appropriate.
- **Request for Support** – One trusted pathway for children, families, and professionals to ask for emotional wellbeing and mental health support. The clinical team will assess every request for support and promptly allocate to the most appropriate service offer to meet the needs of children and young people if required.

How are we going to do it?
System partners work collaboratively within a strategic alliance, ensuring that services are committed to working together to provide the best possible care and support for CYP and their families. This is in line with the Thrive principles, with children and young people at the centre of delivery and resources wrapped around them, enabling them to Flourish.

What action are we taking to address Health Inequalities as part of this work?
We are developing system metrics to ensure activity is captured and reported at demographic level so that we can ensure health inequalities are addressed. A "Mind the Gap" meeting between providers has been established to ensure any CYP whose needs cannot be met with reasonable adjustments can be discussed and an agreed care plan put in place to meet their needs.

How are we going to afford to do this?
This programme of work is established and resourced through Mental Health Investment Standard funding.

What are the key dates for delivery?

Year 1: April 2025 – March 2026

- Continue to onboard system pathways, including "Early Help and Family Support" delivered by Local Authority partners.
- Implement Single Session approaches to ensure CYP can have their needs met in the most efficient way.

Year 2: April 2026 – March 2027

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

Years 3 to 5: April 2027 - March 2030
To be defined by local plans developed in collaboration with system partners.

How will we know we are achieving our Objective?

We will be able to measure an increase in the number of children and young people accessing the right support to meet their emotional wellbeing and mental health needs. This will be evidenced through the CYP Mental Health access metric within the national Mental Health Services Data Set (MHSDS) and through patient reported outcome measures.

Objective 4d: We will see the whole person for who they are, developing pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on dual diagnosis and Complex Emotional Needs (CEN)

The term "Dual Diagnosis" in this Objective, is used to define the experience of those with Mental Illness and substance misuse.

What are we going to do?

Complex Emotional Needs*:

1. Develop a Strategic Plan of Action for people with Personality Disorder/ Complex Emotional Needs in Norfolk and Waveney, including the development of a collaborative pathway.
2. Increasing access to psychological therapy for people with complex emotional needs, wherever they present.

Dual Diagnosis:

3. Develop and implement a recognised dual diagnosis pathway - with consideration to other issues, social or physical that are commonly associated with experience of Mental Illness and substance misuse.

*We are using the term Complex Emotional Needs to encompass people who have previously been described as having a diagnosis of personality disorder or experience of complex Post Traumatic Stress Disorder (PTSD).

How are we going to do it?
Providers and stakeholders will engage those with lived experience at all stages, from design to delivery, to improve access and care for people with dual diagnosis and Complex Emotional Needs, inclusive of those with Neuro Diversity.

A "no wrong door" approach will be developed with system partners to make pathways inclusive, accessible and flexible to promote recovery and independence. Partners will work collaboratively to cover unmet needs.

We will continue to develop mental health provision in primary care, embed the Strategic Plan of Action for people with Personality Disorder/Complex Emotional Needs and pathway, and assist system partners to work collaboratively to support people with dual diagnosis.

We will work more closely as system partners to join up care and help to improve the experience of people with complex needs.

What action are we taking to address Health Inequalities as part of this work?
We will review our pathways against the most recent evidence and guidance to improve quality and ensure that health inequalities are reduced by understanding gaps and barriers to access. We will work with under-represented groups to ensure equity of access.

How are we going to afford to do this?
We will seek to identify what can be achieved through improved partnership working ensuring that any available funding maximises quality, impact and value. We will work within existing resource, and/or scope where additional resource would improve delivery further.

What are the key dates for delivery?

Year 1: April 2025 – March 2026

Complex Emotional Needs

- Strengthen integrated pathways and joint working between providers.
- Develop a Strategic Plan of Action for people with Personality Disorder/Complex Emotional Needs in Norfolk and Waveney.
- Complete a review of patient experience and identify any unmet need.
- Review the offer for carers of people with Complex Emotional Needs, identifying gaps with a view to improve provision.

Dual Diagnosis

- Develop principles to support partnership working.
- Draft a coproduced strategy.
- Begin to implement an integrated mental and substance misuse pathway to improve access and increase inclusion.
- Review training needs to inform expansion of dual diagnosis training programme.
- Review the experience of people with Dual Diagnosis leaving prison, inpatient institutions and other out of system placements, to improve continuity of care.

Year 2: April 2026 – March 2027

Complex Emotional Needs

- Co-produce a set of recommendations to improve inclusion and access for under-served groups and marginalised communities.
- Expand existing training offer to professionals and carers, helping them to identify and respond appropriately to people with co-occurring needs.
- Co-produce a set of recommendations to improve the offer for carers of people with Complex Emotional Needs based on the review of need.

Dual Diagnosis

- Complete a digital options appraisal to improve service access.
- Review pathway and protocol to inform practice and ensure a suitable offer for people of all ages.

Year 3: April 2027 – March 2028

Complex Emotional Needs

Evaluate service user and system outcomes to inform future planning and ensure continual quality improvement.

Dual Diagnosis

Evaluate service user and system outcomes to inform future planning and ensure continual quality improvement.

Year 4: April 2028 – March 2029

Complex Emotional Needs

Develop a plan to improve service user and system outcomes and quality of care and workforce and service delivery.

Dual Diagnosis

Continue to implement improvements to quality of care and patient experience, addressing identified gaps.

Year 5: April 2029 – March 2030

Complex Emotional Needs

Continue to implement improvements to quality of care and patient experience, addressing identified gaps.

Dual Diagnosis

Not applicable as this work is concluded in 2029/2030.

How will we know we are achieving our Objective?

Complex Emotional Needs:

- 300 additional staff trained per year in Knowledge and Understanding Framework, Dialectical Behavioural Therapy, or psychologically informed approaches system-wide.
- Increase in numbers of service users able to access a psychologically informed intervention outside of NHS Talking Therapies and secondary care offer.
- A reduction in presentations to Emergency Departments for patients with Personality Disorder.

Dual Diagnosis

- Achieve an increased number of referrals (as per Year 1 plans and trajectory) accepted via the dual diagnosis pathway.
- A reduction in presentations to emergency departments for service users with mental health needs and drug or alcohol problems.

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Case Study

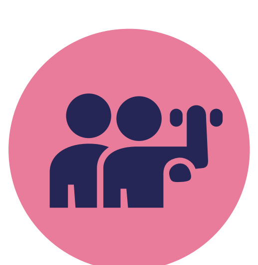
Lydia and Sandra: Our experience of the accessible vaccine clinic

Lydia has a learning disability and uses Makaton to speak so having someone to sign with her is important too.

Lydia just had her covid vaccine she was very frightened of vaccines. She has never had any before all attempts have been unsuccessful. We had tried seven times at various vaccination centres and with a specialist team that came into the school as well and it got to point where she couldn't even walk into the building.

Lydia was so anxious and frightened, even at the vaccination centres she wanted to sit down and be happy to take her cardigan off but the minute she knew there was a needle coming in a little tray, she'd run out the room. She even had her friends come and help too; she was still too scared. A kind nurse gave us the details of the accessible clinic.

It was helpful to have a call and talk about what she needed before coming. When we arrived, she was so incredibly happy seeing the lovely room and toys. As discussed on the phone call she got to practice with the needle. Slowly being introduced to what the needle was like, I just could not believe it just watching the nurse run the needle gently up and down her arm and not being frightened. I just can't believe she has had it, we tried so many times. It was so quick it was and it did not hurt said Lydia. Lydia was so happy and looking forward to coming back. I just do not believe it so thank you so much. Having a clinic for people with learning disabilities is so important.



Ambition 5: Transforming Care in Later Life

Ambition 5: Transforming Care in Later Life

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

Dr Olga Emmerson
Associate Director of Planned Care and Cancer Transformation
NHS Norfolk and Waveney Integrated Care Board

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

Our objective

To have health, carer and support services that are fit for our ageing population - supporting people as they age, to lead longer, healthier, happier lives

What would you like to see in our five-year plan for health and care services? What matters to you most?
Feedback from our Norfolk and Waveney Dementia Round Table Event from patients with lived experiences - *My care needs to be continuous with regular check-ups; I want services to work proactively together so the treatment is of the whole person rather than just the diagnosis. I want to only have to tell my story once. Training for both wider healthcare staff and carers should be improved, and public awareness of Dementia should be improved.*

Feedback from Active NoW Falls Prevention highlights significant improvements in both physical and mental well-being. Participants reported increased confidence in mobility, with one saying, "I feel more confidence when walking, I don't use my stick as much." Others noted enhanced balance, with one sharing, "I feel more confident walking up and down stairs." Many found the sessions beneficial, "The sessions have been extremely beneficial to both my physical and mental health."

An 82-year-old participant added, "I'm 82 and have the exercise bug, I will continue to exercise for as long as possible now!" Several others mentioned feeling stronger and more confident, with comments like, "I'm getting up and down from the chair easier" and "I'm walking with more confidence and much easier".

Why we chose these objectives
Our population is older than in most systems, but a lot of our services have not been designed with older people in mind and may not be known to, or easily accessed by the people who need them. Currently the available support from statutory, voluntary, and charitable services is often unknown to the person, confusing or complicated to access. This can mean that people don't always know what they can do to prevent ill health or get the help they need until far too late. So, we want to design and connect services to inform and support people as they age.

With a focus upon prevention and ageing well, we want to make it easy for people as they age to access the right preventative intervention or support as soon as they need it. We want to simplify and join up the different types of services, social assets and amenities near to people, and delivered as close to home and as early as possible.

By making it easy to access support and by removing the barriers between the different types of support available, we will work together to enable people, as they age, to maintain their independence and preserve their quality of life for longer.

Since April 2024, we have now established four core working groups which will focus on implementing these objectives:

1. **Frailty focussed acute care:** Supporting our hospitals to recognise frailty and ensure that their services are designed around the needs of the individual with frailty and their carers, to extend healthy older life and independence.
2. **Dementia focused care:** Preventing cognitive decline, diagnosing earlier and with a single point of access and improving the quality and coordination of care, as close to home as possible.
3. **Care Homes & Housing with Care:** Improving care, supporting residents to live as independently as possible and reducing unplanned admissions from care homes and supported accommodation.
4. **Prevention:** focusing on health promotion and prevention to support people to keep healthier for longer.

Objective 5a: To have health, carer and support services that are fit for our ageing population - supporting people as they age, to lead longer, healthier, happier lives

In 2024 the Ageing Well Strategic Framework was published with the objective to provide a shared vision and strategy with older people.

From April 2025 we will be focussing on the implementation of core priorities we have identified as a result of engagement with members of lived experience, service leads and our partner organisations such as Norfolk County Council and charitable organisations.

What are we going to do?
Our vision is that Norfolk and Waveney will be a place where people in later life and their carers:

- Are helped to age well, living happier, healthier lives, living as independently as possible, for as long as possible
- Feel heard and respected, and know they will be treated as individuals
- Experience services that ask, 'what matters most to you' and proactively act upon their answer

This year, we will work together with our NHS providers, voluntary, community and social enterprise partners, members of our community, and our public health teams in Norfolk and Suffolk to:

- Integrate digital technology innovations that will support people in care homes.
- Review Frailty and Dementia services across the geography to improve triage and combined assessments.
- Support people to take control of their health through health promotion and awareness campaigns.
- Support the care market through admission avoidance schemes.
- Provide a multi-disciplinary assessment of all people with frailty attending our hospitals as an emergency, to prevent admission where possible, reduce length of stay where admission is required, and to seek opportunities to prevent further health problems.
- Utilise the Enhanced Health and Care Framework to promote healthy living, nutrition, hydration, and oral health support.
- Offer opportunities for the care market to come together through the development of a clinical champions network.
-

To support us, we will use the principles of the World Health Organisation's Age Friendly Communities to shape services and the environment that people age and grow old in to optimise health and wellbeing.

How are we going to do it?
We will research innovative digital systems that support earlier identification of older people with suspected conditions of Frailty & Dementia.

We will integrate digital technology to support residential and nursing homes in their ability to identify residents whose health is deteriorating and improve seamless communication with healthcare.

We will review and redesign Frailty and Dementia pathways to allow for greater communication, combining assessments and identifying people earlier in their health journey whilst supporting the upskilling of staff. We will consider findings from recent public health reports and services that may need to be delivered differently based on deprivation, public transport access and other core inequities of health.

We will promote healthy ageing and awareness of these conditions and through webinars, education support packages, newsletters and wider communications to both staff and the public and take a collaborative approach to winter prevention communications.

We will develop a dashboard to monitor the impact of these changes.

What actions are we taking to address Health Inequalities as part of this work?
The programme aims to enhance patient and carer experience and health outcomes by tailoring healthcare and social service provision to local needs. Instead of uniform pathways, the ICB and partners will adapt pathways to address local health inequalities and deprivation issues, improving access and awareness for all patients, particularly those in our CORE20Plus5 population areas.

How are we going to afford to do this?
Simplifying access and focusing on early and local intervention will reduce long term need and costs e.g.by preventing unnecessary ambulance call outs and hospital admissions.

Co-designing services with older people to focus on maintaining independence will reduce costs long term, but we will need to divert funding toward prevention, early intervention and planning for the future, reablement and care at home.

Co-ordinating services using a system-wide perspective will deliver more integrated, high-quality cost-effective care from multiple sectors so reducing waste and duplication so saving cost for our system.

We will also actively seek new external monies / funds to support people in later life where possible.

What are the key dates for delivery?

Year 1: April 2025 - March 2026
Innovation and prevention

- Develop pathways that support multi-professional triage for older people, with a focus on Dementia and Frailty services, so that they can receive support through one stop or combined assessment and, treatment wherever possible, and in the most appropriate setting.
- Develop a unified frailty virtual ward pathway across all of our hospital partners to provide an at-home alternative to hospital admission for suitable patients.
- Planning for older age - supporting people to take control of their health and maintain healthy older life and reduce the period of time spent in frailty.
- Place-based approaches to proactive support for those identified at risk of poor outcomes in older age.
- Support places and organisations to improve age friendly practices.

Year 2: April 2025 – March 2026:
Reflect, Review, Replan

- Fully integrated care for people living in residential or supported living environments using technology where appropriate.
- Integrate pathways for older people, with a focus on Dementia and Frailty services.
- Work with the acute hospital collaborative to align the current frailty advice lines so that all people have access to this service across system.
- Improve the accessibility of Dementia identification so all care providers can identify the people they are caring for who have a diagnosis.
- Ongoing use of the strategic framework to address gaps in provision across our system.
- Ongoing use of the framework to identify opportunities for prevention and early intervention.

What are the key dates for delivery?

Year 3: April 2027 - March 2028

- Achieve "Age Friendly" status across Norfolk and Waveney, working with residents, local organisations and government bodies and the national Centre for Ageing Better with the aim of ensuring older people are valued and able to live well throughout later life.
- Increase the awareness of Dementia and Delirium for staff delivering care across the geography.

Year 4: April 2028 - March 2029

- Implement further initiatives focussed on prevention of falls and integrating this care.
- Integrate Rapid Assessment units across three acute hospitals for Frailty and Ambulatory Care.
- Redesign pathways to support care at home and improve integration with residential and nursing homes.

Year 5: April 2029 - March 2030
Develop and implement workforce strategies with the three acute hospitals to deliver equity of workforce provision for Frailty.

How will we know we are achieving our objective?

- All statutory providers signed up to the Dementia Charter by April 2025.
- Increased Dementia diagnosis "rate" based on diagnosed patients versus the estimated number of people living with Dementia by March 2027.
- Increased use of a standardised frailty scoring tool across the ICS to ensure better understanding of individuals' needs by March 2026, enabling specific support to be put in place at an earlier stage.
- A reduction in the number of ambulance conveyances and unplanned admissions from care homes and residential homes by March 2027.
- An increase in the number of ReSPECT forms in place for patients with frailty by March 2027.

Case Study

Virtual ward prevents admission to hospital

John is an 84 year old man with long standing issues with his breathing. John was referred to the Virtual Ward by his GP when his breathing became difficult for the third time in 3 months. Both times this had happened before, he had ended up in the hospital emergency department which John found distressing and disorientating, and on one occasion he had been admitted to the hospital for 8 days.

John's GP referred him to the Virtual Ward during an emergency appointment at the surgery. The virtual ward hub accepted the referral and as part of his onboarding, they reviewed his health care records to gain more information about what had happened during his previous admissions and multiple A&E attendances. Remote monitoring equipment was delivered and setup for John at home within two hours of being onboarded. An initial assessment including blood tests were performed in John's own home to confirm the reason for John's deterioration. The virtual ward team developed a management plan and agreed this with John and his family using joint decision making.

John started treatment that day, and remained at home but with daily calls, 24/7 monitoring and two further home visits before he was "discharged" from the virtual ward. Before that happened, the virtual ward team, John and his family also agreed a long term health care plan to try to prevent the need for further A&E attendances and hospital admission.

Ambition 6: Improving Urgent and Emergency Care

Ambition 6: Improving Urgent and Emergency Care

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

Matthew Winn
Chief Executive - Norfolk Community Health and Care Trust
Chair of the Norfolk & Waveney Urgent and Emergency Care Board
Chief Executive - Cambridgeshire Community Services NHS Trust
Specialist Advisor to NHS England on Intermediate Care

Our objectives

a) Improve emergency ambulance response times and ensure patients are seen more quickly in the Emergency Department by meeting the required % of patients being admitted, transferred or discharged within 4 hours.

b) Expand virtual ward services as an alternative to an inpatient stay.

c) Reduce length of stay (LoS) in hospitals.

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

Why we chose these objectives
We want our population to be confident that whenever they have an urgent care need or an emergency happens the local NHS is there to rapidly respond. We will continuously improve our emergency and urgent care services and adapt to our population's changing needs, taking advantage of new technologies and develop trusted relationships across all health and care organisations in Norfolk and Waveney.

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

Objective 6a: Integrate urgent care to improve emergency response times across all organisations

What are we going to do?
We will work with the ambulance service, integrated urgent care providers and community teams to improve how quickly emergency ambulances can respond to our most unwell patients. To do this, we will improve how organisations work together and collaborate to support community teams to respond to urgent care needs which are not life threatening but need a rapid response, thereby allowing the ambulance service to better respond to serious issues that are a threat to life or limb and are emergencies.

This will result in more 999 calls being safely and appropriately transferred to others, including community services. Where the community is best resourced to respond the patient will be visited from a member of the local NHS team. This could be from a community nurse or therapist as part of the 2-hour urgent community response team (UCRT), virtual ward or pharmacy, or a telephone assessment with an urgent care doctor or nurse. Community teams will work with senior medical specialists who will advise on treatments and can access rapid-access clinics and same day appointments at hospital.

For patients with an urgent same day care need this will mean an increasing number of patients able to safely stay at home, supported by local health and social care teams to remain safe.

How are we going to do it?
Appropriate urgent 999 calls will be digitally transferred to community teams for place-based teams to respond. The Norfolk and Waveney unscheduled care co-ordination hub (UCCH) will have clinical consultations with patients who have called 999 and ambulance crews on scene who are responding to a 999 call, to agree if there is a clinically appropriate alternative to hospital. This will allow crews to move on to their next call whilst UCCH arranges to get the patient to the alternative service.

We will work with clinicians in the ambulance service, the community, urgent care and out of hours doctors, primary care and others to develop the framework and digital capability to identify and transfer patients from emergency services to urgent community services.

Our response teams will be integrated, allowing them to work across organisations to share skills and make a greater impact by jointly responding and coordinating care and sharing resources.

This will be modelled and delivered to meet the needs of the local population. It may mean local variation in how services are set up across Norfolk and Waveney but the outcome will be the same; a rapid response from a clinician suitably skilled to assess and treat the patient.

For health and care professionals working in urgent and emergency care services this means consistent and standardised access points, a single access route for alternatives to emergency care and easier referral mechanisms to transfer patients between services, which will further support workforce satisfaction and retention.

What action are we taking to address Health Inequalities as part of this work?
As described above, there will be some local variation in how services are set up however the outcome for all urgent and emergency care services across Norfolk and Waveney will be the same.

How are we going to afford to do this?
We are working together as a system with all our partners to make sure our resources are used to support transformation and deliver the care our patients need in the right place at the right time.

What are the key dates for delivery?

Years 1 and 2: April 2025 – March 2027
Continued integration of urgent and emergency care provision, further collaboration across system partners, including VCSE to increase the support available.

Year 3: April 2027 – March 2028
Fully embedded model of integrated urgent care in place across Norfolk and Waveney ensuring patients get the right care in the right place whenever the need arises.

Year 4: April 2028 – March 2029
Objective to be reviewed / retired.

Year 5: April 2029 – March 2030
Objective to be reviewed / retired.

How will we know we are achieving our objective?

- Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/2026 compared to 2024/2025.
- Improve Category 2* ambulance response times to an average of 30 minutes across 2025/2026.

*National description of Category 2:
C2 - Emergency. These calls will be responded to in an average (mean) time of 18 minutes, and within 40 minutes at least nine out of 10 times (90th percentile)

Objective 6b Expand virtual ward services

What are we going to do?
Virtual wards provide hospital-level care in people's own homes or the place they call home, including care homes. This includes providing urgent access to hospital-level diagnostics, delivering hospital-level interventions and providing care through daily multidisciplinary input. They are for people with acute care needs who would otherwise be in hospital.

During 2025/2026 we will review the virtual ward provision with the intention to create one Virtual Hospital, with three wards; East, West and Central, to ensure that wherever patients live in Norfolk and Waveney they will have equal access to a virtual ward, improved efficiency and value for money, increased levels of admission avoidance and identified longer term developments.

We will work with the whole provider community - Primary, Community and Acute care, 999 and 111 (CAS), embedding virtual ward as part of an integrated urgent care 'pre-hospital' model with enhanced clinical oversight that enables services to safely support patients outside of hospital, and deliver better outcomes for patients.

How are we going to do it?
Virtual Ward is still relatively new and is an area of both national and local focus for research and innovation. Our clinical leads are closely linked into developments, ensuring that locally we build on national best practice.

What action are we taking to address health inequalities as part of the work?
We are reviewing our existing models to ensure there is a standard approach across all providers to be able to visit patients at home and support patients who might be at risk of digital exclusion.

How are we going to afford to do this?
Virtual Ward has an allocation of national funding. The review will include how existing funding can be spent as effectively as possible to support more patients on virtual wards.

As our Virtual Ward expands, we anticipate there will be corresponding changes in where urgent care activity is managed, increasingly this will be outside of hospital settings.

What are the key dates for delivery?

- **Year 1: April 2025 – March 2026**
  System review of virtual ward and development to increase capacity, improve efficiency, reduce unwarranted variation.
- **Years 2 and 3: April 2026 – March 2028**
  Further evaluation and monitoring to continuously improve the service.
- **Year 4: April 2028 – March 2029**
  Objective to be reviewed / retired.
- **Year 5: April 2029 – March 2030**
  N/A

How will we know we are achieving our objective?

By March 2026 the aim is to have 330 Virtual Ward beds available across Norfolk and Waveney, compared to 170 Virtual Wards beds in March 2025.

As well as increasing the number of Virtual Ward beds we want to increase the occupancy of the beds to a minimum of 80% at any time.

Objective 6c: Reduce length of stay (LOS) in hospitals

What are we going to do?
We will continue to improve discharge planning to reduce the length of time spent in hospital unnecessarily. We will support our population to take the next step in recovery and rehabilitation after a period of illness, in a place where they can be as active and independent as possible and stay connected to the people and activities that matter most to them.

If things have changed while someone has been in hospital and home is no longer the right place for a person to live, we will work together to plan what that will look like.

The date and time for discharge home will be agreed in advance, ideally at the point of admission to hospital. This allows us to set expectations and plans with carers, loved ones and/or family members. We will better join up care to support the return home through providing a supply of medication and a discharge letter to share with the GP so they know what help and support is needed at home.

Better discharge planning helps to reduce length of stay in hospital and the risk of changes to mobility through long lengths of time spent in a hospital bed. This increases the ability to return home and maintain independence while ensuring hospital beds are available for the sickest residents within our population.

How are we going to do it?
Through local partnerships, health and care providers will work together to embed the 'home first' principle when planning to leave hospital. Nurses, doctors and social workers will work with patients and their families to plan next steps.

We will build on the process improvements underway that are maximising the care available to our communities. These are showing improvements, and our next priority is to have the right capacity and right type of beds and care available in the community when people need them. To do this we need to ensure we understand the requirements of our population both now and in the future.

In the longer term, there will be a stable and sustainable model of care for discharge support more generally, but particularly for discharge Pathways 1 to 3, which are pathways for patients who require support following a hospital stay.

What action are we taking to address Health Inequalities as part of this work?
Social, economic and environmental impacts are considerations within the model of care for discharge and these will be different according to where patients live. The place-based approach is key to being able to deliver this as local knowledge is key, with support from other sectors including housing, primary care and the voluntary sector.

How are we going to afford to do this?
In 2025/2026 the national Better Care Fund is being targeted towards reducing length of stay as one of its three headline metrics. This is a fund that is delivered in partnership with local authorities. More broadly, reduced length of stay will reduce the risk of patients deconditioning, reducing costs associated with long term complex care packages and residential care.

How will we know we are making a difference?

- Reduction in length of stay is the key outcome metric of this programme and we should see a reduction in the average length of stay in acute and community beds and an overall reduction in use of intermediate care beds.
- An increase in numbers of patients discharged each day.
- Deconditioning and readmission rates will fall.
- We can stop using surge and escalation beds to manage day to day pressures.

What are the key dates for delivery?

Years 1 and 2: April 2025 - March 2027
Deliver a stable and sustainable model of care for discharge. Focus on discharge Pathways 1 to 3, for patients who require additional support following a hospital stay; ensuring there is better patient choice and communication with carers so that decisions can be made together.

Year 3: April 2027 - March 2028
- Digital maturity fully embedded.
- A model of care that meets demand.

Year 4: April 2028 to March 2029
Ensure the system is operating a model of care that meets demand.

Year 5: April 2029 to March 2030
- Review and refine models of care based on outcomes, both short and longer term.
- Ensure that parity of discharge is achieved across physical and mental health.

How will we know we are achieving our objective?
Virtual Ward bed occupancy is at least 80%.

Case Study

Norwich Safe Habitable Homes (SHH)

Based on the learning from the Norwich Integrated Anticipatory Care Team (INTERACT) and funded by the Norwich Health & Wellbeing Partnership, Safe Habitable Homes was established to meet the identified gap in long-term, holistic support for people with issues around self-neglect and hoarding. This high-risk issue which affects a significant number of older people in Norwich (and elsewhere).

Safe Habitable Homes is a tenure neutral, trauma informed service covering the Norwich City Council area with the aim of reducing risks around falls, fire, and eviction. It is delivered by a partnership of St Martins, Norwich City Council and Norfolk County Council, working with wider partners such as the Fire Service.

The ambition was to support 40 residents, but 77 people have now helped by the SHH Co-ordinators with an impressive 70% engagement rate. The small team also provide support to other professionals working with people with self-neglect and hoarding issues. Of the 37 people on the active caseload, 18 were initially assessed as having red (high) Risk Assessment Grades (RAGs) in line with the Norfolk Safeguarding Adults Board guidance on self-neglect and hoarding. This figure has reduced to only 7 residents with red RAGs due to the team's involvement.

Ambition 7: Elective Recovery & Improvement

Ambition 7: Elective Recovery & Improvement

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

Matt Dooley
Executive Director of Commissioning and Performance and Senior Responsible Officer for elective recovery across Norfolk and Waveney

Our objectives

a) Effectively utilise capacity across all health system partners.

b) Implement digital technology to enable elective recovery.

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

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

We are working to improve cancer care across Norfolk and Waveney by strengthening key pathways, addressing workforce challenges, and enhancing early diagnosis. Our focus is on ensuring timely access to treatment, improving service capacity, and reducing delays in detecting and diagnosing cancer. By taking a system-wide approach, we aim to deliver better outcomes and experiences for patients.

This will mean that complex health care is seen and treated at an acute hospital whilst less complex but potentially 'life limiting' health concerns may be treated elsewhere. This links to and aligns with the work we are doing around the way people are referred for diagnostic testing and/or treatment in the community or via the local GP.

Objective 7a: Effectively utilise capacity across all health system partners

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

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

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

How are we going to do it?

We will deliver more diagnostic care
With national funding, Norfolk and Waveney have developed four new Community Diagnostic Centres (DCS's), now partially or fully operational. These centres will:

- Enhance accessibility by bringing diagnostic services closer to local communities.
- Enable GP direct access to diagnostic tests.

These centres and other areas of elective care rely on availability of skilled workforce therefore, we will work with system leads to strengthen workforce support and planning.

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

Initiatives that support the best use of resources, such as a recent volunteer-led initiative to help more people attend their diagnostic appointments, will continue to be explored.

We will deliver more elective care

- We will increase capacity through Elective Hubs at our acute hospital sites.
- We will continue to maximise our capacity where possible, through 'Mutual Aid' - whereby patients are asked if they would be happy to be treated at any of the three acute hospital trusts in Norfolk and Waveney if their treatment can be completed sooner – and using the independent sector where resourcing allows.
- We will encourage and support sharing of best practice, appropriately increasing standardisation of procedures, pathways and support functions.

Increasing rates of 'day case' elective procedures

- We will use national best practice initiatives such as High-Volume Low Complexity (HVLC) and Get it Right First Time (GIRFT) to enable, where appropriate, full benefit from 'Day Case Care' for planned care procedures.
- We will reduce and minimise cancellations of planned care procedures.

Reducing cancer backlogs

- We will use evidence-base, risk-stratification and work with experts, including patients, to improve pathways and experience of care. This includes improving dermatology pathways and management of breast pain, for example.
- Continue to embed system-wide the nationally defined Best Practice Timed Pathways (BPTP) for cancer, and the Non-Specific Symptoms pathway to improve efficiency, diagnosis, and patient experience.
- Work with workforce leads to address our workforce needs.
- Ongoing work to raise awareness and training to support the national cancer guidance and to reduce variation in quality of urgent suspected cancer referrals.

Reducing unnecessary outpatient follow up appointments

- We will empower patients to book, manage and request (or initiate) a Follow Up appointment – this is using Patient Initiated Follow Ups (PIFU) – based on discussion with clinicians about what and when is expected after their

treatment or surgery. This will free-up clinical time and allow people to manage their care.

- Increased use of digital support will reduce duplication and streamline administration of cancer pathways. This links to Electronic Patient Record and the virtual Single Point of Access and business planning for the C the Signs system.

What action are we taking to address Health inequalities as part of this work?

Work with health inequalities services, providers and partners at Place to support vulnerable and disadvantaged patients, especially those with multiple long-term conditions, to access services.

Undertake regular review of local waiting list data, as well as data on people not attending appointments, to understand areas of variation potentially relating to inequality, deprivation and ethnicity and using wider CORE20PLUS methodologies. This will also include improving the quality of data recorded for individuals, so we can better understand need.

Utilise patient forums and local health inequalities working groups to establish service provision which meets the needs of service users.

How are we going to afford to do this?

National capital funding has been secured through the development of local plans and business cases to support the establishment of Elective Hubs, Community Diagnostic Centres, and Diagnostic Access Centres. These programmes have allocated the necessary capital to build and operationalise these sites and their associated services.

How will we know we are achieving our objective?
We will work to achieve national targets:

Elective, by March 2026:

- 60% of patients receive elective treatment within 18 weeks.
- Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list.
- Increase the proportion of patients receiving their first elective care appointment within 18 weeks to 67%.

Cancer, by March 2026:

- Improve performance against the headline 62-day standard to 75%.
- Improve performance against the 28-day Faster Diagnosis Standard to 80%.

What are the key dates for delivery?

Year 1: April 2025 – March 2026

- Support direct GP access to nationally recommended cancer diagnostic tests.
- Develop a system approach to deliver nationally defined best practice cancer pathways.
- Develop career pathways to support recruitment and retention.
- Maximise utilisation of capacity in new system provision, such as CDC's operating CDCs to 12-hour, 7-day.
- Use national minimum standards for patient experience in elective care to inform next steps.
- Expand the use of Patient Initiated Follow-Ups across outpatient services.

Year 2: April 2026 – March 2027

- Plan transition of activity closer to communities.
- Strengthen system collaboration to tackle wider health inequalities affecting elective care.
- Assess how Community Diagnostic Centres and Elective Hubs are improving access to care and reducing inequalities.

Years 3 to 4: April 2027 – March 2029

- Review the benefits of Elective Hubs and CDCs.
- Explore further collaborative opportunities to enhance elective recovery, including developing workforce pathways.

Year 5: April 2029 – March 2030

Complete a system-wide review of elective care and digital innovation efforts, using lessons learned to shape long-term NHS planning beyond 2030.

Objective 7b: Implement digital technology to enable elective recovery

What are we going to do?
Digital is a key enabler for improvements in health and care in Norfolk and Waveney and our ICS Digital Strategy sets out clear priorities for improvement that drives and support elective recovery and improvement. By enhancing patient engagement, streamlining care pathways, and improving efficiency, we can ensure better access to treatment and improved health outcomes.

- Patient Engagement Portal is being rolled out across all three hospitals; an online platform that improves communication between patients and healthcare providers, improves experience and facilitates more timely access to outpatient care.
- The shared Electronic Patient Record will allow clinical teams to see records across all three Norfolk and Waveney hospitals, ensuring access to real-time patient information. This will help reduce delays, support decision-making, and improve the overall efficiency and safety of elective care delivery.
- Expanding the use of digital platforms, such as the NHS App.
- Optimising Advice & Guidance Services – Exploring digital solutions to improve collaboration between primary care and hospital specialists, ensuring timely and effective patient referrals.

How are we going to do it?
We will explore expansion of the Patient Engagement Portal across more specialties and access via the NHS App - simplifying access to key healthcare information.

We will help reduce missed appointments through new digital communication tools that make it easier for patients to manage their appointments.

The shared Electronic Patient Record will help reduce delays, support decision-making, and improve the overall efficiency of elective care delivery.

What action are we taking to address Health Inequalities as part of this work?
Aligned with national ambitions to empower patients through the use of digital tools such as expanding use of the NHS App – we will consider and take steps to address barriers to digital health that may be experienced by some. This work will further connect with the wider digital health transformation across our system, and its work to address access and inclusion.

How are we going to afford to do this?
- No additional major funding is required – The technology and systems needed are already in place.
- The Patient Engagement Portal and NHS App integration are part of ongoing digital transformation programmes, meaning they are being delivered within existing budgets.
- The Electronic Patient Record implementation is fully funded as part of a collaborative programme across all three hospitals.
- These digital improvements will make healthcare services more efficient, enabling patients to access care more easily while reducing administrative pressures—freeing up staff time to focus on patient care.

What are the key dates for delivery?

Year 1: April 2025 – March 2026

- Continued rollout of the Patient Engagement Portal.
- Expansion of automated patient communication tools.
- Introduce targeted measures to reduce missed appointments.
- Implementation of a shared Electronic Patient Record.
- Pending business planning, integration of the C the Signs system as the single repository for urgent suspected cancer referrals in N&W.

Year 2: April 2026 – March 2027

- Further expand PEP functionality.
- Review the impact of missed appointment reduction measures.
- Pilot AI-powered tools to reduce missed appointments.
- Embed the Electronic Patient Record.
- Evaluation and business planning for the C the Signs system.

Year 3: April 2027 – March 2028

Deploy virtual consultations and AI decision-support tools.

Year 4: April 2028 – March 2029

Evaluate the impact of digital innovations (e.g., PEP, AI tools), using insights to guide future improvements and identify new opportunities to further improve elective care.

Year 5: April 2029 – March 2030

Conduct a full system review of digital innovations, evaluating their impact to shape NHS Norfolk and Waveney's future digital strategy.

How will we know we are achieving our objective?

We will measure success through:

- Reduce missed appointments rates to 4% or below by March 2026.
- Increase the uptake of PIFU pathways to 5% of outpatient attendances by March 2026.

Case Study

Talking Therapies

The aim of this project was to raise awareness of the Norfolk & Waveney Wellbeing Service (IAPT) and make access to support easier.

Accessing free mental health services can be difficult due to various barriers. Many are unaware of available resources or feel stigma about seeking help. It's crucial to recognise these challenges to create a supportive environment.

Our approach has improved connections with individuals and increased awareness of mental health support. We saw a rise in participation in talking therapies and wellbeing workshops. Personalised phone calls fostered trust, while follow-ups ensured everyone had the chance to seek help.

By using diverse communication methods and personalising outreach, we empowered many to access care. In the past year, we referred 2,710 patients to talking therapies, achieving a 94% acceptance rate.

Patient feedback:

"I have already done six sessions of talking therapy over the phone with Wellbeing and I am very pleased with the service," said a patient who left us a voice mail to thank us for our proactive intervention.

While speaking with a patient after referral, the patient expressed gratitude for the support received from the Wellbeing service, noting that it really made a difference for both them and the patient's mother.

The patient, who is a paramedic, asked if anyone can access the Wellbeing service directly, as she struggles to refer those with non-physical issues. She appreciated the information on workshops and social events and plans to share it with her patients and colleagues.

Ambition 8: Improving Productivity & Efficiency

Ambition 8 Improving Productivity & Efficiency

"Our ambition is to find ways we can work together more effectively and become more efficient, whilst driving forward service improvements to meet the needs of our local population. It is about saving money and delivering better services and quality outcomes for our population"

Andrew Palmer
Executive Director of Strategy and Deputy CEO
NHS Norfolk & Waveney ICB

Our objective

To deliver our Medium-Term Financial Plan.

What would you like to see in our five-year plan for health and care services?
Lord Darzi's rapid investigation into the NHS (November 2024) report highlights a fall in productivity and efficiency since the COVID pandemic, and the frustrating impact that this has on both patients and staff. This ambition is about systematically reviewing what we do and delivering transformation. In parallel we must have a process in place to support local prioritisation decisions as part of this wider ambition to improve the way we deliver our services.

Why we chose these objectives
There is a clear requirement in the 2025/2026 priorities and operational planning guidance (see Section 4) for the NHS to live within our means, reduce waste and streamline processes to maximise productivity. This ambition directly contributes to one of the "triple aims" of the NHS which is about having regard to the wider effect of decisions made about the provision of health and care. Efficiency and sustainability of use of resources is one of those aims.

Objective 8a: To deliver our Medium-Term Financial Plan

What are we going to do?
The aim is to deliver our Medium-Term Financial Plan. This is one of our Legal Duties and is described in Part 2 of the JFP. This timescale acknowledges the scale of the financial challenge ahead.

Productivity and efficiency improvements will be driven by the data and focussed on clinical leadership with our staff.

How are we going to do it?
We will undertake a continuous programme of systematic productivity reviews that are focused, embed clinical leadership and will achieve quality outcomes.

Workforce and Digital are key enablers to this. These were in the 2023/2024 and 2024/2025 JFP and this work will be consolidated and accelerated. Reducing spend on temporary staff and support functions by improving processes is a key driver for change within the 2025/2026 operational planning guidance. The Electronic Patient Record Systems will contribute to productivity once fully implemented, this is our biggest piece of digital transformation we've ever undertaken.

We have access to the Model Health System Model Hospital which allows NHS organisations to compare themselves with each other and look for unwarranted variances. Opportunities to improve productivity and outcomes identified by Getting it Right First Time GIRFT benchmarking and NHS IMPACT are also being reviewed.

What action are we taking to address Health Inequalities as part of this work?
Programmes of work that deliver service change, transformation and prioritisation include a review of the impact on health inequalities. By using joined up data through a PHM approach we can target the outcomes we want to achieve at system level.

How are we going to afford to do this?
This work will contribute to productivity and support our financial re-set.

What are the key dates for delivery?

Year 1: April 2025 – March 2026
- Providers and the ICB will assess and respond to the NHSE EoE productivity packs.
- There will be a pro-active and regular Productivity Review with each of our Providers that is two-way dialogue. This will be led through Key Lines of Enquiry developed by the ICB and the Providers, sharing national best practice.
- These will be benchmarked, and tracked using national benchmarking tools, reported via a Productivity Dashboard or Report at the Financial Recovery Board.

Years 2 to 5: April 2026 – March 2029
This approach and the scale of the transformation will be reviewed in light of the Spending Review and longer-term plan for the NHS as part of the 10-Year Plan for Health.

The benefits of the EPR system will be realised during 2026/2027 with a full year effect.

How will we know we are achieving our objective?
- Delivery of our Medium-Term Financial Plan.
- Improvement in clinical productivity in our Trusts measured through benchmarking.
- Reduction in spend on bank and agency staff.
- Progress made from Analogue to Digital – go live of the Electronic Patient Record in Q4 of 2025/2026.
- Progress will be monitored through the Financial Recovery Board with updates to the ICB Finance Sub-Committee.

Case Study

What should quality feel like? Meet Charlie

Charlie, aged 19, has been a family carer for most of her life and a member of Norfolk Young Carers' Forum, supported by the charity Caring Together as part of Norfolk and Waveney ICS. The Forum helps to recognise the lives of young carers and ensure that health, care and education services across Norfolk understand their needs. The Forum has carried out surveys of young carers and ran a conference for people working across the health and care system. Forum members have recorded videos, shared their experiences and reviewed all of the materials which are used in carer-awareness training. Charlie has put a lot into the forum, and got a lot out of it too.

Charlie says: "At first I was surprised they gave a 15-year-old the responsibility of doing the lectures, but I'm used to it now. It's still nerve-wracking but I know exactly what I am doing. I was a shy kid, but when I joined the Forum, I felt a real surge in confidence; it gave me a voice. In the Forum, everyone accepts who you are. Everyone is in a similar boat. They all just get it. I've made a lot of friends that I will be friends with for the rest of my life and pushed me to do what I want to do."

Charlie's caring role continues and when she reflects on five years in the Forum, she is positive about the changes that have happened in that time. She remains committed to driving further change for young carers.

5.0 When we expect to deliver

5.0 When we expect to deliver

For each of the Objectives, we have developed a series of key milestones.

As this is a rolling five-year plan it builds on the progress that was made during 2024/2025 financial year.

Figure 9 illustrates the overall profile of work being undertaken and deliverables across a five-year period. The green boxes indicate there is work being undertaken, the amber boxes illustrate where there are interdependencies with other workstreams and the grey boxes indicate when the objective is expected to be reviewed or concluded.

Year 1 relates to the financial year that starts 1 April 2025 and ends on 31 March 2026.

Ambition	Ambition Objective	Timeline for delivery				
		Year 1	Year 2	Year 3	Year 4	Year 5
1	**PHM, Reducing Inequalities & Supporting Prevention**					
1a	Development and delivery of two strategic pieces of work: A Norfolk and Waveney Health Inequalities (HI) Strategic Framework for Action; and a Population Health Management (PHM) Strategy					
1b	Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people.					
1c	Early Cancer Diagnosis – Lung Cancer Screening (formerly called Targeted Lung Health Check or TLHC programme)					
1d	Cardiovascular disease Prevention – develop a programme of population health management interventions targeting High Blood Pressure and Cholesterol.					
2	**Primary Care Resilience & Transformation**					
2a	Developing our vision for providing accessible enhanced primary care services, improving patient outcomes and experience.					
2b	Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.					
3	**Improving Services for Babies, Children, Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS)**					
3a	Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach.					
3b	Continued development of our Local Maternity and Neonatal System (LMNS), including the Three-Year Maternity Delivery Plan.					
3c	Implementation of asthma and epilepsy recommendations, for Children and Young People.					
3d	Develop an improved and appropriate offer for Children's Neurodiversity					
4	**Transforming Mental Health Services**					
4a	We will work together to increase awareness of mental health; enable our population to develop skills and knowledge to support wellbeing and improve mental health; and deliver a refreshed suicide prevention strategy. This will prompt early intervention and prevention for people of all ages, including those who experience inequalities or challenges to their mental health and wellbeing.					
4b	Mobilise an adult mental health collaborative and a children and young people's collaborative so that partners work as one to deliver better health outcomes for our people and communities					
4c	Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'integrated front door' so all requests for advice, guidance and help are accepted, and the appropriate level of support is given to ensure that needs are met.					
4d	We will see the whole person for who they are, developing pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on dual diagnosis and Complex Emotional Needs (CEN).					
5	**Transforming Care In later life**					
5a	To have health, carer and support services that are fit for our ageing population - supporting people as they age, to lead longer, healthier, happier lives					
6	**Improving Urgent and Emergency Care (UEC)**					
6a	Integrated urgent care to improve emergency response time across all organisations					
6b	Expand virtual ward services					
6c	Reduce length of stay (LoS) in hospitals					
7	**Elective Recovery & Improvement**					
7a	Effectively utilise capacity across all Health System Partners.					
7b	Implement digital technology to enable elective recovery					
8	**Improving Productivity and Efficiency**					
8a	To deliver our Miedum-Term Financial Plan					

Figure 9 – outline programme plan for the JFP objectives

Case Study

Reducing isolation and depression by increasing connections in the community

Anne is a 77-year-old lady who regularly attended her GP surgery. She has had to deal with several health conditions including cancer, diabetes, angina, and back pain after surgery.

Anne had been feeling isolated, depressed, and just wanted human contact to help her with these feelings. Anne's GP referred her to a Social Prescribing Link Worker.

The Link worker helped Anne, by forwarding her to a local befriending project in the area. The project aims to connect people to reduce loneliness and isolation by hosting walk and talk sessions. Anne now attends these sessions once a week and really enjoys them.

Anne feels a lot happier now, has reduced her social isolation, gained greater confidence and a wider social network. She also feels fitter, evidenced through lower blood sugar levels. Anne now attends fewer GP appointments.

6.0 How are we going to work together differently?

6.0 How are we going to work together differently?

How we work together differently is critical to the ambitions and objectives because it signals the change required to successfully deliver our plan.

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

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

3. **Existing ICS Strategies** – ensure everything we do is aligned with strategic commitments that we have already agreed such as those set out in our Integrated Care Strategy and Joint Health and Wellbeing Strategy, Population Health Management, Health Inequalities, Clinical, Digital, Quality, Estates, Research and Evaluation and Net Zero Green strategies and our People Plan. The existing Strategies and ambitions in our JFP need to all pull in the same direction.

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

5. **People and Culture** – continue to develop inclusive partnerships as our leaders work together to facilitate a climate of improvement for all our teams as they deliver the ambitions of our JFP.

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

7. **Our Voluntary, Community, and Social Enterprise (VCSE) sector as system partners** - integrating VCSE provision into our design and delivery models for services.

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

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

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6.1 Our place-based approach

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

We have five Place Boards and eight Health and Wellbeing Partnerships (HWPs) shown on the map below in Figure 10. The Place Boards and HWPs have complementary roles.

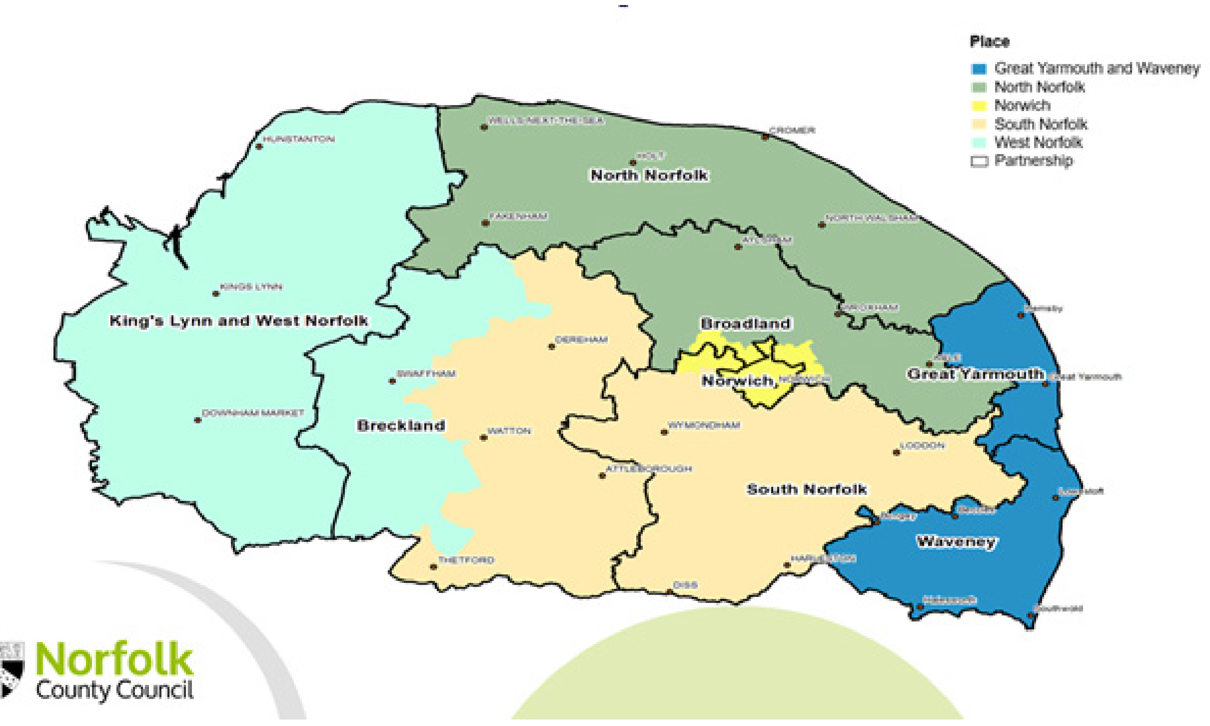

Figure 10 – Five Place Boards and eight Health and Wellbeing Partnerships map

- **Place Boards** bring together colleagues from health and care to integrate services, with a focus on effective operational delivery and improving people's care.
- **Health and Wellbeing Partnerships,** established on district council boundaries, seek to address the wider determinants of health and wellbeing by bringing together colleagues to focus on greated integrated working between county and district councils, the VCSE sector, health organisations, and other partners. The HWPs are optimally positioned to reduce health inequalities and focus on prevention through collaboration and empowering resilient communities to address the wider detriments of health.

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

Our Place Boards are delivering against all eight of the JFP ambitions and are also involved in working up some of the details around our two new hospitals (part of the national New Hospital Programme) at the James Paget in Gorleston-on-Sea and the Queen Elizabeth in King's Lynn.

Furthermore, there are opportunities for Place Board and HWP to work together on their common priorities such as reducing health inequalities. West Norfolk Place and King's Lynn and West Norfolk HWP are working together to develop West Norfolk into a 'Marmot Place'. This includes working directly with Professor Sir Michael Marmot and his team at the Institute of Health Equity to produce a report for West Norfolk detailing where health inequalities lie and what actions are needed from partners to tackle them.

We acknowledge that the place-based approach has significant potential to support the three priorities within the new 10-Year Health Plan for the NHS, but particularly 'from hospital to community' and 'from sickness to prevention'.

The responsibility map in Figure 11 supports our principles and overall direction of travel. This approach sets out an intent and a signal that if we can deliver locally in our communities we will.

The HWPs have developed a strategy for each area across a two to five-year period and action plans developed to ensure delivery. Future plans will be determined through place-based health and wellbeing strategies for the 2025/2026 period and beyond, developed with reference to key strategic priorities from the district they serve and the ICS vision to reduce health inequalities and drive integration. Current priorities are set out in Figure 12 and all of them can be linked to at least one of the ambitions in the Joint Forward Plan. The HWPs have some resources allocated to them through funding from the Contain Outbreak Management Fund, Better Care Fund and Active NoW. In 2025/2026 Public Health are providing funding to enable HWPs to focus on prioritising prevention and driving integration. Adult Social Services are working with HWPs to develop a new model of prevention for older people via place-based Proactive Interventions. We are also reviewing the resources that are available to support the place-based approach, with support from clinical and care professionals.

Setting the Strategy
(Assessing need, priority setting and resource allocation)

ICS
- Integrated Care Strategy for Norfolk and Waveney
- Joint Forward Plan and transformation priorities
- Business planning
- Medium Term Financial Plan
- ICS Strategies e.g. clinical, research, estates, digital, people plan, population health

County
- Care Market strategy
- Joint Health and Wellbeing Strategies
- Joint Strategic Needs Assessments

Place
- Bring partners together to align priorities

Securing Services
(Specifying outcomes, designing services, shaping the structure of supply e.g. procurement)

Regional
- Commissioning of highly specialised services

ICS
- Commissioning of services, e.g. planned care, urgent and emergency care, primary care, community services, acute, MH and LD&A
- Prioritising services
- Procuring services
- Contract management

Place
- Taking a lead on service re-design/ specifications/ outcomes
- Bottom-up input from local needs assessments and intelligence about health inequalities

Delivering Services
(Managing demand and capacity, delivering transformation and improvement)

ICS
- Co-ordinating recovery plans and Winter Plans
- Innovation Network
- Convening e.g. data sharing agreements, business intelligence and information, governance support, estates, wider digital functions, workforce, project management and communications and engagement

Place
- Providing a local response via partnership working e.g. with the voluntary, community and social enterprise sector, district councils, health and wellbeing partnerships

Monitoring and Evaluation
(Managing performance against agreed outcomes and seeking users' views)

ICS
- Commissioning and Performance Committee
- Evidence and Evaluation Hub
- Quality Management Approach

Place
- Bringing the lived experience to the fore
- Case studies

Assurance
(Assuring quality, safety and governance)

Regional (NHSE)
- Tiering meetings
- ICB review meetings
- NHS Overnight Framework
- Investigation & Intervention regime (I&I)

ICS
- ICB Board and the Board Assurance Framework linked to the 8 JFP Ambitions
- Underpinned by Sub-Committees of the Board e.g. Commissioning and Performance, Patients and Communities, Finance, People, Quality and Safety etc

Figure 11 - Responsibility Map

Partnership	Priorities
Breckland	Through inclusivity, innovation, and engagement: • Prevent Cardiovascular Disease • Improve Mental Health • Tackle issues arising from alcohol dependency and other alcohol related concerns.
Broadland	• Mental Health and Wellbeing • Resilient and Healthy Communities • Access and Prevention Cross-cutting themes: Covid-19 Recovery and Cost of Living Crisis.
Great Yarmouth	• Health Inequalities • Supporting Educational Attainment, Skills and Aspirations • Tackling Vulnerable and Exploitation • Reducing Loneliness, Isolation and Social Exclusion.
King's Lynn and West Norfolk	• Enhance Mental Health and Wellbeing • Improve Weight Management • Reduce alcohol consumption Cross-cutting themes: Prevention, Address Health and Wellbeing Inequalities, Engagement and Collaboration.
Norwich	• Social and economic wellbeing: Food equity, Social Mobility • Physical and mental HWB: Mental health and social isolation in targeted populations, Physical activity • Community resilience and voice: Hearing community voices, Community access to support.
North Norfolk	• Older people • Mental Health • Health Inequalities.
South Norfolk	• Mental Health and Wellbeing • Resilient and Healthy Communities • Access and Prevention Cross-cutting themes: Covid-19 Recovery and Cost of Living Crisis.
Waveney	A new strategy for Great Yarmouth and Waveney is being developed which may change Waveney HWPs priorities. However, the current sub-groups are: • Physical Activity • Children and Young People • Healthy Hearts • Prevention.

Figure 12 - Health and Wellbeing Partnership priorities

In summary we are clear about the role of the place-based approach in delivering the medium to longer term priorities in the Norfolk and Suffolk Joint Health and Wellbeing Strategies and the eight ambitions in the Joint Forward Plan, but we cannot do everything at once. However, we are pulling in the same direction and aiming for the same things, whilst ensuring the place-based approach can respond to local needs.

6.2 Provider Collaboration

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

Acute hospital collaboration
The Norfolk and Waveney Acute Hospital Collaborative (N&WAHC) is a Provider Collaborative formed by the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, the Norfolk and Norwich University Hospitals NHS Foundation Trust and the James Paget University Hospitals NHS Trust.

The N&WAHC was formed in 2020 to enable the acute trusts to work even more closely together to deliver shared objectives, align decision making and strengthen collaboration across Norfolk & Waveney.

The N&WAHC's vision is that, by working together, we will provide you with high quality hospital care when you need it, supporting you to get the care and treatment you need. Closer partnership working will allow us to more closely integrate patient pathways and provide equitable access for all patients to sustainable, high quality acute care and deliver against our objectives:

- We will listen to what you say and work together to build health services which meet your needs and the needs of our local communities across Norfolk and Waveney.
- Together, we will support our staff to have rewarding careers and a good experience working in our hospitals.
- Public money will be used efficiently to provide better, safer and faster care across Norfolk and Waveney.

To improve efficiency, standardise practices, and enhance patient care in delivering against this vision, the three hospitals are moving to a group model from 1 April 2025. Closer integration of governance frameworks across the three hospitals will offer significant benefits including flexibility, advantages, and opportunities for collaboration, enabling the delivery of consistent care quality and outcomes. The move will also enable alignment of decision making helping the speed of decision making given the challenges and opportunities we face. This analysis and potential options will be developed and embedded throughout 2025/26 and will be designed in support of our current activities summarised below.

Current Activities

Implementation of Community Diagnostics Centres: We have delivered three new Community Diagnostic Centres across Norfolk & Waveney. This £86m programme will create new, digitally linked, imaging diagnostic facilities with standardised practices and collaborative working across the three acute sites. The first centres at JPUH and QEH opened July and September 2024 respectively, and the NNUH centre opened in February 2025. A fourth centre is due to open at Northgate Hospital in Gt Yarmouth in two phases, in April and June 2025.

Joint delivery of an Acute Clinical Strategy through the development of Specialty Clinical Networks with a focus on working in partnership with the ICS to implement priority pathways in 2025/2026.

Our agreed acute clinical ambitions align directly to the ICS clinical strategy objectives and set out how acute clinical services will be delivered across Norfolk & Waveney, setting our shorter and longer-term ambitions for:

1. Delivering acute services more effectively out of the acute hospital setting and/or in collaboration with our Place health and care partners.
2. Optimising the efficiency of service delivery between the three acute trusts in N&W for the care that must be delivered from an acute hospital setting.
3. Acute specialties to operate with common standards, procedures and technology, removing unwarranted variation and assisting workforce development.

Development of two new hospitals: Collaborative work on the planning for the two new hospitals planned for Kings' Lynn and to serve the Great Yarmouth and Waveney area, which are part of the national New Hospitals Programme. We are committed to working together to ensure that our hospitals provide high quality and resilient services, meeting the current and future needs of our patients.

Collectively deliver a **single Electronic Patient Record (EPR)** across the N&WAHC: Within a comprehensive digital programme to streamline operations, improve communication, and enhance patient care, we will implement a single EPR in the three acute hospitals by 2026. This will enable efficient sharing of patient information and enhance clinical decision-making, all of which will improve patient experience, timeliness of care and clinical outcomes.

Delivering shared clinical pathways 2025/2026: We are committed to working with our wider System Partners to focus on delivery of transformational change in the clinical priority areas of maternity services, stroke, and cancer services and oncology. We are working closely with partners to define new models of care that will provide sustainable and safe care within Norfolk and Waveney. You can read more about our approach to this in Section 4 of the JFP.

An aligned approach to transformational change across the N&WAHC: We are developing a collaborative approach to transformational change management which will be delivered through the development of common approaches to Project Management Office functions, alignment of Quality Improvement approaches and continuing to build a network of transformational change professionals across all three acute providers.

The N&WAHC is integrated with and supports Ambitions throughout the JFP. For example, the adoption of a tri-acute EPR is a key workstream within the ICS Digital Roadmap, Community Diagnostic Centres will support elective recovery and improvement (Ambition 7), and shared transformation methods will underpin the service change necessary to improve our productivity and efficiency as a system (Ambition 8).

6.3 Our partners' plans and existing ICS plans

A key principle of the JFP is that it builds on existing local strategies and plans. By lining up our efforts and doing a few key things well, once, at system level and in a co-ordinated way with partners, ensures we are using these strategies to best effect.

All the strategies refer to collaboration and / or integration with partners, the importance of developing and encouraging our staff to be the best version of themselves that they can be for our local population and offer the best quality services we can, and how we must ramp up the pace of digital transformation in Norfolk & Waveney.

Partner Plans
The table on the next page shows the consistency of messaging and alignment between our partners strategies and plans and the JFP.

Partner Plans	Alignment with the JFP
Norfolk County Council Better Together for Norfolk Strategy	Norfolk County Council's guiding principles, commitments, and plans for delivery aim to improve the quality of life for Norfolk residents through collaboration, innovation, and prudent resource management. These three areas of focus are referred to within the JFP as part of the five-point approach to delivery, within Part 2 Legal Duties and Ambition 8.
Norfolk County Council Flourishing in Norfolk: A Children and Young People Partnership Strategy – Norfolk County Council	Ambition 3 is dedicated to Improving Services for Babies, Children and Young People. It acknowledges that the health of this group of our local population is determined by far more than healthcare and sets out objectives that aim to improve their outcomes.
Suffolk County Council Corporate Strategy 2022-26	The key objectives from Suffolk County Council comprise promoting and supporting the health and wellbeing of all people in Suffolk, strengthening Suffolk's economy, protecting and enhancing Suffolk's environment and providing value for money for the Suffolk taxpayer. These four pillars are delivered through considered, prudent financial management and these are all aligned with the JFP as we strive to improve productivity, efficiency and sustainability. Suffolk County Council will lead this agenda by example as the strategy highlights the council's commitment to ensure Suffolk enhances its reputation for collaboration, innovation and delivery. Collaboration is a key theme within the JFP as it's about delivering outcomes that can only be achieved by working together.
Norfolk and Norwich University Hospital NHS Foundation Trust Caring with PRIDE Strategy	The approach that the strategy sets out in the areas of investing in people and how they work, continuously improving quality and becoming more digitally enabled are all areas that chime with the JFP. How we improve is a key tenet of the JFP as well as what we do to improve, and the NNUH strategy reflects this.
James Paget University Hospitals NHS Foundation Trust Strategy	The strategy refers to reducing health inequalities and the role of the hospital as an anchor institution, as well as a specific priority about digital transformation, and collaborating with partners both at system and place. These are key elements of the JFP, which is cross-referenced within the JPUH strategy.
Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust Strategy	The strategy refers to addressing health inequalities and the role of the hospital as an anchor institution with specific strategic objectives in relation to becoming a digitally enabled organisation and collaborating with communities and partners. Both the ICS clinical strategy and the JFP are cross-referenced, together with the Norfolk & Waveney Acute Hospital Collaborative.
Norfolk & Waveney Acute Hospital Collaboration (NWAHC) Joint Acute Clinical Strategy	The acute clinical strategy is one element of the N&WAHC work. The ten design principles of the strategy already align well to the governments three shifts of hospital to community, analogue to digital and from sickness to prevention. Collaboration is a central thread within the strategy. The acute collaborative is referenced in section 6 of the JFP as it is a key vehicle for delivering change.
Norfolk and Suffolk NHS Foundation Trust's Strategy	NSFT works across Norfolk and Suffolk and is commissioned by both ICB's. The strategy references both the Norfolk & Waveney and the Suffolk & North-East Essex JFP's. The strategy includes wording from Ambition 4 which is about Transforming Mental Health Services, giving a direct read across from one strategy to the JFP. This further evidences the principles of all partners aligning collective efforts to deliver on some key areas that we have agreed.
East Of England Ambulance Service NHS Trust's Corporate Strategy	EEAST strategy sets out how we will evolve our role, not just as responders, but as leaders who can drive innovation and collaboration across our region. It sets us on a new path, not only continuing to improve but embracing bold, new approaches to the way we work. It calls for us to pull in the same direction, aligning to the same shared missions. And it shows how we are moving forward with a renewed commitment to working with system partners in developing alternative pathways and delivering care closer to home. The strategy links with Ambition 6 of the JFP for improving urgent and emergency care.
Norfolk Community Health and Care NHS Hospital Trust's Strategy	NCH&C is a key partner in the delivery of the JFP particularly within the Ambitions to Improve Urgent and Emergency Care including reducing length of stay, virtual wards and community first, Primary Care Resilience and Transformation where we are seeking to join up services and Transforming Care in Later Life.
East Coast Community Healthcare's (ECCH) Strategy	The focus on subsidiarity where if we can do something better locally, then we should do so, aligns with section 6.1 of our JFP. The principle of simplification and partnering with others aligns with other Ambitions more generally as we set out plans to deliver improvements together and improve ways into finding the right services, first time.

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Our existing ICS strategies

Existing ICS plans and strategies also support the eight Ambitions in the JFP as enablers. As they are refreshed, they will shift with the direction of national and local policies, including the forthcoming 10-year Health Plan.

Norfolk and Waveney ICS strategies have been through wide consultation and are agreed with system partners. The JFP ambitions lean into the infrastructure that these enablers can provide, particularly the role of digital, workforce and estates. Some of the key existing ICS Strategies are highlighted below.

The Norfolk and Waveney Integrated Care System covers the whole of Norfolk and part of Suffolk. Norfolk and Suffolk each have their own joint health and wellbeing strategy:

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

There is close alignment between the priorities in the Norfolk strategy and the cross-cutting themes in the Suffolk strategy. We can see the theme of collaboration running through our partners plans and the JFP as described in the previous section, the importance of health inequalities in our work which we have reinforced within each of the eight Ambitions in 2025/2026, and encouraging communities and our local population to be resilient through our place-based approach.

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

Guidance on the development of JFPs makes it clear that ICPs are required to build on these Joint Local Health & Well-Being Strategies, which are a statutory requirement, and the JFP is a delivery mechanism for these strategic priorities.

Digital Transformation Strategic Plan and Roadmap
All our Partner's Plans refer to digital transformation. Moving from paper-based patient records to electronic ones in our three acute hospitals is the start of one of the biggest pieces of digital transformation work the Hospitals have ever undertaken. You can read about it here. There have been many successful digital programmes delivered in Norfolk & Waveney over the past two years.

A Shared Care Record is live in all provider organisations and is being accessed by an average of 7,500 staff each month, helping 44,500 patients to tell their story only once.

All GP Practices have digital access methods for patients, and have new Cloud Telephony systems, improving resilience and providing patient call-back ability.

Over half the population of Norfolk & Waveney use the NHS App, viewing GP records 400,000 times in a month and requesting 900,000 prescriptions. The 3 Acute Hospitals are sharing outpatient appointment information via the NHS App.

Virtual Wards and remote monitoring technologies are enabling patients to receive care in their own homes, and integration with clinical systems used in practices and out of hours services is making the observations recorded more accessible to clinicians.

Norfolk County Council has developed an award-winning Tech Skills for Life program to help members of the community engage with technology. The coaches help with many tasks such as using Smartphones, or shopping online.

Norfolk County Council is using AI technology to identify people at risk of falls. Once identified, people are then contacted and offered a range of support such as assistive technology or help with mobility.

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These are just a few examples of digital innovations in Norfolk & Waveney.

Nationally, data has become an increasingly vital part of health and care delivery. It supports the insight we can have into what is happening, which leads to better decisions earlier, and better outcomes. We have invested in a 'Data Hub' driven by new, national data standards as well as regional and local requirements. We can simplify, standardise, collate and link the data sets, providing the capability to connect what the data tells us, and aggregate it for strategic and tactical analysis, decision making and reporting to enable us to achieve our goals, drive quality improvements and to support front line services in the delivery of safe, effective, and person-centred care.

You can read the Digital Transformation Strategic Plan and Roadmap here.

Delivery of all the Ambitions require digital as an enabler to a greater or lesser extent. Using data to evidence delivery of the JFP Ambitions has been part of our design of the objectives.

People Plan
Workforce development is a key priority for all our partners and is referenced in their strategies and plans. Central to our People Plan is the development of cultures where staff feel valued and supported to deliver outstanding care to patients and service users; in doing so it enables the service transformation in our JFP Ambitions 2 to 7 and is integral to the productivity improvements in Ambition 8. A key supporting initiative will be the continued development of an ICS-wide approach to leadership and management development to foster a "One Workforce" approach.

Multi-professional educational and training investment plans with sufficient clinical placement capacity will be required to maintain education and training pipelines. These will be supported by increased apprenticeship opportunities to "grow our own", along with a continued focus on retaining staff through enhanced support for their health and wellbeing, and the embedding of a more flexible approach to work. Part 2 of the JFP provides greater detail on how we will fulfil our duty to promote education and training, along with our plans to Train, Retain, and Reform our workforce in line with national policies for workforce transformation.

In addition, the People Plan contains several programmes to improve efficiency and productivity across the system as part of Ambition 8. Further reduction in bank and agency spend is required to meet national efficiency targets; integrated workforce plans across providers are being developed at a system level to align with the 2025/2026 operational planning requirements referred to in section 4.

You can read the current Norfolk and Waveney People Plan here.

Estates
Our Estate Strategy has recently been refreshed to incorporate the latest NHS England guidance for System Estates Infrastructure Strategies. Our system strategy is also reinforced by individual NHS Trust, GP Primary Care, and PCN estate strategies.

Our buildings and estate infrastructure play a vital role in achieving the systems mission and ambitions, and our ten-year strategy sets out how we will enable this and deliver our vision of providing estate that allows delivery of the right care in the right place, enables better patient outcomes, and empowers health, social care and third sector staff to provide the best possible care.

We are making significant investments in our hospitals, GP practices, community and mental health services. Coupled with our investment in new technology, this will help us to improve the quality and safety of people's care, the services we provide and the working lives of the thousands of people who work in health and care.

Our refreshed Estates Infrastructure Strategy is framed around four key goals: to improve access; to improve quality and condition; to improve environmental sustainability; and to improve efficiency. More detail on our strategy, goals and alignment to national and local priorities can be found in Part 2 of the JFP.

You can read the Estates strategy here.

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Net Zero Green Plan
The NWICS Green Plan drives our journey toward achieving the Net Zero NHS between 2040-2045 through actions such as:

- Supporting Primary Care Network (PCN) development in ways that promote integrated services, closer to home (Ambition 2)
- Developing Family hubs (Ambition 3)
- Primary Care Hub projects (Ambition 2)
- Community Diagnostic Centres (Ambition 7)
- An expanding virtual ward service enabling patients to recover and be monitored at home (Ambition 6)

Other parts of our Green plan include digital transformation such as our electronic patient record programme, optimising medicines to minimise impacts on the environment such as our inhalers programme and changing to inhaler types that exclude harmful propellants. We also use our programme for Nature Connection and Biodiversity to coordinate investment in our built environment to provide spaces that promote health and aid wellbeing. The ICB has a legal duty as to climate change and our response to this is set out in Part 2 of our JFP.

You can read the Net Zero Green Plan here which is about to undergo a refresh programme.

Quality Strategy
Our Quality Strategy provides a clear focus on improving care quality and outcomes, using insights around health inequalities and population health to ensure services are safe and sustainable for future generations, underpinned by continuous development of clinical leadership, quality governance, management and assurance, research, evaluation and innovation. Quality is a key theme throughout the delivery of the objectives within the eight Ambitions in the JFP.

This can be illustrated by the following examples:

- Using quality input into service development to ensure mental health services are included in wider physical health initiatives, to reduce health inequalities and promote prevention (Ambition 1) for people experiencing serious mental illness, as well as clinical quality input to the design of new pathways of care, e.g. the Dual Diagnosis pathway for substance misuse and mental health, as part of transforming mental health services (Ambition 4).Working alongside general practice, pharmacy, optometry and dental partners to take forward local, regional and national primary care resilience, improvement and transformation opportunities (Ambition 2), supporting and enabling clinical input and leadership.
- Triangulating quality assurance insights; including clinical effectiveness, safety, experience of care and learning from harms and mortality, to support and inform urgent and emergency care (Ambition 6) and elective (Ambition 7) improvement priorities.
- Empowering staff and service users to work together to improve the quality and safety of services and pathways. A good example of this is the Norfolk & Waveney Integrated Care System (ICS) Glove Reduction project which is driving a reduction in the unnecessary use of non-sterile gloves across the system, to achieve efficiencies (Ambition 8), as well as benefits for sustainable green care and patient experience.

You can read the Quality Strategy here.

Clinical Strategy
Our clinical strategy has six objectives setting out "what my NHS will do" in Norfolk and Waveney. Each of the six clinical strategy objectives can be clearly mapped against the JFP ambitions and we have adopted this approach to ensure we are consistently focusing on the same things and do not duplicate effort or reporting requirements.

You can read the Clinical Strategy and a comprehensive "You said, we did" analysis of Year 2 here.

The ICS clinical strategy, digital roadmap, the Estates strategy and Net Zero Green Plan are inter-dependent and refer to each other which gives the JFP a good foundation to build upon. The acute clinical strategy referred to in section 6.2 uses the ICS clinical strategy as its over-arching framework to ensure our workplans are aligned.

Research and Innovation
Research and Innovation can transform how we deliver care and support better use of resources to address differences in life expectancy, health outcomes and preventable causes of disease.

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Evidence from national research projects, as well as local evaluations and quality improvement projects from our system, can help us choose the best services and ways of working to address unequal health outcomes. This is one of our Legal Duties and is set out in Part 2 of the JFP. We have cross referenced Research and Innovation into the JFP Ambitions and Objectives as part of this year's refresh and priorities align directly with the JFP.

You can read the Research and Innovation Strategy here.

Medicines Optimisation
Medicines optimisation is crucial to the NHS as it ensures the safe, effective, and efficient use of medicines, improving both patient outcomes and financial sustainability.

Medicines represent the second-highest area of NHS spending after staffing; optimisation helps to manage costs while maintaining high standards of care and getting the best value healthcare for the population.

In Norfolk and Waveney, we address five key areas:

1. Quality & Safety – focuses on minimising medication errors and adverse events, ensuring that patients receive the safest and most effective treatments. Promotion of continuous improvement through monitoring, evaluation, and implementation of best practices.
2. Interface & Formulary – works to agree and improve the use, governance and commissioning of medicines.
3. Population Health & Data Analysis – uses local population data to inform strategic direction, monitor targets, and identify opportunities to improve efficiencies & health inequalities through targeted initiatives.
4. Clinical Experience & Delivery – collaboration with primary care and community healthcare professionals including Primary Care Networks to enhance patient outcomes by promoting value-based decisions using data and evidence-based guidelines.
5. Repeat Prescribing and Support - provides support and advice to GP practices to improve the quality and efficiency of repeat prescribing systems.

All the medicines optimisation key areas are enablers of the JFP Ambitions. For example, prescribing low intensity statins as a preventative measure, de-prescribing where appropriate and focusing on alternative therapies for some mental health conditions, asthma and epilepsy bundles of care for children and a focus on medicines as an area of spend across all areas of the NHS in Norfolk & Waveney as part of Ambition 8.

Ageing Well, Population Health Management and Health Inequalities Strategic Frameworks
During 2024/2025 three Strategic Frameworks were published that were as a direct outcome from Ambitions within last year's JFP.

You can read them here: Strategic Frameworks and they are also referred to in the Achievements Section 5.0.

6.4 Empowerment

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

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

6.5 People and culture

Change happens when people work together differently.

Our Organisational Development (OD) Programme will improve performance and effectiveness to shape a thriving Norfolk and Waveney ICS. We will focus on relationships with and between people and organisations we work with, the culture and processes, and support our leaders to navigate the challenges and complexity of working across organisations to consolidate and align organisational goals with shared vision and purpose for an integrated Norfolk and Waveney system. The foundation of strong relationships, a deep sense of community, a desire to make the system work for the local population of Norfolk and Waveney and, positive developmental work with key stakeholder groups and Boards across the ICS are the bedrock of our maturing ICS.

Specifically, we have implemented, and continue to build on, our 'Collective Culture' programme of compassion and inclusion to support managers, leaders and teams across our system. We are working with all of our Boards and key stakeholder groups to develop mature working relationships and structures to support the goals and ambitions of the ICS, embedding our Leadership Framework, incorporating the new NHS Code of Practice, to support the people that are leading the changes; and evaluate and review our actions with the aim of planning and co-creating the next phase of the maturity journey.

An integral part of the People and Culture enabler is the way that **clinicians and care professionals** (CCPs) are involved in decision-making. This ultimately improves the quality outcomes and experience of our local population, and it is also recognised nationally as best practice. The CCP voice is included in every decision-making group across the ICS – no decision regarding the care we provide or commission is made without formal consideration by a CCP.

We are implementing a **Leadership Framework and 10-point CCP manifesto which is on our website** CCPL Programme to take action on the 5 core principles for effective clinical and care professional leadership. New **CCP** leadership roles have been aligned to each of the ambitions outlined in the Joint Forward Plan with a focus on areas highlighted in the national Core20PLUS5 agenda, further strengthened by leadership development and wider training as we continue to establish a Norfolk and Waveney pipeline of suitably trained, supported and empowered CCPs.

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

You can read more about the Quality Faculty in part 2 of the JFP under the legal duty to improve quality of services.

We will focus on embedding a culture of innovation across the ICS and support the system to have an integrated innovation culture based on learning from, and sharing with, each other. We recognise that developing and nurturing an integrated innovation culture across a system is an evolving process, but we aim to position the importance of innovation as a central, shared concern. We will use a multi-level approach across the system to grow innovation culture and capacity, this includes a system-wide vision for innovation, sharing of innovation across teams and providers, upskilling staff across all levels, and working with external organisations. You can read more about our plans for innovation in part 2 of the JFP under the legal duty to promote research and innovation.

6.6 Engagement and Co-Production

Norfolk and Waveney are committed to listening and facilitating inclusive engagement with our people, patients and their families and carers, so we can deliver responsive and joined up care that is genuinely co-designed and produced with those that use our services. We believe that all feedback has value and should be supported through a spectrum of participation methods (Figure 13):

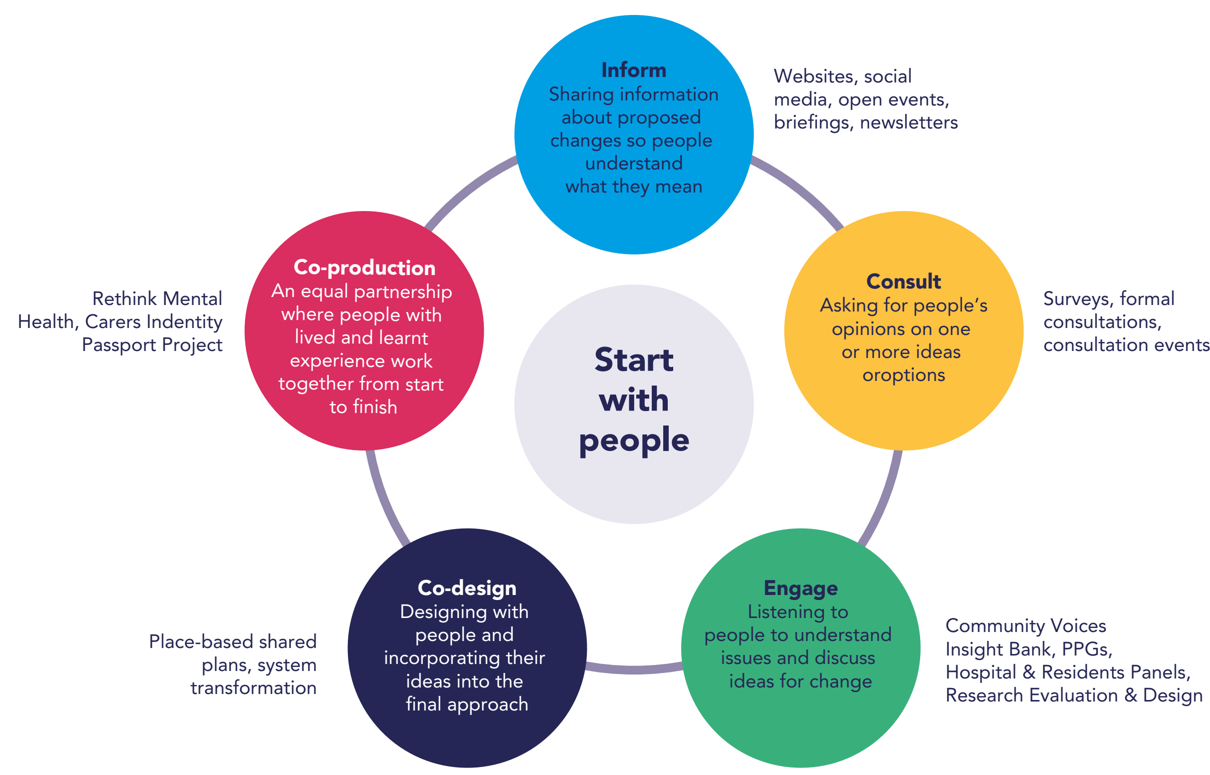

Figure 13 - spectrum of participation

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

We are working with system partners to align and develop a broad range of participation methods:

- The Norfolk and Waveney Community Voices (NWCV) Programme. NWCV works with trusted communicators – "people like me" - to speak with communities who may not already engage with the NHS and other statutory bodies to hear what is important to them. We have learned that when talking to people about health services they also talk about a range of other issues that affect their health and wellbeing, such as housing and employment. We are designing ways to capture all this insight and make sure it is shared with people who design and deliver a range of services across Norfolk and Waveney.
- Each Place Board has access to some light touch support to support them to engage with their communities. Working with people and communities at 'place' level will support all the different voices of our people and communities to be part of local decision-making, as conversations about 'the place where I live' are often much richer.
- Norfolk and Waveney Patient Experience and Engagement Leads meetings have been taking place weekly for several years and give an opportunity for people working in NHS provider trusts to meet and share practice across the system and to begin to test and develop the idea of the 'wider team' working with people and communities across the ICS to listen to and involve patient experience feedback in quality and wider commissioning.
- Communications and engagement support is being given to the Norfolk and Waveney VCSE Assembly.

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

Communications and engagement work, at a very local level, is key to developing ongoing relationships with people and communities and our new networks for engagement will be vital in supporting the work of the Joint Forward Plan.

One particular area of participation that we want to develop further with partners is around the promotion of true co-production. This refers to a process of shared power to effect change.

Examples of co-production exist in Norfolk and Waveney:

- Development of a co-production hub as part of our People and Communities hub to share examples from the system, to promote co-production principles and to signpost to support materials.
- Development of a Norfolk and Waveney Mental Health Co-production strategy and interactive toolkit Mental Health Co-production strategy for lived experience to effectively influence ICS mental health transformation, services and support.
- The Norfolk Making It Real (MiR) steering group which promotes co-production particularly for people with lived experience of physical and learning disabilities. This is in partnership with Norfolk County Council Adult Social Care.
- Supporting various NHS England funded initiatives in Norfolk and Waveney such as a series of co-production projects across the ICS around Quality Improvement, research and health inequalities.

6.7 Our VCSE Sector as system partners

Norfolk and Waveney benefits from a broad and diverse VCSE sector in which there are over 3,600 registered charities, 220 community interest companies and 124 registered societies with their offices based in Norfolk and Waveney. Many of these organisations have been born of local communities of interest or geography, responding to the local and emerging specialist needs to provide not for profit services and support. Many of these organisations will focus on early intervention and preventative services, empowering communities to build resilience and maintain control of their own lives. Alongside this are thousands more informal or unregistered organisations – often providing vital services and support to their local communities.

Our VCSE Assembly launched in July 2022 with a headline objective to connect this rich and diverse public benefit across the overarching mission for Norfolk and Waveney ICS. The Assembly provides the sector with a space in which VCSE leaders can sit alongside statutory ICS partners and have a shared agenda across local health and care priorities. Our current VCSE Assembly model aims to ensure suitable connectivity within our emerging ICS governance arrangement, enabling collaborative decision making and effective partnering.

The VCSE sector in Norfolk and Waveney continues to face a ‘perfect storm’ of rising running costs and reduced fundraising income against a backdrop of increasing demand for services and wider ICS financial pressures. More and more VCSEs are facing tough decisions as they try to maintain their public benefit mission, inevitably capacity must be reduced and in a growing number of cases services are being forced into closure. With the establishment of our Assembly, we have an opportunity for ICS partnership and strategic alignment across Ambition 1 in our JFP. This could start to shift demand away from intervention and it will help our residents live longer, healthier, and happier lives.

At its heart, the VCSE Assembly is the vehicle through which our ICS will shape the development of effective strategic and operational partnerships across the diversity of our VCSE sector. The graphic below (Figure 13) sets out how the listening and involvement work of the Assembly is being augmented; through the support, nurturing and development work of our VCSE infrastructure organisations and through improved collaboration, co-production and shared governance as an integral part of our ICS.

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Our ICS building blocks	Primary functions & responsibilities	Desired outcomes
Empowering Communities Partnership & CAS Support, nurture,develop	• Grow and enable volunteering for the ICS. • Build VCSE sector capacity & capability through practical advice, support & training. • Advocate widely on behalf of the sector and supporting sector collaboration. • Raise awareness of and support the sector to access funding and income sources. • Support the sector to maximise funding to provide sustainability and resilience. • Provide financial support to VCSE organisations seeking to grow, expand or innovate their services. • Provide opportunities for the sector to meet & collaborate for peer to peer support, and share insights.	**The collective ambition is to embed effective collaboration and partnership working between all ICS partners.**
Norfolk and Waveney VCSE Assembly Listen and involve	• Develop innovative engagement mechanisms to connect the sector into the ICS, focused on health inequalities and prevention - developed at system, place and neighbourhood levels of our ICS. • Increase the influence and participation of the sector in the collaborative design and innovative delivery of health and care services within the ICS. • Lead development of a MoU between ICS partners based on 5 priority areas of; equal partnering, sustainable resourcing, digital integration, data sharing & consistent evidence and evaluation.	**Closer working will support us to achieve our shared goals and priorities, and enable our ICS to harness the expertise, insight and innovation of the VCSE sector.**
Norfolk and Waveney ICS & VCSE Integration Collaborate, co-produce and embed	• Embed the sector in ICS governance to ensure involvement in system-wide workstreams, place-based partnerships, primary care networks and provider collaboratives. • Support sector sustainability through strategic investment and market development. • Commit to upholding the ambitions of the MoU developed in partnership with all ICS partners. • Lead a system-wide approach to developing and sustaining effective social prescribing. • Collaboratively develop a new approach to health and social care VCSE commissioning.	**N&W needs a VCSE sector that is vibrant, sustainable and resilient, is seen and treated as an equal partner and fully integrated into our ICS at system, place and neighbourhood levels.**

Figure 14 – building effective partnerships with the VCSE sector

VCSE Assembly Development
An initial focus on place-based VCSE representation through the first pilot year of the Assembly has helped to build a strong blueprint for improved partnering across some parts of our system. Moving into the second year of the Assembly, this model was adjusted to reflect the ways of working across the ICB and our Places, and we have continued to learn from this. With a new VCSE Assembly Chair in place (October 2024), we will explore how we can maximise place-based representation so local voices are heard at a system level. We have also recognised a need to strengthen the way in which VCSE experience, and the lived experience of the communities which we serve, is brought to our ICS strategic framework.

Facilitating the effective development of an Assembly operating model, alongside suitable Assembly Board memberships continue to demonstrate our shared ambition to respond to the national ICS commitment which highlights the VCSE sector is a key strategic partner. They have an important contribution to make in shaping, improving, and delivering services, and developing and implementing plans to tackle the wider determinants of health.

Health Inequalities Strategic Framework for Action
The VCSE sector was extensively engaged in the development of this framework, setting an approach for the way in which such lived experience is brought to the development of other ICS wide strategies. A newly formed Health Inequalities and VCSE Partnering team will both champion the roll out of this framework and the engagement of the VCSE sector in its delivery.

Impact and evaluation
So many conversations keep coming back to building a shared understanding of the value that improved VCSE partnering will bring to our system. To support this, we will continue to work collaboratively with both VCSE and statutory partners to develop a new approach to VCSE sector commissioning, as well as exploring how we best partner with the sector, and support sector resilience. There are numerous local examples of health and care commissioners working together with VCSE organisations, to deliver improved outcomes for our population.

Feedback from the sector and commissioners confirms to us that having an effective ICS VCSE commissioning strategy would enable us to do more. A further priority for the VCSE Assembly is to work with ICS partners to understand how VCSE led work, alongside prevention activity delivered by ICS statutory bodies can support with long term cost savings and enable us to move towards achieving the goals of the new 10- year Health Plan for the NHS, primarily the shift from sickness to prevention. Following the publication of our Health Inequalities Strategic Framework, we will have more opportunity to understand and monitor the impact of preventative and early interventions for members of our local population who are in greatest need of support.

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Case Study

Great Yarmouth and Waveney Health Connect

In Great Yarmouth and Waveney, we had evidence that residents often face challenges in finding the right community support when their health needs change, particularly after being discharged from the hospital. This observation led to the establishment of a welfare support team known as Health Connect.

Health Connect is a collaborative initiative led by the NHS, VCSE and local government. The programme aims to help residents recover more quickly following a hospital discharge and avoid hospital readmissions by providing practical and emotional support at home, while also linking them to broader health, social, and community services.

The service is delivered by four trained connectors employed by East Coast Community Healthcare. These connectors reach out to patients shortly after a referral made by their clinician, to assess their ongoing needs. If necessary, they visit the patient at home to discuss their health or wider concerns. Appointments may include problem-solving, health observations, equipment provision, care coordination, or connecting the resident with community services, such as social groups, clubs, classes, events, volunteering, or counselling.

Now in its second year, the service has contacted over 9,000 residents following a hospital discharge or NHS community intervention and provided one-on-one follow-up support to over 2,000 residents. Feedback from residents has been positive, highlighting the importance of adopting a holistic approach and why linking clinical and social needs is critical to ensure continued health improvement.

An example of the model is on the following page.

Actions

Phone call to recently discharged patients with an underlying respiratory diagnosis
Questions:
How are you? Do you need help with:
- Stopping smoking
- Vaccination
- Keeping your house warm or damp/mould free
- Social support
- Access to respiratory services such as pulmonary rehabilitation
- Keeping active
- Eating well
- Money matters
- Keeping well

Outputs

Referrals to:
- Smoking cessation
- Warm Homes Suffolk
- Vaccination
- NHS services
- Social services
- Dietician
- Support or exercise groups

Number of people who have:
- Attended smoking cessation
- Had a home environment assessment
- Had all 3 vaccines
- Improved wellbeing and have better access to services

Outcomes

Short-term

Increased knowledge, awareness, motivation for all availability and accessibility of services

Increased health and wellbeing behaviours
- reduced smoking
- vaccinated flu, covid, pneumonia
- increased physical activity
- better diet
- protective behaviours (hand washing etc)

Healthy home environment:
- damp & mould
- home >=18C in winter

Improved attendance to support services:
- pulmonary rehabilitation
- support groups eg BreathEasy

Improved mental health and wellbeing

Intermediate

Reduced emergency hospital admissions for respiratory conditions

Long-term

Reduced COPD and chronic respiratory disease in Suffolk

Improved health and wellbeing for those with respiratory conditions

7.0 Commitment to achievable, measurable and impactful improvements

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7.0 Commitment to achievable, measurable and impactful improvements

The improvements we make are quantitatively and qualitatively measured through system Programme Boards and monitored using a Programme Management Office (PMO) approach, reported to the ICBs Commissioning and Performance Sub-Committee, the Integrated Care Partnership and Health & WellBeing Board in annual plans and on our ICS website. A summary of key metrics is shown in Figure 15.

Our commitment is to listen to the people who use our services to hear if we are successfully improving the health and care for the people and communities of Norfolk and Waveney and in doing so deliver our JFP ambitions.

Joint Forward Plan eight Ambitions and underpinning objectives

Ambition	Ambition Objective	How will we know we are achieving our objectives?
1	**PHM, Reducing Inequalities & Supporting Prevention**	
1a	Delivery of two strategic programmes: The Norfolk and Waveney Health Inequalities (HI) Strategic Framework for Action and the Norfolk and Waveney Population Health Management (PHM) Strategy	Delivery against the objectives in our published action plans. Monitor progress using our Population Health and Inequalities dashboard of key measures.
1b	Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people	We aim to see annual smoking at time of delivery rates to reduce by March 2026 towards the regional and national average of 9% and to reduce further to 6% by the end of March 2028.
1c	Early Cancer Diagnosis – Lung Cancer Screening (formerly called the Targeted Lung Health Check or TLHC programme)	We will track the number of invitations sent, and how many of these invitations result in people attending for a lunch health check (we call this a 'conversion rate'). We also provide quality assurance and audit data on a quarterly basis against the national quality standard. This includes our lung cancer diagnoses and other findings including other cancers.
1d	Cardiovascular Disease (CVD) Prevention – develop a programme of population health management interventions targeting High Blood Pressure and Cholesterol	In the short-term, our digital tool will enable us to track numbers of patient contacts, new prescriptions, and optimisation rates in real time. In the longer term we would expect to see reduction in inequalities in terms of early mortality, reduction in admissions related to CVD related events. Data will be available via CVD PREVENT to benchmark our system. Targets for treatment will follow national NHSE operational planning guidance which will be adopted once made available each year.
2	**Primary Care Resilience & Transformation**	
2a	Developing our vision for providing accessible enhanced primary care services, improving patient outcomes and experience	Publication of a Strategic Framework for Primary Care Publication of long-term plans for community pharmacy and general practice Improve patient experience of access to general practice as measured by the ONS Health Insights Survey. Implement Primary Care Improvement Plans in line with NSHE priorities and planning guidance for 2025/2026, including: • Reduction in unwarranted variation. • Increased activity for Pharmacy First, and clinical services
2b	Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.	Increased unscheduled care appointments in line with the 2025/2026 NHSE trajectory for Norfolk & Waveney The number of new patients being seen and treated by an NHS dentist from April 2023 as a baseline

Figure 15 final metric summary (continues overleaf)

Ambition	Ambition Objective	How will we know we are achieving our objectives?
3	**Improving Services for Babies, Children, Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS)**	
3a	Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach.	The programme team is currently working with the DfE/DHSC to ensure impact associated with the first three years of this transformation programme can be showcased and sustained into year four. At a local level a performance measurement dashboard has been developed to track the identified KPI's across the programme and for each individual work strand and this will continue to be refined throughout the next 12 months, for example: 1. Feedback from families on Start for Life and Family Hubs offer (e.g. inclusive, 90% accessible, co-ordinated approach, greater connection through services, easier to navigate access services). 2. 90% access integrated referral pathways tell story once and 90% of families access the advice, information and guidance they need feedback from parent and carer panel feedback. 3. More Practitioners across agencies work in a whole family approach (data single view – data sharing agreements). 4. Families receiving help to manage financial challenges (measured through Department of Work & Pensions advisors embedded in Family Hubs). 5. Families accessing non funded services. 6. Parents accessing Start for Life and Family Hub services have improved understanding of the contribution to child's wellbeing, achievement and school attendance. Measured increase in number of families receiving support and increase in school attendance. 7. Families with SEND receive early support reducing escalation measured through reduction in Education Health and Care Plan (EHCP) and needing access alternative provision. 8. Improved health and development outcomes for babies and children with focus on most deprived 20% of Norfolk population (measured by aligned public health outcomes).
3b	Continued development of our Local Maternity and Neonatal System (LMNS), including the Three-Year Maternity Delivery Plan	Implementation of the Three-Year delivery plan for maternity and neonatal services.
3c	Implementation of asthma and epilepsy recommendations for Children and Young People.	• Decreased asthma related hospital admissions for young people aged 10-18. • Decreased epilepsy related hospital admissions for children and young people aged 0-19. • Reduction in the use of reliever medications • 20% of CYP from deprived areas have asthma care plans in place. • Increased access to epilepsy specialist nurses in the first year of care.
3d	Develop an improved and appropriate offer for Children's Neurodiversity	• Improved patient experience evidenced through feedback with families. • A reduction in waits to specialist services. • Increase in 'appropriate' referrals to services. • Reduction in complaints regarding barriers to accessing care. • Number of unique users of the digital library.
4	**Transforming Mental Health Services**	
4a	We will work together to increase awareness of mental health; enable our population to develop skills and knowledge to support wellbeing and improve mental health; and deliver a refreshed suicide prevention strategy. This will prompt early intervention and prevention for people of all ages, including those who experience inequalities or challenges to their mental health and wellbeing.	There will be a measurable change in self-reported mental wellbeing – the number of people reporting high anxiety, low happiness and low worthwhile scores. Rates of suicide and self-harm will decrease.

Figure 15 final metric summary (continues overleaf)

Ambition	Ambition Objective	How will we know we are achieving our objectives?
4b	Mobilise an adult mental health collaborative and a children and young people's collaborative so that partners work as one to deliver better health outcomes for our people and communities	The impact will be measured by actively seeking feedback from our people and communities, families and carers, and workforce, before and after any change that is implemented. We will see an increase in the numbers of children accessing mental health support at an earlier stage and a reduction in admissions to inpatient provision.
4c	Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'Integrated Front Door' so all requests for advice, guidance and help are accepted, and the appropriate level of support is given to ensure that needs are met.	We will be able to measure an increase in the number of children and young people accessing the right support to meet their emotional wellbeing and mental health needs. This will be evidenced through the CYP Mental Health access metric within the national Mental Health Services Data Set (MHSDS) and through patient reported outcome measures.
4d	We will see the whole person for who they are, developing pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on dual diagnosis and Complex Emotional Needs (CEN)	Complex Emotional Needs • 300 additional staff trained per year in Knowledge and Understanding Framework, Dialectical Behavioural Therapy, or psychologically informed approaches system-wide. • Increase in numbers of service users able to access a psychologically informed intervention outside of NHS Talking Therapies and secondary care offer. • A reduction in presentations to Emergency Departments for patients with Personality Disorder. Dual Diagnosis • Achieve an increased number of referrals (as per Year 1 plans and trajectory) accepted via the dual diagnosis pathway. • A reduction in presentations to emergency departments for service users with mental health needs and drug or alcohol problems.
	Transforming Care in later life	
5a	To have health, carer and support services that are fit for our ageing population - supporting people as they age, to lead longer, healthier, happier lives	• All statutory providers signed up to the Dementia Charter by April 2025. • Increased Dementia diagnosis "rate" based on diagnosed patients versus the estimated number of people living with Dementia by March 2027. • Increased use of a standardised frailty scoring tool across the ICS to ensure better understanding of individuals' needs by March 2026, enabling specific support to be put in place at an earlier stage. • A reduction in the number of ambulance conveyances and unplanned admissions from care homes and residential homes by March 2027. • An increase in the number of ReSPECT forms in place for patients with frailty by March 2027.
6	**Improving Urgent and Emergency Care (UEC)**	
6a	Integrate urgent care to improve emergency response times across all organisations	• Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/2025. • Improve Category 2* ambulance response times to an average of 30 minutes across 2025/2026.
6b	Expand virtual ward services	Virtual Ward bed occupancy is at least 80%
6c	Reduce length of stay (LoS) in hospitals	We will monitor our acute hospital average Length of Stay and aim to reduce this to 7 days.

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Ambition	Ambition Objective	How will we know we are achieving our objectives?
7	**Elective Recovery & Improvement**	
7a	Effectively utilise capacity across all Health System Partners	We will work to achieve national targets: Elective, by March 2026: • 60% of patients receive elective treatment within 18 weeks. • Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list. • Increase the proportion of patients receiving their first elective care appointment within 18 weeks to 67%. Cancer, by March 2026: • Improve performance against the headline 62-day standard to 75%. • Improve performance against the 28-day Faster Diagnosis Standard to 80%.
7b	Implement digital technology to enable elective recovery	• Reduce missed appointments rates to 4% or below by March 2026. • Increase the uptake of PIFU pathways to 5% of outpatient attendances by March 2026.
8	**Improving Productivity and Efficiency**	
8a	To deliver our Medium-Term Financial Plan	• Delivery of our Medium-Term Financial Plan. • Improvement in clinical productivity in our Trusts measured through benchmarking. • Reduction in spend on bank and agency staff. • Progress made from Analogue to Digital – go live of the Electronic Patient Record in Q4 of 2025/2026.

Figure 15 final metric summary

Glossary

A glossary of terms for the Joint Forward Plan is available here.

We have also developed a list of the latest acronyms and terms that are used in the NHS and on our social media channels for the Integrated Care System (ICS). It is available on the ICS website here.

Sources

The data that is referenced in Section 3.0 has been sourced from:
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