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Norfolk and Waveney Integrated Care System

Health Inequalities Impact Report: A response to the NHSE Statement on Information on Health Inequalities

Norfolk and Waveney Integrated Care Board, April 2025

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Foreword

Our Norfolk and Waveney Integrated Care System (ICS) published a Health Inequalities Strategic Framework for Action in May 2024, which is overseen by our Integrated Care Partnership. Our 10 year framework sets out a vision, principles and a clear ask of all our ICS partners to take action in their own organisations to address inequalities. The Health Inequalities Framework is being delivered by its partner organisations, all making commitments which has given us a firm foundation in the first year of its implementation, but there is still much for us to do.

It is important we maintain momentum. NHS England and our Norfolk and Waveney ICB alongside other ICBs across the country, are all currently under national reform, as is local government. In addition our collective system partners are all financially challenged, this means it is more important than ever that we continue to take action together and build on our foundations to address health inequalities found in our most underserved communities. This can only be achieved by working both close to and with our communities across N&W.

This report gives us a very clear steer on where we need to prioritise our focus to make a lasting impact. Not only should we be engaging with our communities and different groups that experience discrimination to ensure services are accessible and delivered in a way that is appropriate for all, we also need to ensure that we support our workforce in all our organisations to ensure we tackle inequalities in all we do.

This statement demonstrates our understanding of health care needs. We demonstrate use of data including the qualitative insights from our communities to plan, strategically commission and transform health care working with our communities of N&W and with all our partners, health, care, local government and our Voluntary, Community and Social Enterprise (VCSE) . We will use this improved quality of data and insights from communities to support our strategic planning and ensure we are prioritising our valuable resources to ensure the best outcomes for our Norfolk & Waveney residents.

Tracy Williams, Clinical Steward - Health Inequalities and Inclusion Health

Introduction

About this document

This report demonstrates how as a NHS Integrated Care Board we are meeting our duties to understand the health inequalities in Norfolk and Waveney and how we are acting to reduce them.

This requires us to collect, analyse and publish information in relation to the Statement on Information on Health Inequalities as given by NHS England (NHSE) further to its duty under section 13SA of the National Health Service (NHS) Act 2006.

This statement providers the opportunity:

- To help the Integrated Care System identify disparities in access to services and patient outcomes, highlighting where change is needed.
- To improve data collection and recording, for example ethnicity recording which will support action on reducing health inequalities.
- To distil key messages and explain what the data is saying - leading to more detailed and robust analysis to further reduce inequalities.
- To provide evidence that we are meeting our legal duties and taking action on the healthcare inequalities we are seeing in our system.

This report also responds to the ask in the operational planning guidance 2025/26.

How are we using the Statement on Information on Health Inequalities in Norfolk & Waveney?

We recognise the differences in our communities from their health needs, their ability to acecss services (both digitally and in person) and the ways they want to get involved.

It is intended that the information within this report should be used by services, our staff and decision makers to inform service improvement and reductions in healthcare inequalities, as well as build understanding of the actions already underway and planned for 2025/26. This lets us tailor services to the needs of our population in each area, improve peoples health, prevent illnesses and make better use of public resources.

The NHSE Statement on Information on Health Inequalities requires us to:

Understanding general healthcare needs

- Adopt a population health management approach, which helps us to understand people's health and care needs and how they are likely to change in the future, underpinned by hearing from our people and communities.
- Build from our Joint Strategic Needs Assessment (JSNA) to support our integrated care systems strategy development.

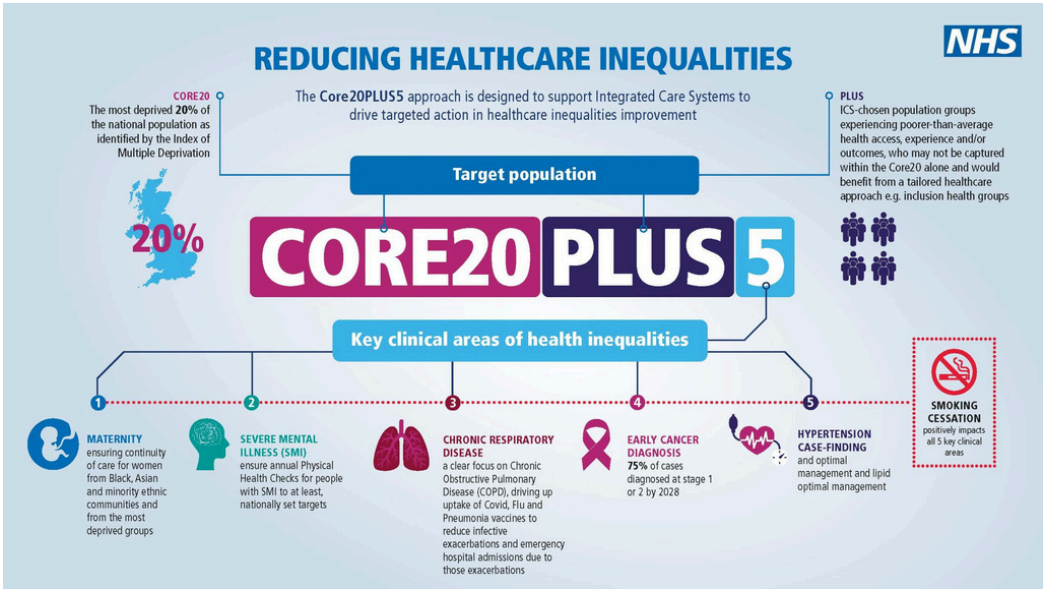
Understanding healthcare access, experience and outcomes

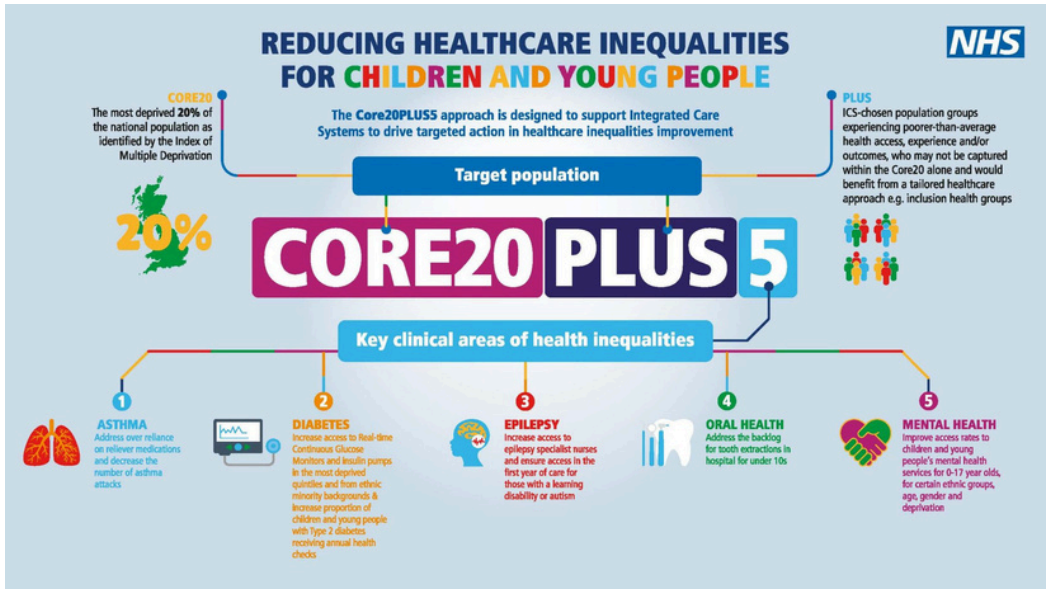
- Collate, analyse and publish performance information disaggregated by a limited number of variables where available (mainly age, sex, ethnicity, deprivation).
- Access to healthcare refers to the availability of services and can be measure by monitoring uptake of services and referrals. Some factors may be more likely to negatively impact those in the most deprived areas and people from minority ethnic groups. Other barriers such as location of services, transport, and work commitments may also affect ability to access healthcare.
- Experience data alongside other insights such as patient feedback, and listening to those with lived experience are key in helping healthcare drive forward positive, patient-centred change and embedding personalised care approaches which will help to breakdown any barriers and to reduce health inequalities.

Informing service improvements and reductions in healthcare inequalities

- Enabling preventative and proactive healthcare, equitable access to health services and co-producing services with people with lived experience to support improvement in outcomes and reducing inequalities.
- Use data to inform service improvements e.g. through resource allocation.
- Encouraged to collect, analyse (and publish) other information.
- Support service evaluations, commissioning and delivery decisions.

Norfolk and Waveney has adopted the Core20plus5 frameworks





In Norfolk & Waveney the following 'PLUS' groups have been identified as having poorer outcomes:

- Ethnic minority communities
- Inclusion health groups
- People with a learning disability and autistic people
- Coastal and rural communities
- Young carers and looked after children
- Armed Forces community

Inclusion health groups include:

- People who experience homelessness
- People with drug & alcohol dependence
- Vulnerable migrants and refugees
- Gypsy, Roma & Traveller communities
- People in contact with the justice system
- Victims of modern slavery
- Sex workers
- Other marginalised groups

Our overall approach

Norfolk and Waveney ICS Health Inequalities Strategic Framework for Action

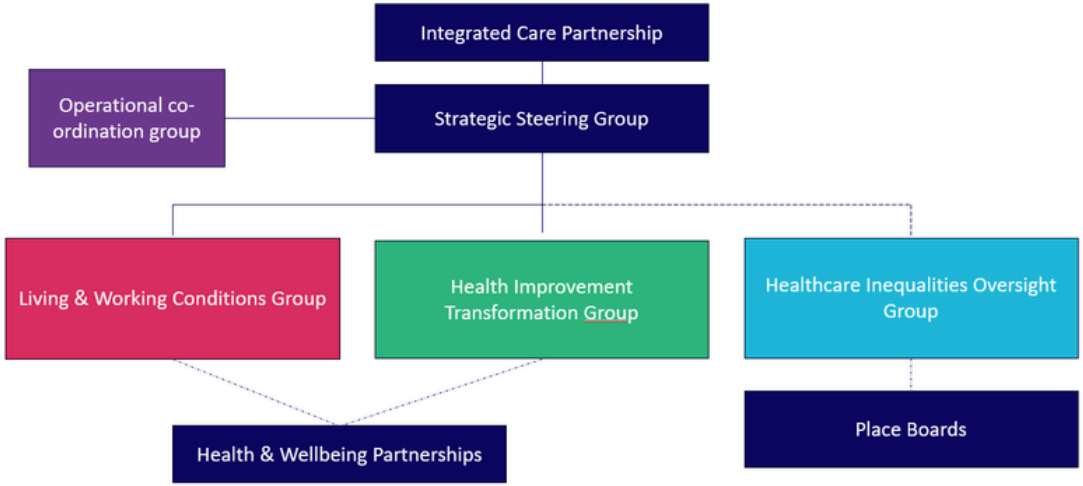
The ICB, working with partners from across the Integrated Care System, co-designed a Health Inequalities Strategic Framework for Action which was published in 2024, to drive our collective action across Norfolk and Waveney.

The 'Framework' was developed via an extensive engagement approach, working with colleagues across the NHS, local government and the Voluntary, Community and Social Enterprise (VCSE Sector).

The Framework identified 10 actions for the first 10 months, with a focus on creating the foundations for success and tackling structural inequalities in our system. These actions lay the foundation for future success.

A leadership structure, reporting to our Integrated Care Partnership, has been established to take forward our collective action.

Leadership groups for each of the 3 pillars or 'areas of focus' of our Framework have been established. Living and Working Conditions is being led by our local government and VCSE colleagues, Health Improvement (primary prevention) by Public Health and Healthcare Inequalities by the ICB. A whole-system, multi-agency approach is implicit within all of these groups.



A Health Inequalities Strategic Steering Group, made up of the Chairs and Vice-Chairs of the Leadership Groups has been established to support, enable and embed our collective action.

This Steering Group is supported by an operational Coordination Group, who are practically driving the implementation of the first 10 actions in the first year and responsible for the development of future year plans.

Our first 10 actions in the first year

We committed to 10 actions in our first year of implementation that will create a stronger foundation for future long-term activity. These actions have been delivered via a cross-agency approach facilitated by the Coordination Group. Some of the key actions and progress made includes:

- A continued 'Health Inequalities Conversation' with emphasis on creating strong system-leadership, ICP development and establishing leadership groups that create a foundation on which to further implement the framework and ensure sustained efforts throughout a period of significant change.
- Changing the ICP terms of reference to enable a 'sub-group' to lead and oversee the implementation of the Framework – the ICS Health Inequalities Steering Group. This group consists of the Chairs and Vice Chairs of the Living & Working Condition Group, Health Improvement Transformation Group, Healthcare Inequalities Group, VCSE Assembly and Coordination Group.
- Creation of learning and sharing environments, including initial scoping, planning and launch of an ICS Health Inequalities Ambassadors Network, initially bringing together the 35 Core20 Ambassadors that are participating in the national programme.
- Continued investment into and development of our VCSE Assembly to further our strategic relationships with the VCSE sector and enable equitable partnering and a increased collaboration with partners that are working closely with communities.
- A demonstrable increase in knowledge around the Health Inequalities Framework, development of collaborative relationships and understanding of what the system is doing to tackle inequalities, as demonstrated by our 'temperature checks'.
- Launch of self-assessment processes that supports organisations to develop organisational improvement plans, undertaken by a range of organisations including the Integrated Care Board, Queen Elizabeth Hospital, James Paget Hospital, Norfolk and Norwich Hospital, Norfolk and Suffolk Foundation Trust, East Coast Community Healthcare, as well as VCSE and local government organisations. (See appendix x for example improvement plans from Queen Elizabeth Hospital and the Integrated Care Board).
- Developing and launching a primary care Health Inequalities training pilot, commenced in Feb 2025, an ambition to scale this up across the integrated care system for other organisations to access.
- A health inequalities dashboard which includes the key metrics for each of our 'building blocks' for success and will enable our leadership groups and place-based structures to plan and monitor impact.
- Continued development and a system commitment to the Community Voices programme, enabling seldom-heard voices to inform and influence service design and planning, as well as improve health literacy and access to services in our communities.
- A system commitment to developing an 'equitable resourcing' approach and policy.
- A review and refresh of 8 Health and Wellbeing Partnership strategies, utilising a Health Inequalities Toolkit to enable alignment to the Health Inequalities Framework commencing from April 2025.
- Resourcing an integrated, shared post between ICB and Norfolk County Council Public Health to drive year 2 actions and continued development of our leadership structures.

Embedding health inequalities in everything that we do within the ICB

The Integrated Care Board has formally made the **Health Inequalities Commitment** and has undertaken a number of actions in 2024/25 to further our progress in addressing structural inequalities and tackling differences in outcomes, experience and access for our Core20plus communities. These actions include:

- Continued oversight of our work to tackle health inequalities via our Patient and Communities Committee, Population Health and Inequalities Board, Health Inequalities Oversight Group and Population Health Management Oversight Group.
- Investment into a Health Inequalities and VCSE Partnering team to lead our organisation, and wider system, in our approach to addressing health inequalities.
- The co-design of an ICB Health Inequalities Organisational Improvement plan, following a self-assessment and engagement process across leadership and the wider workforce. This process established a baseline understanding and generated solutions and ideas to embed tackling health inequalities in all that we do. The ICB Health Inequalities Improvement Plan 2025-2027 can be seen here.
- Every objective within the 8 ambitions of the 5 year Joint Forward includes a requirement for action and reporting against health inequalities.
- The redesign and relaunch of a robust Equality and Health Inequalities Impact Assessment (EHIA), including the formation of a panel to review and support development of all EHIAs and integration with the Quality Impact Assessment to ensure a combined approach. Regular reviews are underway, and feedback is being sought from colleagues completing the assessment, to inform future training and development.
- A review and refresh of the Equality and Diversity Staff Group, including new terms of reference developed following a cross-organisational survey with our workforce to seek feedback. More information can be found here.
- Participation in the NHSE Core20plus Ambassador programme to further develop our network of organisational advocates.
- Identification of 2 Non-Exec Directors to participate in an NHS Providers ICB health inequalities training programme, and the identification of a nominated Non-Exec Director ‘health inequalities sponsor’
- Programme groups and work plans established for 5 key workstreams - Population Health Management, Core20plus5, NHS Anchors, Inclusion Health and Access, Support & Health Literacy.
- Continued investment into our Community Voices, Wellness on Wheels and Protect NoW programmes.

Community Voices

The Community Voices programme works with trusted communicators in the VCSE sector and local government organisations to engage communities that experience health inequalities. Initiated during the pandemic, this programme seeks to improve access to services with a focus on the 5 clinical priorities of the Core20plus5 health improvement frameworks. Through training of trusted communicators, we aim to improve health literacy within communities, and we record and analyse the insights gathered around barriers and enablers to influence and support future service design and strategic decision making ,captured in a central Insight bank. Community Voices has delivered 10 projects, including access to Covid vaccination, bowel cancer screening, smoking cessation, refugee and asylum seeker health, asthma in children and young people, healthy hearts (CVD) and on focusing on diversity in research participation aligned with the Research Engagement Network (REN) programme.

- Gained insights from over 1,500 residents that experience significant health inequalities and recorded these on a central insight bank.
- Worked in partnership with 50+ VCSE and local government organisations.
- Provided training to over 120 trusted communicators, such as Making Every Contact Count (MECC) and behaviour change, the COM-B model and smoking/smoking in pregnancy, asthma risk and management, CVD and cancer signs, symptoms and screening.
- Read a Community Voices case study here.

Community Voices

Using your feedback to improve care

Community insights and data that is recorded in the Insight bank is being used to inform service reviews, to target services in certain areas of Norfolk and Waveney where access has been poor, and to support multiple funding bids. For example, Community Voices insights have informed and supported:

- the procurement of the NHS talking Therapies in Norfolk
- the development of the Health Inequalities Framework for the Norfolk and Waveney Integrated Care System

Wellness on Wheels

The Wellness on Wheels bus is a service that seeks to engage our Core20plus communities, enabling access a variety of health services alongside support for socio-economic elements of someone's life. This is in recognition that a number of our Core20plus Communities do not access services in traditional ways and due the rurality of Norfolk and Waveney some populations have to travel longer distances to gain support.

Over the last 12 months from April 2024 to March 2025, the WoW bus has visited over 70 different locations across Norfolk and Waveney. These locations include a number of our Core20 Communities, of which there are 42 and several of our Plus Communities working with the VCSE sector, General Practice and statutory organisations.

These visits have been supported by a number of service providers that include:

- COVID vaccines alongside teenage vaccine boosters.
- NHS Health Checks.
- Community Dental Service
- Eye clinics
- Family hubs across all of Norfolk.
- Happy Smiles Club
- Breast Cancer Now
- Wellbeing Hub in Lowestoft
- Planning and Integrated Care – Waveney, Adult Social Care (ASC)
- iCaSH outreach - contraception and sexual health

From April 2024 to January 2025 over 593 Covid vaccines and 281 "other vaccinations" delivered onboard the Wellness on Wheels bus. These other vaccinations include childhood immunisations and RSV vaccination in pregnancy. Alongside the vaccinations almost 100 Health Checks were delivered onboard the bus identifying patients with high risk factors for cholesterol, high blood pressure and pre-diabetes.

Protect NoW

Population Health Management (PHM) is the foundation of how we design and deliver proactive, preventative care across the Norfolk and Waveney ICS. The PHM team uses linked data, local insight, and a targeted approach to reduce health inequalities and improve outcomes. In 2024/25, PHM delivery was fully aligned to the Core20PLUS5 approach, with interventions and patient engagement prioritised by deprivation and need.

What action have we taken?

Targeted Outreach via Protect NoW virtual support team

- Our Virtual Support Team (VST) reached over 60,000 residents in 2024/25 through a wide range of personalised interventions.
- Outreach was tailored and sequenced by Index of Multiple Deprivation (IMD), ensuring those living in the most deprived areas (IMD 1–2) were contacted first.
- This equity-first approach was used across key programmes including diabetes prevention, cancer screening, cold homes, and mental health access.

Infrastructure and data tools

- Rolled out Eclipse, enabling real-time population segmentation and risk stratification.
- Linked in with the development the Registered Population Explorer Tool created by the ICB BI Team to support analysis by deprivation, ethnicity, condition, and geography.
- Local Authority built an integrated a PHM Insights Platform to link health, care, and local authority data for informed planning and action.

Protect-NoW

Proactive Population Health and Care for Norfolk and Waveney

Protect NoW is tackling inequalities and improving access to health and care services for Norfolk and Waveney.

Example PHM-led interventions:

Maternity Social Prescribing Pilot

- Launched to support pregnant women from IMD 1–2 areas, offering non-clinical support from the first midwife appointment.
- Referrals included financial, housing and community wellbeing support through Family Hubs.

Bowel Cancer Screening

- Identified practices with low uptake and high deprivation, enabling the VST to deliver proactive outreach and reminders to boost screening participation.

Digital Weight Management & NDPP

- PHM engagement campaigns significantly increased uptake in priority areas, particularly among patients with diabetes, obesity or hypertension in IMD 1–4. Norfolk & Waveney was one of the lowest performing areas in respect to the Digital Weight Management and NHS Diabetes Prevention Programmes. PHM leadership has boosted Norfolk & Waveney's performance to one of the highest in the country

Energy Efficiency (West Norfolk)

- Combined health and housing datasets to identify individuals at risk due to cold homes and respiratory conditions, especially in deprived and rural areas.
- Eligible patients were supported with grants and home improvements. PHM also supported Waveney in this type of work, applying similar approaches to identify and assist residents facing fuel poverty and related health risks.

Mental Health Access

- Applied PHM segmentation to identify and directly contact people with mild-to-moderate needs, supporting self-referral into Talking Therapies and reducing pressure on primary care.
- Targeted outreach focused on individuals in the lowest IMD quintiles.

What impact have we had?

- Engaged over 60,000 people with tailored PHM outreach, prioritised by need and deprivation across Norfolk and Waveney.
- Achieved above-national uptake rates for the Digital Weight Management and NHS Diabetes Prevention Programmes in areas with previously low engagement.
- Improved early cancer detection by focusing screening outreach on practices in the most deprived areas with lowest uptake.
- Supported better maternity outcomes by addressing early social risk factors among pregnant women in high-need areas through non-clinical referral pathways.
- Enabled targeted action on housing-related health risks (e.g. cold and damp) by combining clinical and socioeconomic data, leading to more efficient use of support grants.
- Increased mental health access and choice through self-referral promotion, especially among populations in deprivation deciles 1–4.
- Embedded PHM infrastructure (Eclipse, Data Hub, Population Explorer Tool) is now in routine use across ICS workstreams, supporting data-driven and equitable decision making.

What action do we plan to take in 2025/26

- Extend Protect NoW outreach to additional populations and localities, continuing to prioritise support using IMD and Core20PLUS5 criteria.
- Support further PHM-led outreach and engagement across the ICS — including lung cancer screening, diabetes education, and weight management — guided by population-level data and risk stratification.
- Integrate evaluation and equity monitoring into all programmes using our PHM assurance and reporting framework.
- Continue to roll out PHM training and workforce development, embedding the approach across neighbourhood, place, and system levels.
- Expand use of predictive analytics through Eclipse to enable earlier, more personalised interventions that prevent escalation of need.

West Norfolk Marmot Place Programme

Partners within King's Lynn and West Norfolk have initiated a two-year Programme, in association with Professor Sir Michael Marmot's Institute of Health Equity, to drive action in reducing health inequalities across the Borough.

A Marmot Place recognises that health and health inequalities are mostly shaped by the social determinants of health: the conditions in which people are born, grow, live, work and age, and takes action to improve health and reduce health inequalities.

The King's Lynn and West Norfolk Programme was launched in March 2025, and reflects the commitment from partners to work together to tackle significant inequalities; which currently result in as much as a gap of 10 years of life expectancy between communities within the Borough. There is a willingness to learn from fellow Marmot Places, be guided by expert input from the Institute of Health Equity and to take collective action.

The Marmot Programme is working on assembling data in relation to the Marmot 8 principles and engaging with community members and stakeholders. There is currently a particular focus on gathering evidence and ideas regarding the theme of 'Starting Well' – enabling children, young people and their families to get the best start in life. The team are also mindful of the significant rurality within King's Lynn and West Norfolk and the inequalities that can sometimes be under-appreciated within conventional need assessments. This is therefore a cross-cutting theme that the team will return to over the course of the Programme.

The methodology and learning from the Programme will be shared with colleagues across the wider Norfolk & Waveney system, and there will be opportunities to collaborate with East Suffolk as they will also be participating in the Marmot Programme in the near future.

Active NoW

The Active NoW model aims to support inactive populations, those with identified long term conditions (LTC), and those that experience the greatest inequalities, to more effectively access appropriate physical activity opportunities to improve their health and wellbeing, in line with the NHS England Physical Activity Position Statement.

The programme has three key elements:

- Strategic programme development, management and growth planning, including embedding in health pathways
- Single point of access referral service for both health and social care professionals to directly refer to physical activity
- Locality delivery with Health & Wellbeing Partnerships - aligning with existing local assets to create more capacity

The programme is led by a Partnership including colleagues from local government, ICB and Active Partnerships, and has leadership support from the ICS Physical Activity Strategic Leadership Group.

Active NoW has received over 10,000 referrals, since it's launch in January 2023. Of these referrals 69% have gone on to access some of physical activity, with 66% of these still taking up activity 6 months later.
This referral data can then be broken down further:

- 21% of all referrals are from Core 20 populations, with a Core 20 referral rate increasing to between 23% - 50% in district areas with more deprived MSOA's (Great Yarmouth, East Suffolk, Breckland and West Norfolk).
- 295 referrals have COPD, 1848 referrals have Hypertension, 288 referrals have Chronic Heart Disease, 1212 referrals have Diabetes, 1319 referrals have mental health concerns, 277 referrals have Severe Mental Illness, 146 referrals have Cancer
- 27% of referrals have a disability
- 61% of referrals are female
- 15% aged 45-54, 21% 55-64, 21% 65-74, 20% 75+

Impact

- 58% of participants stated that managing their health condition had somewhat improved, with a further 23% saying it had greatly improved.
- 65% of participants had said their general health had somewhat improved, with a further 21% saying it had greatly improved.
- 54% of participants had said their mental wellbeing had somewhat improved, with a further 24% saying it had greatly improved.
- 70% of participants stated that their physical fitness had somewhat improved, with a further 22% saying it had greatly improved.
- 53% of participants have said that they somewhat feel better about themselves, with a further 23% saying it had greatly improved.

Active NoW has also demonstrated a social return on investment of £22.45 for every £1 spent in primary wellbeing value and £1.55 for every £1 spent in secondary system value. This was calculated using the Sport England ROI tool, which is endorsed by the Treasury.

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Norfolk and Waveney Integrated Care System

Norfolk and Waveney Data

As of April 2025

Key

How to interpret the information

DSR takes account of different age structures between groups or areas. A crude rate does not. Crude rate is used when age is not likely to impact indicator e.g. % of patients in whom the last blood pressure reading is below the age-appropriate treatment threshold.

These ethnic groups are compared to White British

A higher value has been assigned "Good" or "Bad" and is a starter for 10 to enable discussion and highlight significant differences between groups. It can be changed.

Indicator	Measure	Sex Female vs Male	Core20 vs Non Core 20	Inclusion Health vs Non Inclusion Health	Asian or Asian British	Black or Black British	Chinese	Mixed	Any other ethnic group	White Other	Not Recorded	Deprivation SII	Higher Value
Indicator 1	DSR	higher	no different	higher	lower	lower	lower	lower	lower	lower	lower	higher in most deprived to lower in least deprived	Good
Indicator 2	Crude Rate	no different	no different	Lower	no different	no different	no different	no different	no different	no different	no different	not significant	Good
Indicator 3	DSR	no different	higher	higher	Not Enough Data	Not Enough Data	lower	no different	no different	no different	no different	higher in least deprived to lower in most deprived	Bad

Higher value	Colour and text	Interpretation
Good	higher	**A higher value is generally a better outcome**. A statistically significant higher value compared to the comparator group that indicates a better outcome
Bad	lower	**A lower value is generally a better outcome**. A statistically significant lower value compared to the comparator group that indicates a better outcome
Good	lower	**A higher value is generally a better outcome**. A statistically significant lower value compared to the comparator group that indicates a worse outcome
Bad	higher	**A lower value is generally a better outcome**. A statistically significant higher value compared to the comparator group that indicates a worse outcome
Good / Bad	no different	The value is not significantly different from the comparator group
Good / Bad	Not Enough Data	Not enough data to calculate standardised rate

Deprivation SII = Slope Index of Inequality	Interpretation
higher in most deprived to lower in least deprived	The slope across deprivation deciles is statistically significant and indicates the value generally **increases** with deprivation
not significant	No significant slope across deprivation deciles
higher in least deprived to lower in most deprived	The slope across deprivation deciles is statistically significant and indicates the value generally **decreases** with deprivation

Elective Care

Indicator	Measure	Sex Female vs Male	Core20 vs Non Core 20	Inclusion Health vs Non Inclusion Health	Asian or Asian British	Black or Black British	Chinese	Mixed	Any other ethnic group	White Other	Not Recorded	Deprivation SII	Higher Value
Waiting list overall	DSR	higher	no different	higher	lower	lower	lower	lower	lower	lower	lower	higher in most deprived to lower in least deprived	Good
Size and shape of planned care waiting list (admitted & non admitted combined): <18 weeks	DSR	no different	no different	lower	no different	no different	no different	no different	no different	no different	no different	not significant	Good
Size and shape of planned care waiting list (admitted & non admitted combined): 18 to 51 weeks	DSR	no different	no different	higher	no different	no different	no different	no different	no different	no different	no different	not significant	Bad
Size and shape of planned care waiting list (admitted & non admitted combined): 52 to 64 weeks	DSR	higher	no different	no different	no different	no different	Not Enough Data	no different	no different	no different	lower	higher in least deprived to lower in most deprived	Bad
Size and shape of planned care waiting list (admitted & non admitted combined): 65+ weeks	DSR	higher	no different	no different	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	no different	not significant	Bad
Age Standardised activity rates with 95% CI for first outpatient attendances	DSR	higher	lower	higher	lower	lower	lower	lower	lower	lower	no different	higher in least deprived to lower in most deprived	Good
Age Standardised activity rates with 95% CI for follow up outpatient attendances	DSR	higher	no different	higher	lower	lower	lower	lower	lower	lower	higher	higher in most deprived to lower in least deprived	Good
Age Standardised activity rates with 95% CI for virtual outpatient attendances	DSR	higher	lower	higher	lower	lower	lower	lower	lower	lower	lower	higher in least deprived to lower in most deprived	Good
Age Standardised activity rates with 95% CI for elective inpatient admissions	DSR	higher	no different	higher	lower	lower	lower	lower	lower	lower	no different	not significant	Good
Age Standardised activity rates with 95% CI for emergency inpatient admissions	DSR	higher	higher	higher	lower	lower	lower	lower	lower	lower	higher	higher in most deprived to lower in least deprived	Bad

What does the data tell us?

The waiting list data and outpatient data does not take into account how unwell people are.

The data shows that:

- Females and inclusion health groups are more likely to be on the waiting list, the slope index of inequality shows that the more deprived an area is the more likely people are to be on the waiting list. However, when information is aggregated for core20 vs. non-core 20 the difference is not significant. All ethnic groups are less likely to be on the waiting list compared to White British.
- Inclusion health groups are more likely to be waiting longer than 18 weeks compared to non-inclusion health groups.
- Females are more likely to be on a list waiting longer compared to males - this may have something to do with the specialties for which people are waiting.
- For outpatient attendances there are higher rates for females compared to males, lower in Core20 areas, higher in Inclusion Health groups, lower across all ethnic minority groups compared to White British and for first outpatient and virtual outpatient rates appear to be higher in less deprived areas compared to more deprived (for core 20 vs non core 200 too).
- A similar picture to outpatient attendances is seen for elective admissions but there is no significant gradient in admission rates by deprivation decile.
- Emergency admission rates are significantly higher for females, core20 areas, inclusion health groups. The slope index of inequality shows that more deprived an area is the higher the emergency admission rate. All ethnicities appear to have lower emergency admission rates than white British.

Summary of Findings

Gender disparities: Females have higher rates for most indicators, including waiting lists and many types of care attendances

Deprivation impact: More deprived areas generally show higher rates for waiting lists and emergency admissions

Ethnicity patterns: Most ethnic minority groups show lower rates across indicators compared to White British

Waiting times: Longer waiting times (52+ weeks) are more prevalent among females and show varied patterns across deprivation levels

What action have we taken and what impact have we had?

System-wide Patient Tracking List (PTL)
A centralised PTL dashboard has been developed to improve visibility across NNUH, JPUH, and QEH. This tool standardises patient tracking lists, creates a system-wide data view and enabling mutual aid redistribution to optimise capacity and reduce excessive waits. The SPTL helps identify geographical and provider-based variations in waiting times, ensuring fairer distribution of resources. By integrating data from multiple sources, the system can supports early identification of high-risk patients, enabling proactive intervention and prioritisation for those most at risk of harm from long waits.

Patient Engagement Portal (PEP) to Reduce DNAs
The implementation of a PEP across all three Acute's, enhances patient communication and engagement through appointment reminders. Patients receive reminders via SMS, email, or app notifications, reducing the likelihood of missed appointments due to forgetfulness or lack of awareness. PEP provides multiple communication methods to improve engagement and accessibility. While digital options offer convenience for many patients, those who opt out or do not respond digitally will receive a hard copy of their appointment details by post to ensure they are fully informed.

Volunteer-Led Initiative to Prevent Missed Appointments
A volunteer-led call service has been piloted across NNUH, QEH, and JPUH to proactively engages patients before their diagnostic appointments. Volunteers remind patients, address potential barriers, and provide practical support, such as transport information or assistance with rescheduling. At NNUH, this initiative has resulted in a 28% relative reduction in did not attend rates (DNAs) for DEXA scans, preventing over 300 missed appointments and improving booking system efficiency. This service reduces waste and improves productivity by ensuring space, staff and equipment are utilised as planned through rebooking patients who are unable to attend and offering the slot to somebody else.

What action do we plan to take in 2025/26?

Supporting Vulnerable and Disadvantaged Patients

- Work with health inequalities services, providers, and partners to improve access for patients with multiple long-term conditions.
- Use patient forums and local working groups to shape services that meet community needs.

Enhancing Patient Engagement and Reducing DNAs

- Continue Patient Engagement Portal (PEP) rollout across NNUH, JPUH, and QEH to improve communication, reduce DNAs, and enhance patient experience.
- Ensure patients who opt out of digital communication receive postal appointment details.
- Initiatives that support the best use of resources, such as the a recent volunteer-led initiative to help more people attend their diagnostics appointments, will continue to be explored.

Maximising Capacity and Reducing Waiting Times

- Optimise system-wide capacity through Mutual Aid, allowing patients to access care sooner at any of the three acute hospitals.
- Increase collaboration with independent sector providers to further reduce waiting times.

Addressing Health Inequalities Through Data and Digital Inclusion

- Regularly review waiting list data (CORE20PLUS methodologies) to identify and address inequalities in access.
- Improve data quality and recording to better understand deprivation and ethnicity factors.
- Expand NHS App use while addressing digital barriers as part of wider system transformation

Urgent and Emergency Care

Indicator	Measure	Sex Female vs Male	Core20 vs Non Core 20	Inclusion Health vs Non Inclusion Health	Asian or Asian British	Black or Black British	Chinese	Mixed	Any other ethnic group	White Other	Not Recorded	Deprivation SII	higher value
Emergency admissions for under 19s	Crude Rate	no different	higher	higher	lower	lower	lower	lower	lower	lower	higher	higher in most deprived to lower in least deprived	Bad
Emergency admissions for under 19s asthma, diabetes, epilepsy	Crude Rate	lower	higher	higher	no different	no different	no different	no different	no different	no different	higher	higher in most deprived to lower in least deprived	Bad
Conversion rate for Type 1 ED attendances	DSR	no different	no different	higher	no different	no different	no different	no different	no different	no different	higher	higher in most deprived to lower in least deprived	Good
A&E 4 hour breach	DSR	higher	higher	higher	no different	no different	no different	no different	no different	lower	higher	higher in most deprived to lower in least deprived	Bad
A&E 12 hour breach	DSR	lower	higher	higher	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	no different	higher	higher in most deprived to lower in least deprived	Bad
A&E attendance rates	DSR	higher	higher	higher	lower	lower	lower	lower	lower	lower	higher	higher in most deprived to lower in least deprived	Bad
Age Standardised activity rates with 95% CI for emergency inpatient admissions	DSR	higher	higher	higher	lower	lower	lower	lower	lower	lower	higher	higher in most deprived to lower in least deprived	Bad

What does the data tell us?

For the selected urgent and emergency care indicators the data shows that:

- For all measures outlined ethnic groups experience rates that are not significantly different or significantly lower than those of White British
- Core 20 populations experience higher rates compared to non-core 20 populations
- Inclusion health groups experience higher rates compared to non-inclusion health groups
- Females experience lower rates compared to males apart for asthma, epilepsy and diabetes and 12 hour breach
- There is a gradient in urgent and emergency care rates where rates are higher in more deprived populations compared to less deprived

Summary of Findings

Deprivation correlation: Higher rates of emergency admissions, A&E attendances, and breaches in more deprived areas

Core20 areas: Show higher rates across almost all emergency indicators

Inclusion Health groups: Experience higher rates for all emergency care indicators

Ethnic minorities: Generally show lower attendance and admission rates compared to White British

Cardiovascular Disease

Indicator	Measure	Sex Female vs Male	Core20 vs Non Core 20	Inclusion Health vs Non Inclusion Health	Asian or Asian British	Black or Black British	Chinese	Mixed	Any other ethnic group	White Other	Not Recorded	Deprivation SII	higher value
Stroke rate of non-elective admissions (per 100,000, age-sex standardised)	DSR	lower	higher	higher	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	no different	higher	higher in most deprived to lower in least deprived	Bad
Myocardial infarction - rate of non-elective admissions (per 100,000, age-sex standardised)	DSR	lower	higher	higher	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	lower	higher	higher in most deprived to lower in least deprived	Bad
% of patients aged 18 and over with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold	Crude Rate	higher	lower	no different	no different	lower	no different	no different	lower	lower	no different	higher in least deprived to lower in most deprived	Good
% of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy	Crude Rate	no different	higher	lower	no different	no different	no different	lower	no different	no different	no different	higher in most deprived to lower in least deprived	Good
% of patients aged 18 and over with GP recorded atrial fibrillation and a record of CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy	Crude Rate	no different	no different	lower	lower	lower	lower	lower	no different	no different	no different	not significant	Good

What does the data tell us?

The cardiovascular disease indicators table shows:

- Gender differences with males experiencing higher rates of stroke and myocardial infarction admissions. There appear to be no difference in secondary prevention and patient management between males and females.
- Core20 areas and Inclusion Health groups show significantly higher non-elective admission rates for both stroke and heart attacks.
- Hypertension management is better for females compared to males, better for those from less deprived communities, worse for Black or Black British, White Other and Any other Ethnic Group
- However, for managing cardio-vascular disease(CVD)risk the proportion on lipid lowering therapy is better in the more deprived communities but worse in inclusion health groups.
- Management of stroke risk for those diagnosed with AF is worse for most ethnic groups and inclusion health groups. However, there appears to be no differences related to deprivation
- Socioeconomic deprivation is associated with higher emergency admission rates for both stroke and heart attacks, though has mixed impact on medication management indicators (hypertension managed to target – higher in less deprived, Atrial fibrillation (AF) patients prescribed anti-coagulant – no difference, high CVD risk patients prescribed lipid lowering therapy – higher in more deprived). This might indicate that more deprived communities are relatively more ill than less deprived and there are also some secondary prevention opportunities to address inequalities.

Summary of Findings

Gender patterns: Lower stroke and MI admission rates for females

Treatment compliance: Varied patterns in secondary prevention across different groups

Deprivation impact: Higher emergency admission rates for stroke and MI in more deprived areas

Ethnic disparities: Some ethnic groups show lower rates of blood pressure control and anticoagulation therapy

What action have we taken and what impact have we had?

Lowestoft Healthy Hearts Programme

Aimed at addressing cardiovascular health inequalities in Lowestoft where emergency admissions and CVD-related premature deaths, exceed both national and ICS averages. 20 Lower Super Output Areas (LSOAs) in East Suffolk are in the 20% most deprived nationally, and 18 of these are in the Lowestoft area. The programme is led by a Place Partnership including colleagues from local government, Primary Care, ICB, Health Innovation East, and Public Health focused on primary and secondary prevention.

To ensure the community were significantly involved in shaping the approach, a 6month N&W Community Voices engagement programme with local VCSE partners was developed, to helped to inform the design of the programme.

As a result, three key components were developed, focused on 1) preventing hypertension, 2) detecting undiagnosed hypertension and finally 3) protecting the health of those with diagnosed hypertension by optimising their health. These elements have included

- Prevent: Supported by a hypertension media campaign and recruitment of a dedicated 'Healthy Hearts' behaviour change advisors as part of the Feel Good Suffolk local team, who leads a heart health programme.
- Detect: Supported by a Sisu Health check pod located in Lowestoft Library and free for any members of the public to use. Launched in September 2024 with 640 health checks completed by 1st April 25. Participant data shows a median age of 38yrs, 58% female, living on average in IMD 2 and 13% had high Blood Pressure, 61% were obese and 24% smokers. 156 triggers to contact GP/Pharmacist for high Body mass index /Blood Pressure.
- Protect: Supported by Expertcare, 3500 Lowestoft patients identified via CVD Prevent data as benefiting from a hypertension case review are being proactively contacted. All practices in the PCN are involved and until 18th Feb, a 16.6% increase in optimised patient outcomes was identified.

Lowestoft Healthy Hearts

What action do we plan to take in 2025/26?

Lowestoft Healthy Hearts

- Complete the optimisation pilot within Lowestoft Healthy Hearts ‘protect’ activity and finalise a full evidence and evaluation of the whole programme.
- Further enhance the follow-up support following a Health Check in Lowestoft library, including options for members of the public to request direct support from Feel Good Suffolk

-Hypertension and Lipids Optimisation Project

- This project will utilise Eclipse to case-find and risk-stratify patients needed CVD intervention. Eclipse criteria will incorporate CORE20Plus as part of this to target communities experiencing inequalities.

Healthy Hearts events and campaigns

- Focusing on our Core20plus communities we will utilise our Community Voices and WOW bus assets to support summer campaign activity in target communities, improving health literacy and supporting access to services.

CVD Prevention

- Norfolk & Waveney ICB are leading CVD prevention elements of the regional new models of care work, which includes a focus on health inequalities activity.

Diabetes

Indicator	Measure	Sex Female vs Male	Core20 vs Non Core 20	Inclusion Health vs Non Inclusion Health	Asian or Asian British	Black or Black British	Chinese	Mixed	Any other ethnic group	White Other	Not Recorded	Deprivation SII	higher value
Variation between people with diabetes receiving all 8 care processes	Crude Rate	lower	no different	lower	no different	no different	no different	no different	no different	no different	no different	not significant	Good

What does the data tell us?

For Diabetes eight care processes the picture is similar to the cardiovascular secondary prevention indicators in that inequality does not appear to be present for most groups. However, this is not the case for Inclusion Health Groups and females where the number receiving all eight care processes is lower than the comparator.

What action have we taken and what impact have we had?

The NHS Diabetes Prevention Programme (NDPP)

- This programme offers face-to-face and digital support to patients with Non-Diabetic Hyperglycaemia (pre-diabetes) or a history of Gestational Diabetes (GDM), helping them adopt healthy lifestyle changes to reduce their risk of developing Type 2 Diabetes.
- The ICB commenced a Population Health Management project in Jan 2025 to recruit underserved communities to the NDPP. The focus is on communities with High Prevalence of Non-Diabetic Hyperglycaemia and 40% most deprived population or comparatively low referrals.

Transitioning Young Adults

- Young adults aged 19-25 with diabetes, especially from deprived communities, have higher care needs and often disengage during their transition to adult services. In March 2023, Norfolk and Norwich University Hospital (NNUH) launched a Transition and Young Adult pilot service to improve outcomes. This initiative reduced missed appointments from 17% to 7%, improved diabetes control, reduced hospital admissions, and enhanced socio-economic factors.

Type 2 Diabetes Path to Remission (T2DR)

- This programme offers a low-calorie, total diet replacement treatment for individuals with type 2 diabetes and obesity. It aims to help participants adopt healthy lifestyle changes to lose weight and achieve diabetes remission. The first year saw greater GP practice engagement and patient participation than expected, particularly from some of the more deprived communities (rate of 43 per 1,000 referrals form Quintiles 1 and 2 compared to a rate of 37 overall).

What action do we plan to take in 2025/26?

- Continue proactive engagement of underserved communities to NHS Diabetes Prevention Programme utilising Population Health Management projects.
- Support the system to roll out dedicated Transitioning Young Adult support within hospital diabetes services.
- Work with the Type 2 Diabetes Path to Remission (T2DR) provider to prioritise engagement of general practices with communities with higher identified need e.g. Core 20 areas and/or high type 2 diabetes prevalence, and or populations that are underrepresented in similar programmes such as males and younger age groups.
- Diabetes Technologies Working Group to review demographics data related to uptake of Diabetes Technologies and refine patient engagement in line with findings.

Learning Disability

Indicator	Measure	Sex Female vs Male	Core20 vs Non Core 20	Inclusion Health vs Non Inclusion Health	Asian or Asian British	Black or Black British	Chinese	Mixed	Any other ethnic group	White Other	Not Recorded	Deprivation SII	higher value
Learning Disability Annual Health Checks	DSR	no different	no different	higher	Not Enough Data	Not Enough Data	Not Enough Data	lower	no different	no different	no different	higher in most deprived to lower in least deprived	Good
Adult Mental Health inpatient rates for people with a learning disability	DSR	Not Enough Data	Not Enough Data	no different	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	Not enough data	Bad
Adult Mental Health inpatient rates for people with autism	DSR	no different	no different	no different	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	no different	Not enough data	Bad

What does the data tell us?

For learning disabilities and autism:

- The numbers are relatively small for meaningful comparison across the different ethnic groups
- Annual health checks are higher in Inclusion Health groups and generally the more deprived the areas the higher the rate of annual health checks
- Mental health admissions: No significant differences observed where data was available

What action have we taken and what impact have we had?

- In 2024/25, Norfolk & Waveney delivered more learning disability Health checks than in any of the previous three years. This marks a significant achievement for the system and demonstrates the ongoing commitment of practices and partners to improving health outcomes for people with a learning disability. There was also an increase in the number of Health Action Plans completed alongside annual health checks
- Delivery of LD Annual Health Checks to 14–17 year olds increased significantly, reflecting targeted engagement effort via school visits, and promotion on the WOW Bus tour
- Despite comprising only two members, the Health Improvement for Disabilities Team provided extensive support to General Practice throughout the year, focusing on increasing LD Annual Health Check uptake, especially among younger patients, and improving the quality of health checks
- ·Over the past year we have continued to develop the Transforming Care Partnership to help expedite discharges from inpatient care. We have rolled out staff training across the whole Integrated Care System (ICS) in Positive Behaviour Support (PBS) and Oliver McGowan Training (OMT) which will provide health and social care staff with the core capabilities to care for people with learning disabilities and Autistic people
- We have established a system wide group to drive the Stopping over medication of people with a learning disability and autistic people (STOMP) and Supporting treatment and appropriate medication in paediatrics (STAMP)
- We have improved the process, systems and governance around the DSR and the CTR process has been updated in line with the new policy 2023 to ensure consistency across the Norfolk and Waveney ICS. The system also ensures targeted wrap around support to anyone in the community who is flagging as an amber risk and is vulnerable to needing an inpatient bed
- We have published Quick Reference Guides for autistic young people and adults
- We have co-produced enhanced resources to ensure information is accessible

What action do we plan to take in 2025/26?

- Learning Disability Annual Health Checks: all localities met or exceeded the national target, with the exception of West Norfolk, which narrowly missed the threshold on this occasion. However, focused efforts are already underway to strengthen delivery in West Norfolk and ensure improvements in the next reporting year
- Sustain and enhance support to General Practice to ensure consistent, high-quality delivery of LD Health Checks.
- Expand the impact of the Health Improvement for LD Team, ensuring their support remains accessible system wide
- Explore how our system could use the Health Equalities Framework (HEF) in learning disability and autism services to implement an outcome-based way of working which better highlights vulnerabilities for people across their lives
- Improve our response to our autistic population, prevent admissions and re-admissions to inpatient services, ensure reasonable adjustments are made to improve access and experience of Autistic people

Cancer

Indicator	Measure	Sex Female vs Male	Core20 vs Non Core 20	Inclusion Health vs Non Inclusion Health	Asian or Asian British	Black or Black British	Chinese	Mixed	Any other ethnic group	White Other	Not Recorded	Deprivation SII	higher value
Cancers diagnosed at stage 1 and 2	Crude Rate	higher	no different	lower	no different	lower	lower	lower	no different	no different	no different	higher in least deprived to lower in most deprived	Good

Indicator	Measure	Sex Female vs Male	Core20 vs Non Core 20	Inclusion Health vs Non Inclusion Health	Asian or Asian British	Black or Black British	Chinese	Mixed	Any other ethnic group	White Other	Not Recorded	Deprivation SII	higher value
Cancers diagnosed at stage 1 and 2	Crude Rate	higher	no different	lower	no different	lower	lower	lower	no different	no different	no different	higher in least deprived to lower in most deprived	Good

What does the data tell us?

For the early stage diagnosis of cancer (cancers diagnosed at stage 1 and 2) :

When we look at crude rates

- Females have a higher % of cancers diagnosed early compared to men
- Inclusion health groups, chinese, black or black British and mixed ethnic groups all experience lower % of cancers diagnosed early
- There is a gradient from most deprived to least deprived in that the more deprived the lower the % of cancers diagnosed early

When we take into account age most of the difference disappears apart from for the Asian or Asian British ethnic group where early stage diagnosis is lower than white british

What action have we taken and what impact have we had?

- Community Voices Women's Health Project – collaborated to include Screening and Signs/Symptoms. Builds on previous Bowel Screening Project – ongoing.
- Community Voices Lung Cancer Screening Project – working with the Great Yarmouth Community Marshalls and Healthwatch to improve uptake onto the programme from our most deprived communities in Great Yarmouth and to gather insights into barriers and enablers to engagement
- Continuation of the Cancer Pathway review with Opening Doors (Health Experts with lived experience of Learning Disability (LD) and or Autism) – Charter and action plan created with input from HCP and teams working with LD and/or A population (primary focus on LD population)
- Cancer Voices – engagement with people with lived experience of cancer.
- Scoping of a Population Health Management approach to maximising Bowel Screening (to focus initially on Practices below 60% target coverage).
- Community Pharmacy –direct referral to Rapid Diagnostic Service – 27 consultations, 8 referrals, I diagnosis.

What action do we plan to take in 2025/26?

- Working with Primary Care to support Early Diagnosis and more preventative activity
- Using data from Public Health and Cancer Alliance alongside patient/population insights to highlight key areas for focus.
- Continuation of System projects that support Health Inequalities and reduce variation
- Expansion of the Lung Cancer Screening Programme across Norfolk and Waveney with the initial focus on areas of highest deprivation in Norwich and Kings Lynn/West Norfolk. Continue the delivery of the programme in Great Yarmouth & Gorleston & Lowestoft. Expand communication and engagement activity across the patch with particular focus on Core 20 populations.
- Phase 2 of the Community Voices project in Great Yarmouth targeting specific groups in the most deprived populations, with a particular emphasis on current smokers who are least likely to engage

Respiratory

Indicator	Measure	Sex Female vs Male	Core20 vs Non Core 20	Inclusion Health vs Non Inclusion Health	Asian or Asian British	Black or Black British	Chinese	Mixed	Any other ethnic group	White Other	Not Recorded	Deprivation SII	higher value
Uptake of Covid-19 vaccines 65+	DSR	no different	lower	no different	lower	lower	lower	lower	lower	lower	lower	higher in least deprived to lower in most deprived	Good
Uptake of Flu vaccines 65+	DSR	higher	lower	no different	lower	lower	lower	lower	lower	lower	lower	higher in least deprived to lower in most deprived	Good
Uptake of COVID and Flu vaccines 65+	DSR	no different	lower	no different	lower	lower	lower	lower	lower	lower	lower	higher in least deprived to lower in most deprived	Good

What does the data tell us?

For the respiratory covid and flu vaccine indicators for those aged 65 and over:

- Females have higher uptake of flu vaccines than males.
- Core 20 communities have lower uptake than non-core 20
- The slope index of inequality shows that the more deprived a community is the lower the uptake of vaccines
- All ethnic groups have lower uptake of vaccines than White British

What action have we taken and what impact have we had?

Great Yarmouth Health Connect Respiratory Pilot

A pilot focussed on reducing respiratory health inequalities in Great Yarmouth and Waveney (GYW), where substantial socioeconomic difficulties have resulted in a higher prevalence of COPD. In GYW, the core 20 population represent 36% of COPD cases, with 48% of these being active smokers. For comparison, the figures for the rest of Norfolk are 16% and 23%, respectively.

- The respiratory pilot builds on an existing GYW service called Health Connect, which supports individuals in GYW at risk of admission or readmission following poor health. The respiratory pilot adds a defined patient cohort and targeted outcomes.
- Developed to identify and support patients being discharged from James Paget University Hospital (JPUH) following a respiratory related admission or those with respiratory conditions as a co-morbidity.
- Led by Place Partnerships including colleagues from East Coast Community Healthcare, local government, ICB, acute trust, Public Health, and VCSE.
- The core ambition is to improve quality of life and prevent, reduce and delay the need to access health and care services
- This is achieved by exploring the wider determinants of health and providing effective care navigation. For example, promoting smoking cessation, the uptake of vaccinations, pulmonary rehabilitation, the development of self-management plans, positive health behaviours, positive lifestyle choices, the benefits of warm homes, damp/mould awareness, and having a ‘what matters to you’ conversation.
- Service access is analysed through a Health Inequalities lens to identify and remedy any challenges that may prevent equal access to care and equitable outcomes across the GYW footprint.
- Delivery commenced in January 2025 and anecdotal evidence suggests improved quality of life.
- Over the 18-month pilot, impact on health service usage will be measured by the ICBs data hub. We anticipate reduced acute activity, with care moving closer to home and delivered in the community.

Vaccine Inequalities

- Outreach to Core20plus communities to deliver COVID and flu vaccines via the Wellness on Wheels bus

What action do we plan to take in 2025/26?

- Continued delivery of vaccine outreach via the Wellness on Wheels bus
- Continue proactive engagement of underserved communities to NHS Pulmonary Rehabilitation Programme utilising Population Health Management projects.
- Development of Pulmonary Rehabilitation Web based platform. Offering information across multiple languages and opportunity to participate in a virtual programme where location, transport and work commitments do not allow face to face attendance.

Mental Health

Indicator	Measure	Sex Female vs Male	Core20 vs Non Core 20	Inclusion Health vs Non Inclusion Health	Asian or Asian British	Black or Black British	Chinese	Mixed	Any other ethnic group	White Other	Not Recorded	Deprivation SII	higher value
Severe Mental Illness (SMI) physical health checks - number of people receiving all 6 checks within last 12 months	DSR	no different	no different	no different	no different	no different	Not Enough Data	Not Enough Data	Not Enough Data	no different	no different	not significant	Good
Rates of total Mental Health Act detentions	DSR	no different	higher	higher	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	higher	higher in most deprived to lower in least deprived	Bad
NHS Talking therapies (formerly IAPT) recovery - Talking Therapies recovery rate by ethnicity	DSR	no different	lower	lower	no different	no different	Not Enough Data	lower	no different	no different	lower	higher in least deprived to lower in most deprived	Good
CYP Mental Health access	DSR	higher	higher	higher	lower	lower	lower	lower	lower	lower	no different	higher in most deprived to lower in least deprived	Good
Adult mental health inpatient admissions	DSR	higher	higher	higher	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	Not Enough Data	higher	higher in most deprived to lower in least deprived	Bad

What does the data tell us?

For the selected mental health indicators, the data shows that:

- For physical health checks for people with severe mental illness there appears to be no difference in the rates of completion of the six physical health checks for different ethnic groups compared to White British, core 20 vs non-core 20, inclusion health groups vs non-inclusion health and there is no gradient with deprivation decile. This suggests no systematic inequality in this metric.
- However, there appear to be inequalities in rates of mental health act detentions (sections) and adult mental health inpatient admissions:
- Higher rates among people who live in Core20 areas and those in Inclusion Health groups
- The more deprived a community is the higher the rates of mental health act detentions
- There is insufficient data for most ethnic groups but there are higher rates for "Not Recorded" ethnic category
- Females appear to be more likely to be admitted as a mental health inpatient when compared to males (which might be due to reasons for admission)
- NHS Talking therapies (IAPT) recovery rate:
  - Lower recovery rates in Core20 areas, Inclusion Health groups, mixed ethnicity groups and for "Not Recorded" ethnic category.
  - There is also a gradient across the deprivation deciles that shows recovery rates are lower the more deprived the community is.
- CYP Mental Health access (age ≤25):
  - Higher access rates for females, the Core20 areas, Inclusion Health groups and the more deprived a community is the higher the access rate. However, there is lower access across all ethnic minority groups compared to White British

Summary of Findings

Access disparities: Children and young people's mental health access is higher for females and in deprived areas

Treatment inequality: Lower NHS Talking Therapies recovery rates in Core20 and Inclusion Health populations

Detentions: Higher rates of Mental Health Act detentions in Core20 and Inclusion Health groups and more deprived areas

Limited ethnic data: Many mental health indicators lack sufficient data for ethnic minority comparisons

What action have we taken and what impact have we had?

All-Age Mental Health Coproduction Strategy
The development of the 2024/2025 ICS all age Mental Health Coproduction Strategy, included a commitment to prioritise focus on addressing mental health inequalities. In addition, the restructuring of the adult mental health strategic commissioning team gave , with a distinct focus on work at and with Place, allowing a more tailored approach to meeting the needs of local communities and reducing health inequalities.

Inpatient Plan
We have supported NSFT to implement an Inpatient Plan delivering a 3-year quality focussed review of Mental Health Acute Inpatient Care across the ICS, including a programme of work on Culture of Care to address, amongst other things, inequity of care.

Talking Therapies
Under the new Talking Therapies contract, we have implemented targeted initiatives to improve access for underserved groups. This includes the collaboration with Broadland Housing's Tenancy Support Team to support older adults and the NSFT refugee assessment clinic, which provides a clear referral pathway into Talking Therapies. Additionally, the In partnership with Norfolk Community Foundation using 'Community Hotspot' data to identifies and engages high-need communities, improving access and reducing barriers to mental health support.

SMI Health Checks
We commissioned an Outreach service provided by Together for Mental Wellbeing to support the uptake of Annual Physical Health checks for people with Severe Mental Illness. (SMI). This service contacts people who have not engaged with their health check, to encourage attendance; they can provide practical support to attend their appointments.

Physical activity
We have funded Active NoW are funded to provide a specialist physical activity pathway to support people with Severe Mental illness (SMI) to become more active. This has seen 277 people with an SMI participate in physical activity.

What action do we plan to take in 2025/26?

- We will work with NHSE regional team and support colleagues leading a review of NSFT Older Peoples provision, to support the ICS to meet the needs of older people experiencing mental ill-health more effectively.
- To deliver a focused NHSE funded pilot, in partnership with primary care, NSFT, ICB Medicines management, and research and development teams; to address the overprescribing of opioids, and anti-depressants in the Great Yarmouth and Lowestoft area.
- Under the new Talking Therapies contract, the focus for 2025/26 is to expand from 19 to 47 delivery locations; ensuring equitable access across rural and deprived communities. We will strengthen physical and mental health pathway integration, enhance co-production with service users, and improve digital accessibility through a system dashboard and portal. Targeted efforts in areas like Nelson and Heacham wards will address low referral rates among deprived and older populations, reducing inequalities in access and outcomes.

Oral Health

Indicator	Measure	Sex Female vs Male	Core20 vs Non Core 20	Inclusion Health vs Non Inclusion Health	Asian or Asian British	Black or Black British	Chinese	Mixed	Any other ethnic group	White Other	Not Recorded	Deprivation SII	higher value
Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (number of admissions, not number of teeth)	Crude Rate	no different	no different	higher	no different	no different	no different	no different	no different	no different	higher	not significant	Bad

What does the data tell us?

For oral health and tooth extractions:

- There is limited data but there appear to be higher tooth extraction rates for children in inclusion health groups and for children without ethnicity recorded

What action have we taken and what impact have we had?

Child Focused Dental Practice pathway
The 'Child Focused Dental Practice' (CFDP) programme is an innovative scheme adopted by NWICB to address the current shortage of access to quality assured dental care for children under the age of 18 in a primary care setting. The pilot aims to empower oral healthcare teams to undertake dental care for these children, thus helping to improve timely access to treatment, and reducing the number of onward referrals to community and specialist paediatric dental services. It is a collaborative approach between local providers and community dental services.

What action do we plan to take in 2025/26?

- Mobilisation of CFDP pathway from March 2025 – end March 2027 supported by Clinical Lead and Fellow
- Mini Mouth Care Matters initiative (led by Fellow) working with GP practices
- Review GIRFT report for community dental services (Jan 2025) and new regional paediatric service specification and agree next steps
- Work in collaboration with local authority public health teams to support toothbrushing scheme for 3, 4 and 5 year olds (national scheme)
- Build upon existing oral health prevention and education schemes for CYP in schools, nurseries etc

Maternity

Indicator	Measure	Sex Female vs Male	Core20 vs Non Core 20	Inclusion Health vs Non Inclusion Health	Asian or Asian British	Black or Black British	Chinese	Mixed	Any other ethnic group	White Other	Not Recorded	Deprivation SII	higher value
Pre-term births under 37 weeks	Crude Rate	NA	higher	higher	no different	no different	no different	no different	no different	no different	higher	higher in most deprived to lower in least deprived	Bad
Perinatal mortality	Crude Rate	NA	higher	no different	no different	higher	no different	no different	no different	no different	no different	higher in most deprived to lower in least deprived	Bad

What does the data tell us?

For maternity:

- This is based on five years of data from 2020 to 2024
- There is a significant association with deprivation in that the more deprived the community is the higher the rates of pre-term births and perinatal mortality
- Pre-term births are higher in inclusion health groups
- Perinatal mortality rates are higher in Black or Black British mothers

What action have we taken and what impact have we had?

In September 2021, NHS England asked LMNS teams to develop an action plan to address how to make care more equitable for our most at-risk women and babies. This was structured around the five priorities outlined within NHS England 2020-21 operational planning guidance. In Norfolk & Waveney, equity and equality is a central theme running through everything we do. This approach enables us to retain a strong focus on our equity and equality priorities.

A snapshot of the projects we have successfully implemented this year, in collaboration with our Trusts and other partner organisations include:

- Maternity social prescribing proactively supporting our Core20PLUS families' needs during pregnancy. We are able to provide a case study for this piece of work if needed.
- #Fixing the digital divide tackling digital exclusion and poverty
- Perinatal pelvic health service supporting women at increased risk of pelvic floor dysfunction
- Maternity tobacco dependency treatment service offering bespoke support to women and birthing people
- Inclusion Health Local Learning Events enhancing staff understanding of our inclusion health communities' needs
- Preterm births pathway scoping a systemwide project to explore, understand and address preterm births.
- MNVPs supporting engagement with those who face the worst health outcomes
- Personalised Care and Support Plans supporting personalisation and informed choice and decision-making through new PCSPs launched across the system

What action do we plan to take in 2025/26?

- Preterm births implementation of the project to improve preterm birth pathways across the system to strengthen and enhance care, quality, safety and patient outcomes
- Translation and interpretation services language barriers are associated with a disproportionate risk of birth outcomes, scoping is underway to develop a project to support improved care for our non-English speaking communities
- Phase 2 of the Local Maternity and Neonatal Systems dashboard supporting improved understanding of our inclusion health population needs in real time
- Implementing a refreshed antenatal education offer to enable consistent online and face-to-face support for families
- Supporting equity and equality in our workforce we have identified a gap in our action plan and scoping will take place to better meet the needs of our workforce
- PhD research looking at refugee and asylum seeker women's experiences of birth trauma and access to support in Norfolk and Waveney

Smoking

Indicator	Proportion (%)
Proportion of mental health inpatient settings offering tobacco dependency treatments.	100%
Proportion of adult acute settings offering tobacco dependency treatments.	33%
Proportion of maternity settings offering tobacco dependency treatments.	100%

What does the data tell us?

As of April 2025:

- All mental health inpatient settings (provided by Norfolk and Suffolk NHS Foundation Trust) are offering tobacco dependence support including provision of pharmacotherapy. To date NSFT have achieved this using capacity from existing staff roles. In 2025/26 investment is being provided by the ICB to support the establishment of 2 dedicated tobacco dependence staff roles and enhance delivery and performance.
- Inpatient tobacco dependence delivery is established at one of our three acute trusts (James Paget University Hospitals NHS Foundation Trust). The acute trusts have worked together to develop a proposed new collaborative approach to tobacco dependence delivery and during the first part of 2025/26 our two remaining acute trusts will join JPUH in establishing dedicated tobacco staff roles. The tobacco advisor posts across all three sites will work together as a joint systemwide team under a shared team leader to provide enhanced sustainability and cross cover and ensure the delivery offer is consistent across Norfolk and Waveney. Therefore we expect the adult acute settings indicator to move to 100% during 2025/26.
- Maternity tobacco services are fully established at all three acute trusts in Norfolk and Waveney

What action have we taken and what impact have we had?

- Delivery of an early implementer community SMI service across Norfolk through Norfolk County Council.
- Work with local authority smoking support service Smokefree Norfolk to develop trial of outpatient support offer for partners of pregnant smokers.
- Other ICS partner work includes targeted community grant schemes in Norfolk and Suffolk and recent launch of a Norfolk social housing smoking project.

What action do we plan to take in 2025/26?

- Reduction of Smoking at Time of Delivery (SATOD) and development of maternity tobacco dependency treatment is an identified Joint Forward Plan priority objective for Norfolk and Waveney. Priority actions for 2025/26 include undertaking an evaluation post first year of delivery to identify barriers and opportunities for improvement. The evaluation will be informed by service user voice aligning with Norfolk and Waveney's Health Inequalities Strategic Framework for Action. The associated data improvement and monitoring dashboards will be used to inform development of targeted health inequalities improvement work, which will be developed and to be monitored through reporting to the Local Maternity and Neonatal System Board.
- There are also plans to work with local authority and VCSE through partnerships at local community level to ensure good access to wider community support for pregnant smokers e.g. social prescribers and peer support groups.
- Investment to establish access to acute inpatient tobacco dependence services at Queen Elizabeth and Norfolk and Norwich hospitals – currently only in place at James Paget hospital. Will enable targeted support to respiratory ward, supporting Core20+5 priority area.
- Supporting trial of COSTED model in our three acute trust ED departments (those attending EDs are generally from more deprived communities and more likely to smoke than general population)