Improving lives **together**

Norfolk and Waveney Integrated Care System

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Part 1: Joint Forward Plan 2023-2028

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Foreword

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There is nothing more important than our own and our family's health. It's why, as a country, we treasure the NHS and its dedicated staff. But vital though it is, the NHS only accounts for a fraction of our physical and mental health and wellbeing. All the rest depends on other things: genetics, our environment - whether we have decent work, enough money, close family and friends, a warm home, clean air - and our own lifestyles.

The development of our Integrated Care System is a unique opportunity to bring together the many different partners who support the health and wellbeing of Norfolk and Waveney's almost 1.1 million residents: the staff and organisations working in the NHS and social care; local government with its responsibilities for public health, social care, housing, leisure and the environment; the voluntary, community and social enterprise sector; and many others in the public and private sectors.

Of course each of us is the expert in our own lives and we all have a responsibility for our own health and wellbeing. This is why our Integrated Care System has at its heart a constant process of listening to people, learning from their experience and acting on what we hear. We are grateful to all the people and organisations who have helped to shape this plan and told us what matters to them.

Our mission as an Integrated Care System is clear: to help the people of Norfolk and Waveney to lead longer, healthier and happier lives. This plan sets-out how we will work towards this over the next five years, working with local people and communities. We are not starting from scratch – we will build on what we have achieved over the past few years, including through the COVID-19 pandemic.

This 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. It describes how we will make it easier for people to get the care and support they need, when they need it. Whether that is in an emergency or when they need a routine appointment at a GP practice, if they need surgery at one of our hospitals or support in the community, if they need help with their mental health and wellbeing, or their physical health.

We must do more to prevent people getting ill and to intervene early when they do. This is of course better for people as they will live longer, healthier and happier lives, but it is also the only sustainable solution to the challenges facing health and care services. We all have a role to play in this.

Over the next five years we will provide more preventative care. We will better use data to identify people who could benefit from a particular course of treatment or support, and then contact them before problems arise or their condition worsens. We will proactively reach out to people with support and information about health conditions and importantly other issues, like debt and housing, which really affect people's health and wellbeing.

By working together, we can create a healthier Norfolk and Waveney.

Rt Hon. Patricia Hewitt, Chair, NHS Norfolk and Waveney ICB

Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB

Norfolk Health & Well-Being Board opinion on the JFP

Firstly, we would like to acknowledge the hard work and dedication of the team who put this Joint Forward Plan (JFP) together. It is comprehensive, ambitious and reflects the feedback of people across Norfolk and Waveney.

We welcome the alignment of the JFP to the four themes of our combined Joint Health and Wellbeing Strategy and Integrated Care Strategy. Through engagement and co-production, the JFP aims to highlight the opinions and experiences of people across Norfolk and Waveney which will, in turn, shape and develop services.

There is a strong emphasis on working collaboratively in an integrated way to improve the health and wellbeing of our populations. This can only be achieved through key partnerships with County, District, City and Borough Councils, Voluntary, Community, & Social Enterprise (VCSE) sector, care providers, and local place-based organisations. We all need to change the way we work to ensure excellent services, best use of existing resources, and financial sustainability. It is positive to see the JFP ambitions alongside how these are going to be achieved, key dates for delivery, and how they will be financed.

The Norfolk Health and Wellbeing Board fully support and endorse the ambitions of the Norfolk and Waveney JFP. We look forward to assisting the Norfolk and Waveney Integrated Care Board fulfil the ambitions and outcomes and sharing our expertise, as partners, to help achieve this.

Councillor Bill Borrett
Chair of Norfolk and Waveney Health and Wellbeing Board and Chair of Norfolk and Waveney Integrated Care Partnership

Suffolk Health & Well-Being Board opinion on the JFP

The Board received the Joint Forward Plan at its meeting on 18 May 2023 and recognises the plan takes account of the Suffolk Health and Wellbeing Strategy and that it has been informed by the Joint Local Health Needs Assessment.

The Joint Forward Plan reflects the Health and Wellbeing Board's strategic priorities to improve health, reduce health inequalities and reorientate toward prevention of ill health through the programmes and actions detailed in the Plan, and the ambitions demonstrated.

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 to be 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 this JFP, the degree of coproduction that has been employed to bring this report and the opportunity the JFP provides for shared learning across organisations. The Board welcomes the approach taken and the commitment to ongoing engagement and co-production in monitoring performance and recommends that review and update reports are brought back to future board meetings.

Councillor Andrew Reid
Chair of Suffolk Health & Well-Being Board

Executive Summary

Executive Summary

Introduction

The Norfolk and Waveney Joint Forward Plan is our plan for the next five years setting out 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 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 retell their story each time, and they expect services to be accessible, tailored to their needs and of good quality. Together with our partners, we are setting out an ambitious vision for improvement that acknowledges what is important to people and shows how and when we intend to make these improvements for the people of Norfolk and Waveney.

This plan is focused on taking action that will begin to make a difference and it will be updated each year to ensure it remains 'live' and addresses current needs. It is a shared plan, developed with and supported by the partners in our local system. The plan has been separated into two parts:

Part one draws together our public health data and learning from the 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 informs our eight ambitions for improvement and the objectives that underpin them. We have been clear about what people will see improve and by when and how all 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. 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 be done in collaboration with 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 Well-being 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. The Life Course infographic on page 24 presents a picture of 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

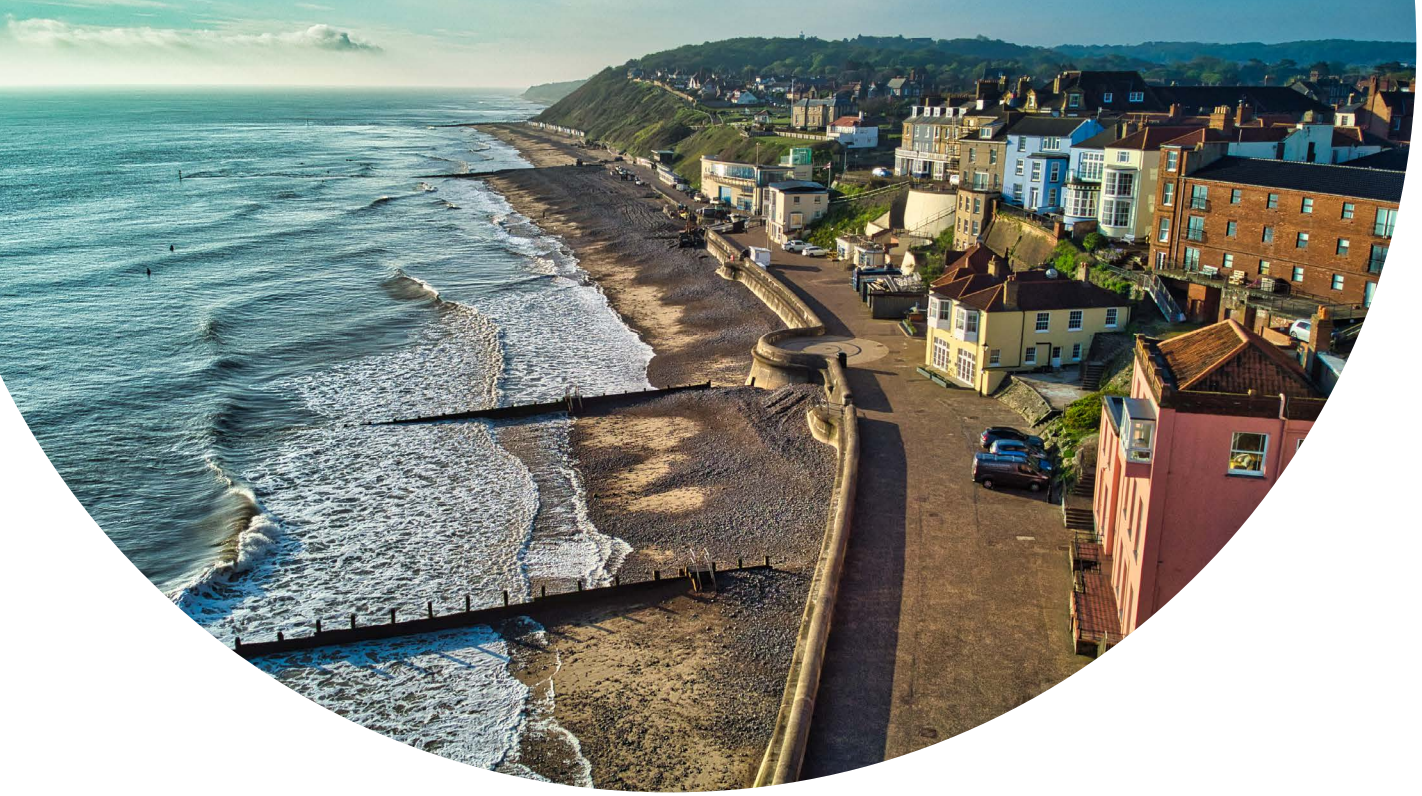
Underpinning the ambitions are 21 detailed objectives. These are clearly set out in this plan, together with expected outcomes and milestones for delivering them. The work required to deliver these is significant, but we have an ambitious vision for our population. There is system-wide support for these ambitions and objectives across Norfolk and Waveney and from both Norfolk and Suffolk Integrated Care Partnerships and Health and Well-Being Boards.

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 signals 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 clearing our long waiting lists, increasing the availability of our primary care workforce and tackling long lengths of stay in hospitals.

Alignment with partners' plans and other strategies
This plan is aligned to the Norfolk and the Suffolk Joint Health and Well-Being Strategies and key ICS strategies in areas including 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.

Affordability
The ambitions and objectives in the JFP are consistent with the current medium term financial planning for our system, but 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.



1.0 Scope of the JFP

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1.1 Introducing the JFP

The JFP is 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 a number of 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. This is our first JFP (published in June 2023), and we will update it each year as we set out on a journey of improvement. Progress against the plan will be publicly visible in each NHS partner's annual report, and in the annual report of the ICB.

Our ICS partners are shown in the stakeholder map.

We will work together in partnership across the Norfolk & Waveney Integrated Care System (ICS) to deliver our eight ambitions.

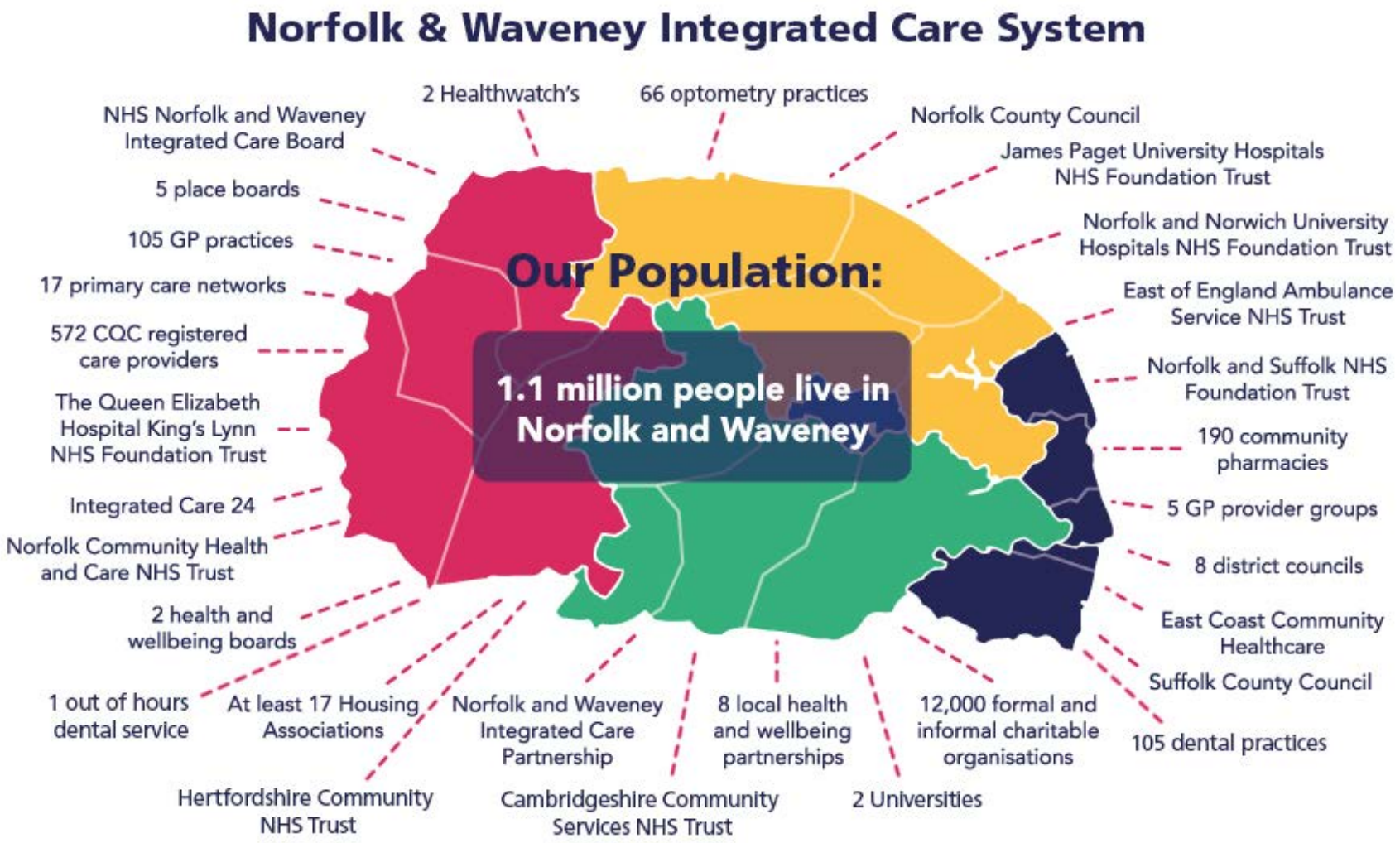


Figure 1 - Stakeholder map

1.2 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 Transitional 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 well-being strategy which includes a link to both the strategies.

1.3 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 6.3. 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 where these are confirmed at the drafting stage. 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 4.2.

Case Study

Providing multi-agency support to ensure people can live in warm, comfortable homes, reducing the impact on their health

Cold homes and Chronic respiratory illness is an issue for many areas across the country. In Great Yarmouth and Waveney, the local health and wellbeing partnerships are building on the approach developed in Gloucestershire, which focused on the direct correlation between cold, damp living conditions, exacerbation of respiratory illness and increased risk of hospital admission. These partnerships are made up of Local Authorities, VCSE and NHS organisations, primary care and others who are truly working together to wrap services around our people and communities.

Clinically led by Dr Sarah Flindall, East Norfolk Medical Practice, the project has been supported through ringfenced funding agreed between Great Yarmouth Borough Council and East Suffolk Council and has supported approximately 750 people this winter.

The project is reducing respiratory ill health caused by cold homes, by seeking out vulnerable people with chronic respiratory conditions who are living with fuel poverty, providing them with financial support from the national Household Support Fund.

The project is also linking individuals with other support services for their wider health and wellbeing needs, with the intention of helping people to lead longer, healthier and happier lives. This project has a big focus on prevention, helping to reduce the number of related hospital admissions and supporting people to help prevent respiratory illness from starting or indeed getting worse.

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 Transitional 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.

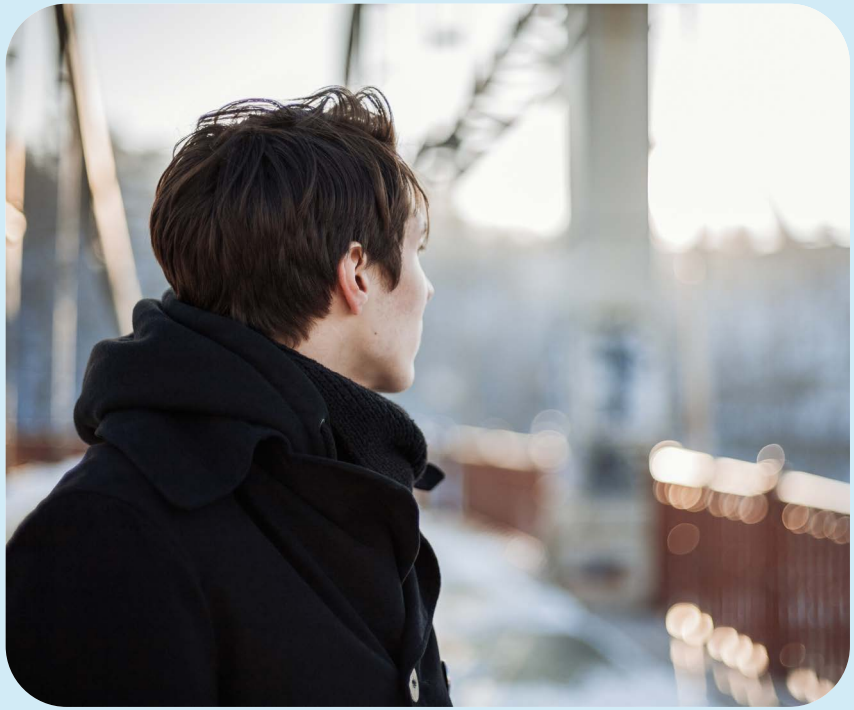
Case Study

Working together to reduce re-offending, substance misuse and supporting better mental health

As a result of working together, a new clinical psychologist role has been rolled out across the Norfolk and Waveney ICS, commissioned by Norfolk County Council, employed by Norfolk and Suffolk NHS Foundation Trust, and deployed into the Project ADDER team within our VCSE-provided local drug and alcohol service (Change Grow Live).

Project ADDER aims to reduce re-offending, reduce substance misuse and promote mental health in service users with complex emotional needs, substance misuse and a history of contact with the criminal justice system. In this role, the psychologist works directly with individuals to provide intervention and indirectly with staff to increase the provision of brief psychologically informed treatments.

This reduces barriers to access as service users with high levels of complexity can be seen in a setting they are familiar with where they are used to engaging with support. The role also forms a bridge for service users to access more specialist mental health treatment within the mental health trust as needed, and a channel for specialist resources and training from within the mental health trust to be made available to project ADDER and CGL staff.



3.0 Why we are doing this – the case for change

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 help us to give us information about 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?

Populations 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 well-being.

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

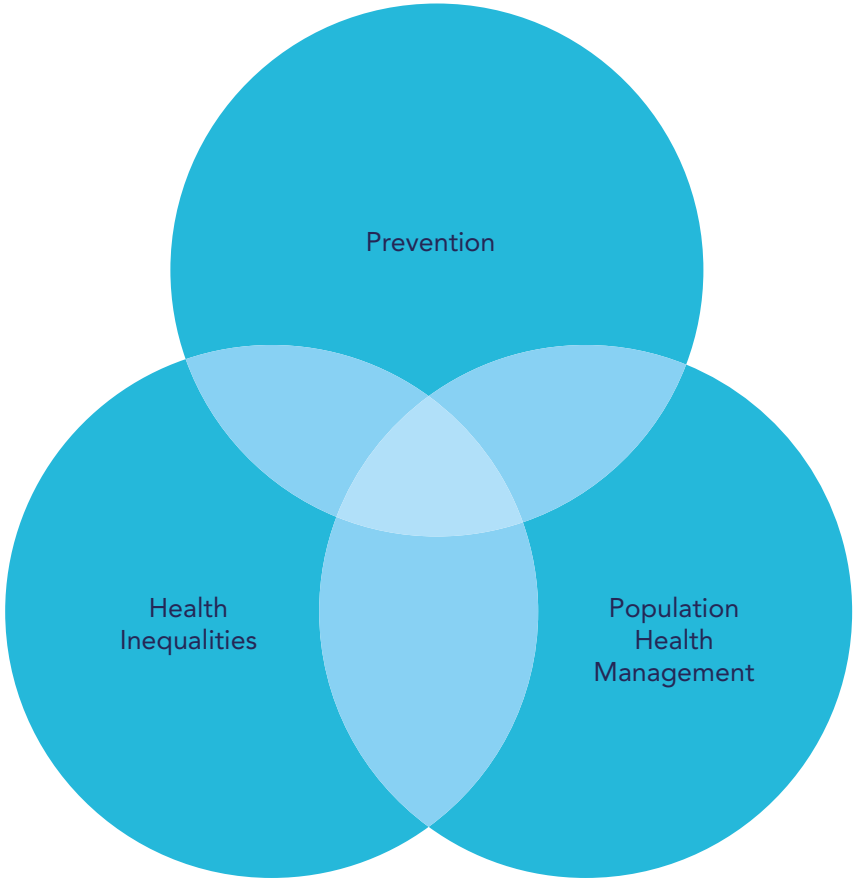


Figure 2 - PHM, Health Inequalities and Prevention

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 focussing on the ambitions we have chosen, and particularly what we can do now on prevention, to improve our health and well-being for the future. Let's look at some of the key facts about Norfolk and Waveney:

In 2021 there were **8,750** births and **12,860** deaths

In June 2022 there were **1,081,700** people registered with a General Practice in Norfolk and Waveney.

During 2022, patients attended **6,280,000** appointments with General Practice (this means that on average, each person across Norfolk and Waveney attended about 6 appointments), and **75.6%** of people have a positive experience of their GP practice

In June 2022 **75,000** children had visited an NHS dentist in the previous 12 months and **309,000** adults visited an NHS dentist in the previous two years

During 2021/2022

57,000 people in Norfolk and Waveney were in contact with Mental Health, Learning Difficulties or Autism services and **16,000** of these were under 18. This is over 5% of the total population and over 8% of the population under 18

A&E departments saw **298,500** attendances with **101,105** Norfolk and Waveney patients admitted as an emergency.

There were **1,285,000** hospital outpatient appointments and **165,700** hospital operations – of which **111,650** were operations for people on the waiting list

165,000 people in Norfolk and Waveney live in the 20% most deprived communities in England (known as the core20 population)

As of January 2023, **126,700** people in Norfolk and Waveney have 4 or more diagnosed long term health conditions (LTC's) (physical health and/or mental health conditions)

In terms of physical health, in 2021/2022 the number of people diagnosed with LTC's include **176,900** with high blood pressure, **70,400** with diabetes, **39,600** with heart disease, **30,200** with atrial fibrillation or a common abnormal heart rhythm, **24,400** with Chronic Obstructive Pulmonary Disease (COPD) which is a lung condition that causes breathing difficulties and **78,900** with asthma.

In terms of mental health, **9,800** people are diagnosed with dementia, **10,400** people are diagnosed with a serious mental illness and **111,500** are diagnosed with depression

In 2020 across Norfolk and Waveney there were **6,580** cancers diagnosed

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

- more than **120,000** smokers, more than **500,000** people overweight or obese and more than **180,000** who do not exercise
- more than **89,000** 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 LTC's highlight where we can focus to make a difference.

3.2 The growing population – our older population

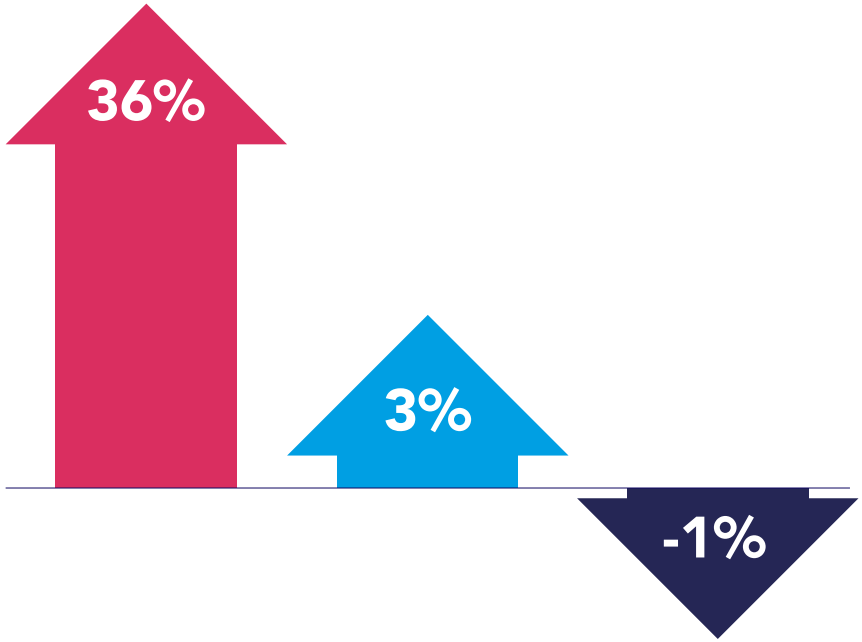
Norfolk and Waveney generally has an older population, projected to increase at a greater rate than the England average. This creates a key challenge for our health and care system and is why we have an ambition of transforming care in later life.

From 2020 to 2040 there will be an estimated:

36% increase in people aged over 65, mostly in those aged 75+

3% 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.

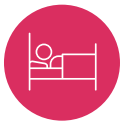
Over the next five years the population is expected to grow by more than 25,000 people, and about 20,000 will be those aged 65+. We anticipate this to continue, and by 2040 the population is likely to have increased by about 110,000 people, this is about the same as the current population of North Norfolk.

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 LTC's 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 with 4 or more LTC's which need ongoing management is likely to have increase by about **1,800 per year**

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**

For the 126,700 people with 4 or more LTC's the average cost for hospital care for is more than £4,300 per year. The expected increase in the number of people with 4 or more LTC's is likely to add an additional £7.75 million pounds per year to hospital care costs. There are also additional prescribing costs for medication, and GPs will spend time managing these patients.

This is just the tip of the iceberg and 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 LTC's 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 for some people at different stages along their life course (Figure 3) and we want to tackle those. For example, for children and young people a higher proportion of pregnant females smoke, and young children are more likely to be admitted to hospital as an emergency. When developing our ambitions and objectives we have carefully considered what this outcomes life course is telling us and focussed 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**

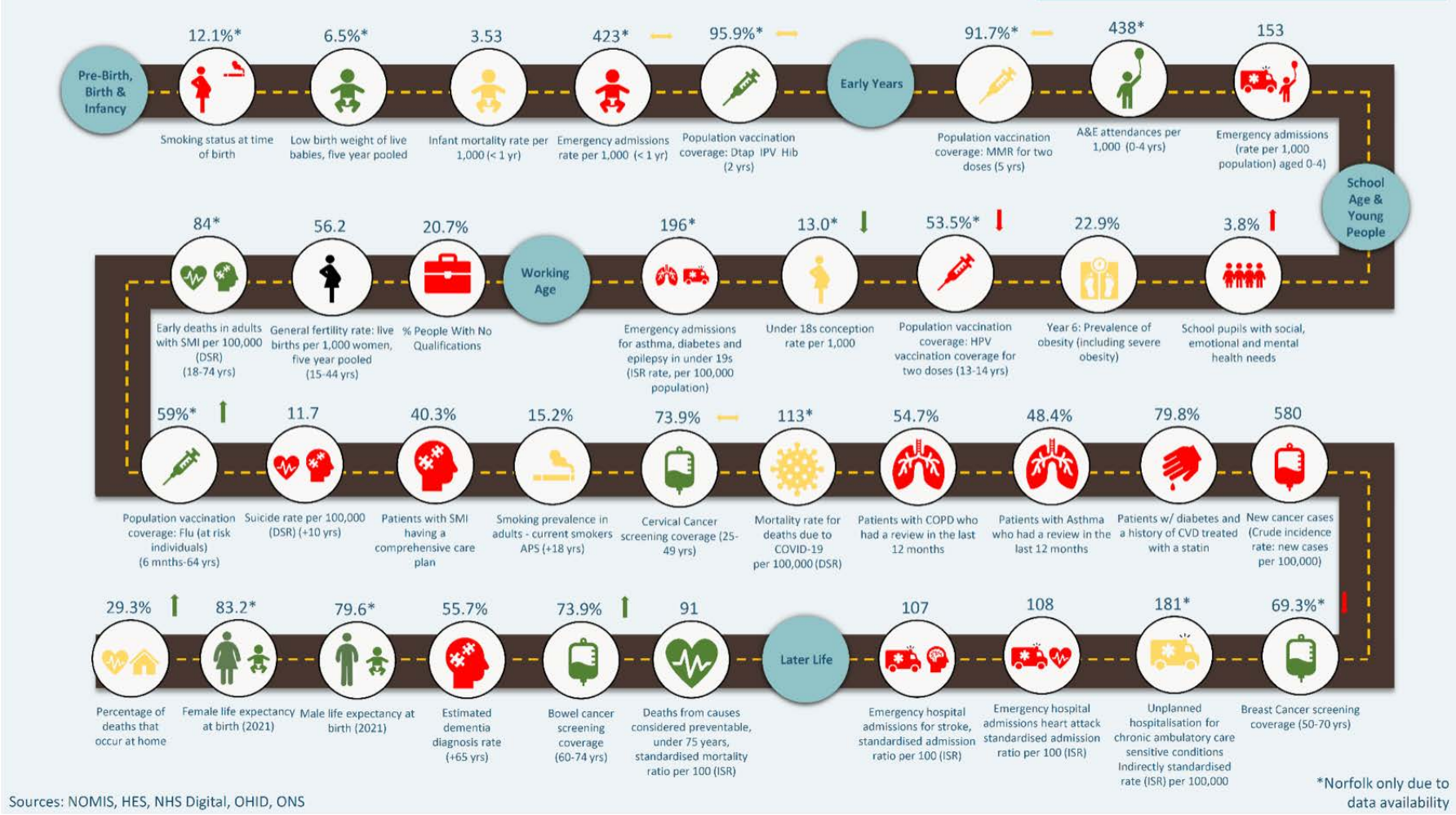


Figure 3 – Outcomes along the life course for people in Norfolk and Waveney

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 "core 20"), 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 165,000 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
- and to 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 core 20 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.

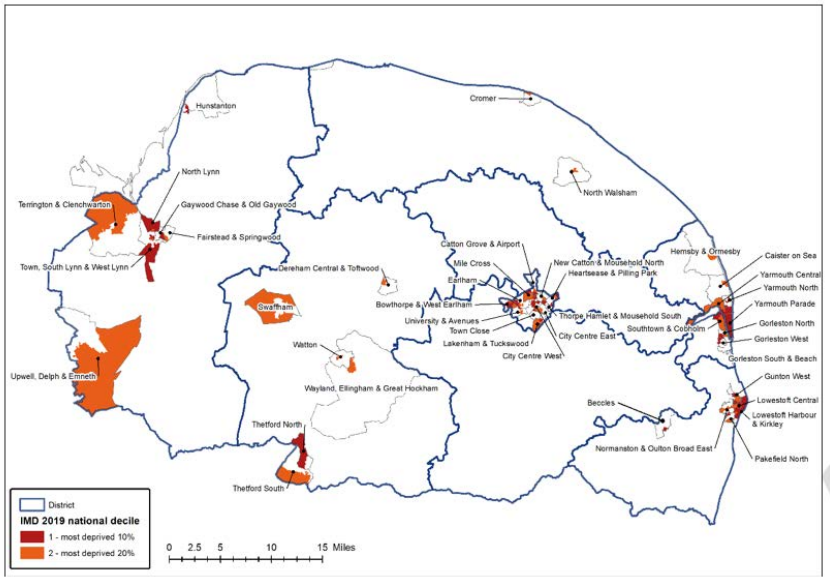


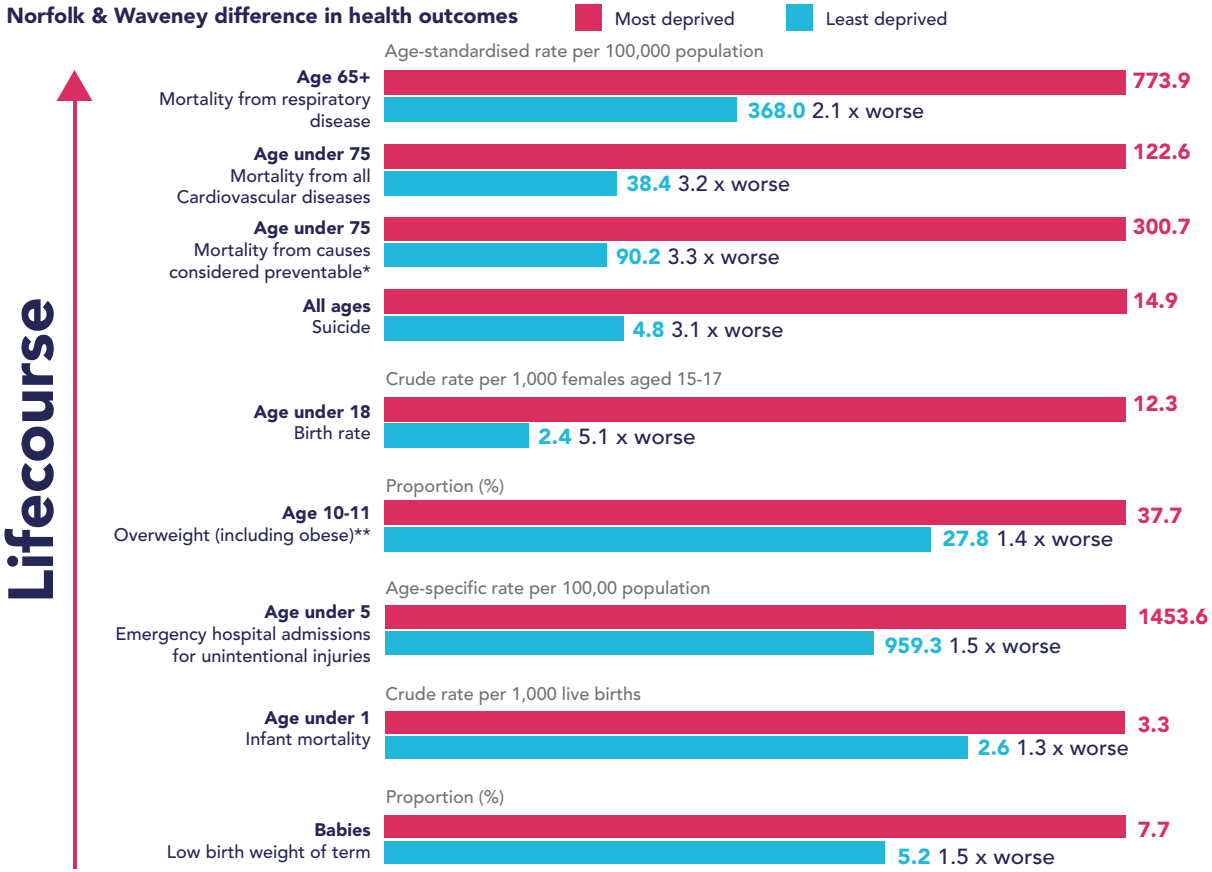
Figure 4 – "Core20" communities across Norfolk and Waveney where some or all of the residents live in the 20% most deprived areas in England according to IMD2019

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.

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
- and people are more than 3 times more likely to die from preventable causes



Comparison between the most and least deprived 20% (quintiles) of the population Norfolk & Waveney. *Pre-2019 definition for preventable mortality. **'Age 10-11, Overweight (including obese)' compares areas within Norfolk and excludes Waveney.

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).

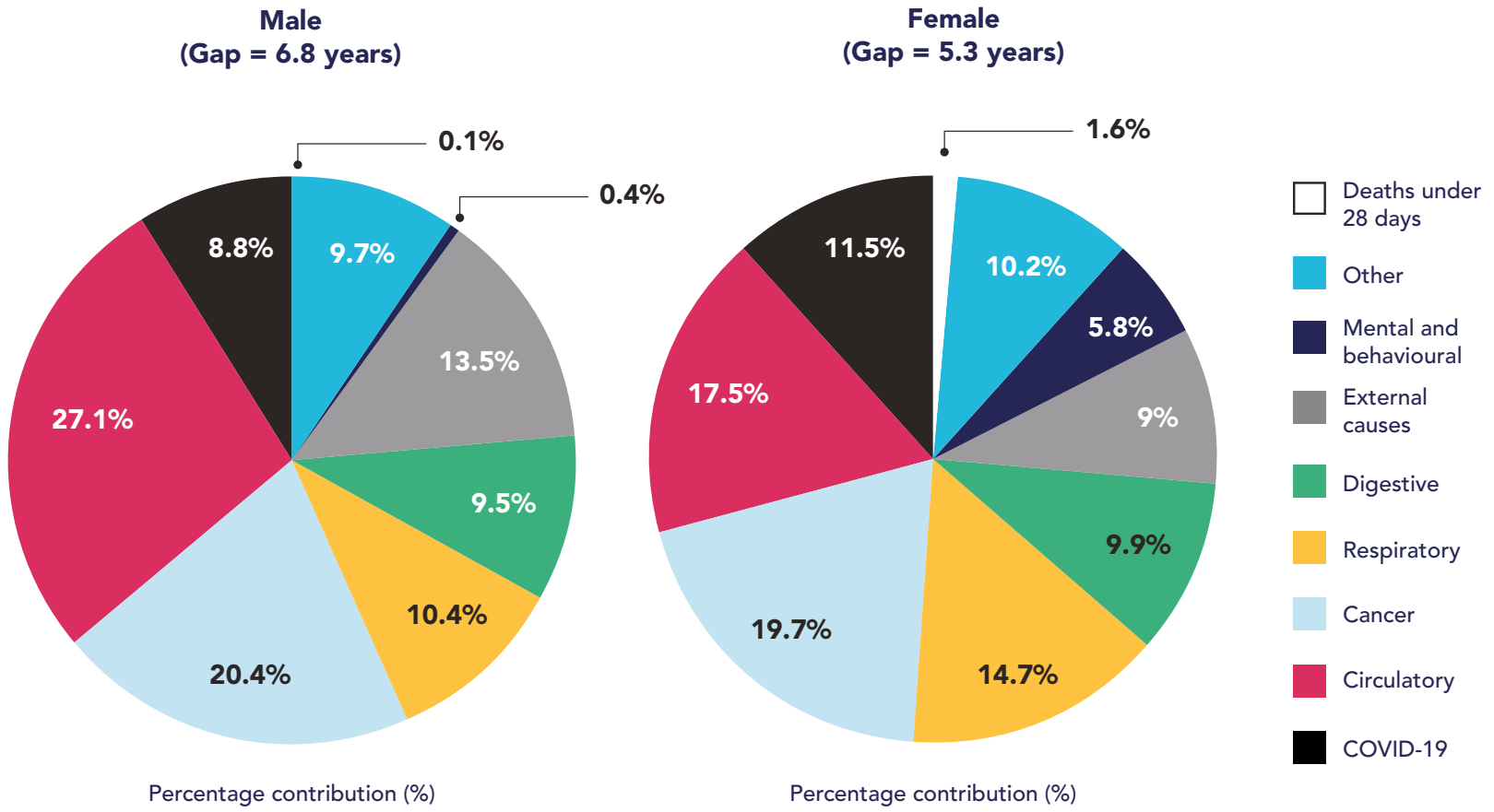


Figure 6 Breakdown of the life expectancy gap between the most and least deprived quintiles of NHS Norfolk and Waveney by cause of death, 2020 to 2021 (https://analytics.phe.gov.uk/apps/segment-tool/)

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 3,500 people would be screened for cancer. For the Core20 most deprived GP practices this is an additional 1,300 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%) but has a lower proportion of COPD patients that receive a 12-month review (55% vs 60%). And there is variation across Norfolk and Waveney from practices with 10% of patients with a 12-month review to practices with over 90% 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 the 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 40% have a comprehensive care plan compared to the England average of 50%. Across the Norfolk and Waveney GP practices this ranges from under 5% of patients to 100% of patients. By at least matching the England average across Norfolk and Waveney, 900 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 well-being 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

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 have also 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.

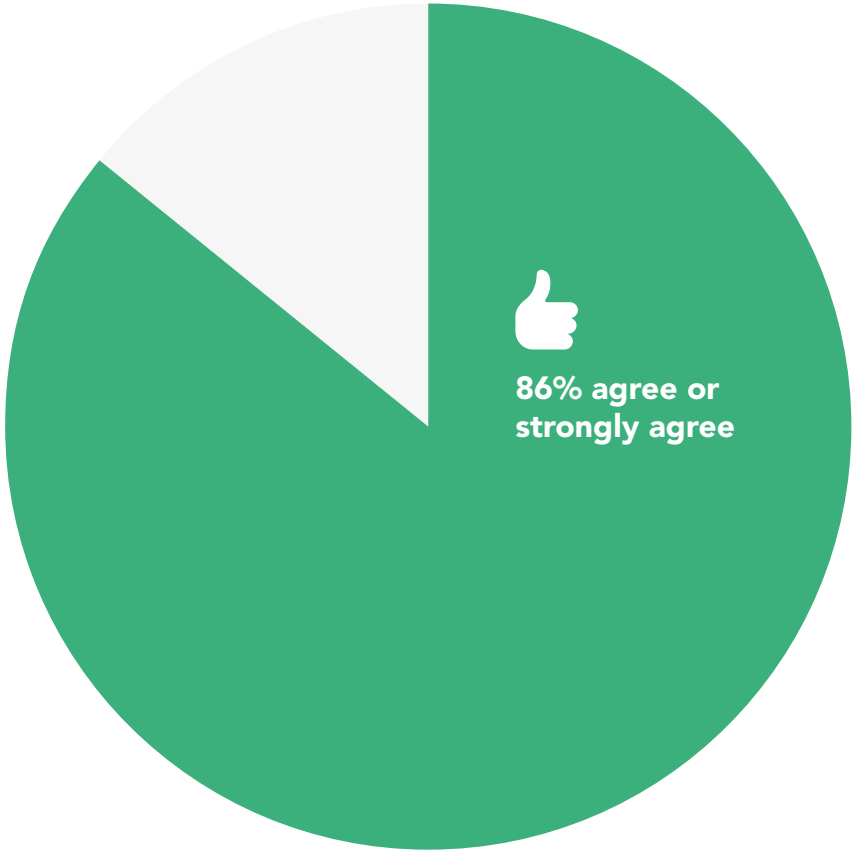
- Transforming Mental Health services
- Improving Urgent and Emergency Care
- Elective Recovery and Improvement
- Primary Care Resilience and Transformation
- Improving Productivity and Efficiency

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.

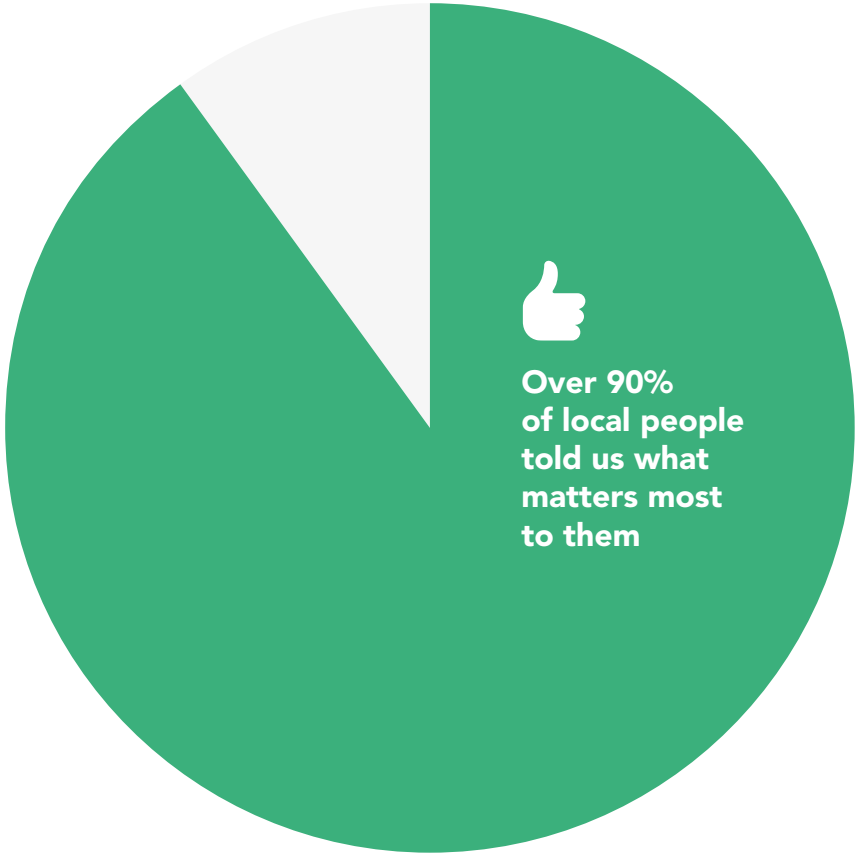


249 people also left free text comments

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

I-statements – working with our experts by experience

Through a series of workshops and discussions with Experts by Experience, facilitated by Rethink Mental Illness and NHS Norfolk and Waveney's Mental Health programme team, a set of I-Statements, tailored to Community Transformation (CT) were developed during 2022-23.

We are now taking steps to ensure service provision is aligned with the I-Statements. A project is now being planned to develop an outcomes-based commissioning approach, building on this work.

An expert by experience said: "Working with NHS Norfolk and Waveney and the wider Norfolk and Waveney ICS has really helped bring the views and experiences of people who have experienced mental ill health.

"This is a fresh, new innovative approach which is valuing the views and experiences of people with lived experience."

4.0 Our ambitions for improvement

4.0 **Our ambitions for improvement**

4.1 2023/2024 immediate priorities

We have two timescales, the immediate priorities that Norfolk and Waveney ICS confirmed to NHS England to meet national NHS planning requirements, and the longer-term improvements captured in our eight ambitions.

We have summarised the immediate priorities below as they are important and form some of the first year elements of our 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 as set out in the NHS Priorities and Operational Planning Guidance. The latest 2023/2024 NHS guidance can be found here: Operational Planning Guidance

The operational plan contains many different metrics to enable the NHS to monitor its delivery during the year and there are many links through to the ambitions in the JFP such as:

- Improving the flow of urgent and emergency care patients in to and out of our services. We have said we would improve our discharge pathways through increasing the number of virtual ward services for example. This in turn will reduce the length of stay in hospital, bed occupancy, and enable the emergency department to see more patients within 4 hours; allowing ambulances to be released to respond to category 2 calls in the community.
- Continue to reduce the number of people waiting for diagnostics and elective care. During the year the plan is to reduce the number of people waiting over 65 weeks for elective care by over 8,000. This and future reductions in waiting times will be achieved by working more closely together, reducing waiting times for diagnostics, faster earlier cancer diagnosis and using technology.
- Increased capacity for people of all ages to access mental health services earlier, such as Psychological Therapies and specialist community perinatal services. To manage care closer to home by reducing out of area placements.
- Continue to address health inequalities and improve prevention services. 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. For children and young people, the focus will be on asthma, diabetes, epilepsy, oral health and mental health.
- Continue to support people living with learning disabilities and/or autism through the number of annual health checks and health action plans being delivered by Primary Care for people with a learning disability, building on the achievement of the national 75% target for 2022-23. Improve the adult autism diagnostic offer and reduce waiting times. Provide timely support for neurodiverse children and young people. Build alternative care and support community models across the system to help prevent avoidable admissions to inpatient hospital services.

According to the public health 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. These people matter to us as a system; so we have set an additional priority to address health inequalities and improve the quality of care and support:

- Continue to embed Positive Behavioural Support and reasonable adjustments that empower and enable people to access care and treatment equitably. Roll out the national Oliver McGowan mandatory training [oliver-mcgowan-mandatory-training] for staff on learning disabilities and autism to improve services and health and wellbeing outcomes. Continue to learn from the lives and deaths of people with a learning disability and autistic people.

Through the work undertaken to develop our local plans, we have built upon the system integration and joint working to produce a cohesive and challenging set of targets to deliver on, for the benefit of our population. These are consistent with a number of the ambitions and objectives in the JFP.

4.2 Our eight longer-term ambitions for improvement

The 2023/2024 immediate priorities are not quick fixes and so feed into the longer-term ambitions. Our eight ambitions are evidence based and consistent with what we heard from our public engagement, with a clear focus on 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', such as existing and on-going work that is already underway to support the delivery of the NHS Long Term Plan. 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 number of 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. Some of the objectives commit to doing more work to develop key strategies, such as for Population Health Management (PHM), Health Inequalities and for people in later life. Others are much more specific projects with defined and measurable outcomes in the shorter term.

We will refresh this JFP annually, with the next version ready for April 2024, and ensure our objectives remain current and focused on what we need to deliver. A summary of the eight ambitions and 21 underpinning objectives is set out in Figure 7.

Joint Forward Plan eight Ambitions and underpinning objectives

Ambition	Ambition Objective
1	**PHM, Reducing Inequalities & Supporting Prevention**
1a	Development and delivery of two strategies: A Population Health Management Strategy, and a Norfolk and Waveney Health Inequalities Strategy to deliver the "Core20PLUS5" approach
1b	Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people
1c	Early Cancer Diagnosis – Targeted Lung Health check 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 a wider range of services closer to home, 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 Occupational Therapy
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 develop a shared vision and strategy with older people that will help us to transform our services to be easy to access and designed and wrapped around the needs of older people.
6	**Improving UEC**
6a	Improve emergency ambulance repsonse times
6b	Expand virtual ward services
6c	Delivery of the Improving Lives Together programme to 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	Improve the services we provide by enhancing productivity and value for money, and delivering services together where it makes sense to do so.

Figure 7 – 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 2022 – 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. Including 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

Tracy Williams Queens Nurse
Honorary Fellow Faculty Homeless and Inclusion Health
Norfolk and Waveney ICB Clinical Lead for: Health Inequalities & Inclusion Health
Norwich locality Adviser

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

a) Development and delivery of two strategies:

- A Population Health Management Strategy, and
- A Norfolk and Waveney Health Inequalities Strategy to deliver the "Core20PLUS5" approach

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

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

What matters most to you?
Recent 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 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, Chronic conditions – Cancer (including earlier diagnosis), Cardiovascular and Respiratory. We will be aspiring to a reduction in the differences in outcomes we currently experience in terms of accessing services and improvements in the health care processes for the Core20PLUS5 populations. We will also be seeking to prioritise prevention activities, particularly relating to smoking, alcohol, diet and physical activity and uptake of cancer screening and immunisations.

Objective 1a Development and delivery of two strategies to support prevention: A Population Health Management (PHM) Strategy, and a Norfolk and Waveney Health Inequalities (HI) Strategy to deliver the "Core20PLUS5" approach

What are we going to do?
We are going to develop two strategies. The strategies will ensure we are clear on our priorities for targeting resources and that we are working on agreed priorities for PHM and HI together. There is good work happening in pockets across the system, which needs to be co-ordinated so we set out a clear plan of what we are going to tackle first, how we will do it and why.

Develop 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 will include our plans for how we will be using data, how we will be developing our ICS-wide intelligence function and a single analytical platform to carry out relevant analysis to support our local decision making and planning and how we will evaluate our programme.
This proactive approach will be focussed 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.

Develop a strategy for reducing health inequalities, aiming to deliver "equitable access, excellent experience and optimal outcomes" for all people and communities living in Norfolk and Waveney. This strategy will include how we plan to implement the "Core20PLUS5" national health inequality improvement framework which identifies population groups and clinical areas which require accelerated improvement.

We will also be seeking to increase uptake of vaccinations and cancer screening where there is low uptake in patient groups and communities. We will be seeking to minimise the health inequalities as a result of the impact of Covid-19. We will also include the wider factors that impact on health and well-being such as housing and the environment we live in.

How are we going to do it?
By using joined up data to proactively identify prevention opportunities and groups of people who would benefit most from targeted health and care interventions.

We will need to have a data hub in place to allow access to joined up data and facilitated interpretation of the data and insight to support local teams to identify their own priorities.

This approach will be 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.

How are we going to afford to do this?

No additional funding is required to develop the strategies, but further 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. Some national funding is allocated to the ICS to support the delivery of the Core 20 plus 5 priorities.

What are the key dates for delivery?

Year 1 April 2023 – Sep 2023

- Mapping of existing work, gap analysis, and development of strategic priorities that are evidence based.

Year 1 Oct 2023 – March 2024

- Two strategies published by March 202

Year 2 April 2024 – Sep 2024

- Action plan developed for each strategy with SMART objectives, milestones and trajectories.

Year 2 Oct 2024 – March 2025

- Delivery of the action plan, reflection and review, reporting and re-set for year 3 based on year 2 outcomes.

Year 3 April 2025 – March 2026

- Strategy refresh/update if required, and continued delivery

Year 4 April 2026 – March 2027

- Continued focus on extending our PHM approach and reducing HI based on the data, re-set of clear objectives, milestones and trajectories

Year 5 April 2027 – March 2028

- Reflection and continued focus on using PHM to drive improvement across the system and inform where we focus our effort, and a continued targeted focus on reducing HI

How will we know we are achieving our objective?
Publication of a system wide Population Health Management strategy, and a Health Inequalities Strategy setting out our ambitions to reduce health inequalities over the next 5 years and the improvement we expect to see. Develop a programme of evaluation based on the best available data 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.

How are we going to do it?

- The NHS will work together with local authorities, service users and others through our Tobacco Dependency Clinical Programme Board, 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.

- We will focus on health inequalities ensuring that we understand access by population subgroups (such as age, ethnicity and deprivation) to ensure equity of access.

- We will work with the VCSE around wider issues like income, cost of living and mental wellbeing that could be linked to smoking choices.

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. In 2023/24 a total of £555k will be received, of which it is suggested £203k should be used for maternity. We are expecting this funding to be made available every year, though this is yet to be formally confirmed by NHS England.

The Tobacco Dependency Clinical Programme Board will lead on agreeing how tobacco support (including maternity) should be rolled out over the next five years and the estimated cost, based on learning from areas where support has already gone live. If it is identified that the national funding will not be enough, a formal request will be made for additional investment from NHS and local authority partners.

What are the key dates for delivery?

Year 1 April 2023 – Sep 2023

- Gather learning from existing services and agree a new plan.
- Equality and equity plan published.
- Deliver a Population Health Management pilot project, addressing smoking during pregnancy working with midwives at Queen Elizabeth Hospital (QEH).
- Pilot a Smoking in Pregnancy incentive scheme with Norfolk Public Health.

Year 1 Oct 2023 – March 2024

- Recruit more maternity tobacco advisors and roll out support at QEH and Norfolk and Norwich University Hospital in line with the new plan.

Year 2 April 2024 – Sep 2024

- Roll out longer term plan, in line with the evaluation of year one.

Year 2 Oct 2024 – March 2025

- Roll out smoking in pregnancy incentive scheme in line with learning from any previous pilots and in alignment of further announcements from the Department of Health and Social Care.

Year 3 April 2025 – March 2026

- Review support provision for partners of pregnant women to support smokefree homes.
- Review the current service with service users

Year 4 April 2026 – March 2027

- Review longer-term support available in the community after the baby is born.
- Review engagement with local authority and VCSE to ensure good access to wider community support e.g., social prescribers and peer support groups.
- Explore opportunities to enhance joined up working e.g., between tobacco advisers, antenatal team and mental health for women with perinatal mental health conditions.

Year 5 April 2027 – March 2028

- Use the Maternity and Neonatal Safety Improvement Programme to ensure we continue to improve on smoking reduction in pregnancy.
- Explore opportunities for the use of technology to improve the support to pregnant smokers and their wider families.

How will we know we are achieving our objective?

We will begin to see our approach is working because we will begin to be able to measure a reduction in the percentage of women in Norfolk and Waveney who are smoking at time of delivery.

Data for Norfolk and Waveney from December 2022 shows that 12% of mothers were smoking at time of delivery.

We aim to see this reduce over the next three years, by March 2026, towards the regional and national average of 9% and to reduce further to 6% by the end of year 5, 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 – Targeted Lung Health check programme

Targeted Lung Health Checks are a preventative approach to improve the health of those who may be at risk.

What are we going to do?
Deliver a Targeted Lung Health Check (TLHC) 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.

We will prioritise patients in our most deprived, Core 20 populations. 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. 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.

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.
- Those eligible 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 considered to be at high risk of lung cancer, they are then 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 is contacted with further information and referred for further tests and treatment. Most of the time no issue is found, but if a cancer or an issue with a participant's breathing or lungs is found early, treatment could be simpler and more successful.

How are we going to afford to do this?

- The TLHC programme is currently funded by the National Cancer Action Team, pending the decision from the National Cancer Screening Committee to incorporate it into the National cancer screening programme.

What are the key dates for delivery?

- **Year 1 to March 2024**
  - Continue to deliver TLHC to the Great Yarmouth population and expand to the Lowestoft area by end of July 2023.
- **Year 2 April 2024 – March 2025**
  - Continue to deliver TLHC to the Great Yarmouth and Lowestoft populations. Finalise modelling/planning and commence roll out to Central Norfolk and West Norfolk. The initial target will be our Core 20 areas of highest deprivation.
  - Confirmation of system model July 2024
- **Year 3 April 2025 – March 2026**
  - Complete the Lung Health Checks for the initial eligible population in Great Yarmouth and Waveney and commence 24-month follow-up scanning.
  - Invite patients who have reached the age threshold to join the programme. Continue roll out to the remaining ever smoked group across Norfolk and Waveney focusing initially on areas of higher deprivation.
- **Year 4 April 2026 – March 2027**
  - Continue expansion to the remaining 'ever smoked' populations in Norfolk and Waveney, including invitation of patients who age into the programme and 24 month follow up scanning.
  - Target of expanding to cover the whole eligible population of approximately 125,000 individuals by 2028/29.

How will we know we are achieving our objective?

Proposed trajectory for 2023/24:

	Baseline Position	Q1	Q2	Q3	By Q4
Uptake (%) of Lung Health Checks	25% at the start of the programme	40%	40%	50%	50%

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 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
2) One of six high-risk conditions associated with CVD and are not being reviewed or treated in line with national guidance.

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

In addition, we will be implementing a PHM pilot as part of our system wide "Priority Patient Review initiative", by case finding specific patients who will benefit from low intensity statins or who have untreated hypertension.

How are we going to do it?
We will be using a national audit tool called "CVD PREVENT".

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.

How are we going to afford to do this?
Funding is identified to support the delivery of the Priority Patient Review initiative.

There are links with Primary Care funding and Quality Outcomes Framework funding.

What are the key dates for delivery?

- **Year 1 April 2023 – Sep 2023**
  - We will scope a reliable source of robust data which will be needed by our PCNs.
- **Year 1 Oct 2023 – March 2024**
  - We will commence production of local data reporting to align with the metrics that are already produced nationally via CVD PREVENT and share with PCNs.
- **Year 2 April 2024 – Sep 2024**
  - Delivery to commence through monitoring of identified patients with a diagnosis of CVD or at higher risk.
- **Year 2 Oct 2024 – March 2025**
  - Year one evaluation to be undertaken.
- **Year 3 April 2025 – March 2026**
  - Metrics in CVD PREVENT domains should see Norfolk and Waveney in the top quartile for all.
- **Year 4 April 2026 – March 2027**
  - Second evaluation
- **Year 5 April 2027 – March 2028**
  - Further evaluation.

How will we know we are achieving our objective?
In the first 6 months, we will gather all relevant baseline data and complete the creation of our patient-specific reporting tools for Primary Care. We expect to see more patients with high blood pressure identified and treated and those who would benefit treated on low intensity statins – This data will be readily available on the next quarterly CVD PREVENT Audit. We aim for a 5% improvement in each of these hypertension metrics 6 months after these reporting tools have gone live.

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 and via the Model Health system for trajectory tracking. Tangible targets for reduction will follow national NHSE operational planning guidance which will be adopted once made available each year.

Ambition 2: Primary Care Resilience & Transformation

Ambition 2: Primary Care Resilience & Transformation

Dr Jeanine Smirl
N&W ICB clinical lead for primary care

"The aim is to integrate primary care services to deliver improved access to a wider range of services from a multi-disciplinary team. This will deliver more proactive care, preventing illness and improving outcomes, for local communities closer to home."

Our objectives

a) Developing our vision for providing a wider range of services closer to home, improving patient outcomes and experience.

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?
Recent 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."

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 which outlines the new vision for integrating primary care services to improve access, experience and outcomes for our patients and communities.

NHS England has recently published the Delivery plan for recovering access to primary care which focuses on the need to streamline access to care and advice, reducing the number of people struggling to contact their practice and so that patients know how their request will be managed, on the day they contact their practice. The plan also outlines the ambition for expanding community pharmacy services to make them the first port of call for minor common conditions, supporting better integration in line with the vision set out in the Fuller stocktake report.

Objective 2a Developing our vision for providing a wider range of services closer to home, improving patient outcomes and experience.

What are we going to do?
First, we will develop some overarching principles and our strategic vision for future primary care delivery supporting our ambition to deliver cohesive primary and community care services across Norfolk and Waveney.

We will build on this to develop a detailed general practice and dental strategy which we will begin to implement across the second year of this plan.

We will develop our local delivery plan for the existing East of England Partnership Strategy for Community Pharmacy, recognising that this strongly supports the Fuller Stocktake vision for integrating primary care.

We will develop our plans for implementing the referral pathway for NHS 111 and urgent care providers to the Community Pharmacist Consultation Service to reduce the need for patients to attend their GP practice when their needs can be met by a pharmacy.

We will also develop our plans for implementing the Pharmacy First approach, which is planned to be launched by NHS England by the end of 2023 to support pharmacies to provide treatment for seven common health conditions (sinusitis, sore throat, earache, infected insect bite, impetigo, shingles, and uncomplicated urinary tract infections in women) without the need to visit a GP.

We will also develop our strategy for Optometry services alongside the on-going system Eye Health transformation.

Currently, our PCNs work as groups of general practices to deliver care to their population. Our next step is to provide our Community Pharmacy PCN Leads with the support, training and mentorship to develop the skills they need to integrate local community pharmacies into Primary Care Network planning and activities.

Going further, our vision is to create Integrated Neighbourhood Teams that will deliver joined up primary and community care in a model that is closer to patients' homes.

The specific delivery model will be designed locally by our Place teams where they will decide which services are needed and how this will improve patient outcomes and experiences. We will deliver services at scale where possible and at PCN level where more targeted local services are required.

How are we going to do it?
We will support our Community Pharmacy PCN Lead roles to engage with the Integrating Community Pharmacy into Primary Care Networks programme.

We will agree a local definition of an Integrated Neighbourhood Team and how we will approach new ways of working.

We will use population health data to identify the priorities for developing new models to meet local population health and care needs.

We will work collaboratively and in partnership with our partners in secondary care, community services, VCSE and wider groups to support a blended model of care that not only focusses on a patient's health needs, but also their socio-economic needs providing more holistic and joined up care, including management of clinical risk.

How are we going to afford to do this?
We will work with our partners to agree how new pathways of care will be resourced and funded from within the current funding allocations across the system.

What are the key dates for delivery?

- **Year 1 April 2023 – Sep 2023**
  - Develop an outline for key milestones for strategy development including which stakeholders we will engage with and by when.
  - Review population health data to identify key priorities and need within each Place.
  - Develop local definition of an Integrated Neighbourhood Team.
- **Year 1 Oct 2023 – March 2024**
  - Overarching Primary care strategy vision and principles developed.
  - Engagement with our local population and system partners.
  - General Practice Strategy developed.
  - Dental strategy developed.
- **Year 2 April 2024 – March 2025**
  - Implement the first stage of the General Practice and Dental strategy.
  - Develop the delivery model for Integrated Neighbourhood Teams at Place and PCN level.
  - Local delivery plan for the East of England Community Pharmacy Partnership strategy developed.
  - Develop strategy for Primary Optometry services alongside the system ICS Eye Health Transformation programme.
- **Year 3 to 5 April 2025 – March 2028**
  - Continue to implement the new strategy with frequent monitoring of outcomes.

How will we know we are achieving our objective?

We will have published the first stage of our overarching vision and our strategy for general practice by March 2024, informed by strong public engagement and using data to meet the needs of our population.

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?
Develop a near term plan to identify and prioritise populations in the greatest need of access to NHS dental services using data from the renewed Oral Health Needs Assessment (OHNA) and Public Health data for Norfolk and Waveney. This will ensure we can deliver short term interventions and begin to improve access to NHS dental services by Autumn 2023.

Next, we will develop a Norfolk and Waveney strategy to improve the oral health of our population and explain our approach to build resilience across all our NHS dental services including our local workforce plan. This five-year strategy will be ready for implementation from April 2024.

Working with key stakeholders and system partners to develop solutions for securing access to NHS dental care for the whole population.

How are we going to do this?
We will develop a plan for the near term to address immediate needs:

- 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 appointments they are able to offer on a short-term basis.
- We will monitor the impact these actions have to improve access to dentistry and build this information into our next part of the objective – to develop a dental strategy for Norfolk and Waveney.

Next, we will develop a five-year dental strategy for Norfolk and Waveney:

- Establish a 'Dental Taskforce' to hear to the challenges faced by the profession and work collaboratively to find solutions to improve access to dental care.
- To listen to our patients and hear about their lived experiences, and 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, OHNA we will ensure our strategy 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.

How are we going to afford to do this?
We will utilise our existing dental funding allocation to commission services with flexibility to meet the needs from the Oral Health Needs Assessment published in 2023.

We will work with partners, such as NHS England, to ensure their funding is invested appropriately across Norfolk and Waveney and to meet our workforce development and training needs.

What are the key dates for delivery?

Year 1 April 2023 – Sep 2023

- Updates to the OHNA published in Spring 2023 and updated in Summer 2023.
- Develop plan for short term interventions based on updated to the Oral Health Needs Assessment targeting the areas requiring the greatest interventions.

Year 1 Oct 2023 – March 2024

- Develop a Dental Strategy to outline our commissioning intentions for the next three to five years, our strategic approach to commissioning and how we plan to build resilience across all our NHS dental services alongside the development of our local workforce plan for Norfolk and Waveney.

Year 2 April 2024 – March 2025

- Implement the first stage of the dental strategy.

Year 3 to 5 April 2025 – March 2028

- Continue to implement the new strategy with frequent monitoring of outcomes.

How will we know we are achieving our objective?
We will have published our strategy for dentistry by March 2024, informed by strong public engagement and using data to meet the needs of our population.

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)

Sue Cook
Executive Director People Services
Suffolk County Council

Sara Tough
Executive Director Children's Services
Norfolk County Council

Tricia D'Orsi
Executive Director of Nursing,
and LMNS SRO, Norfolk & Waveney 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 Occupational Therapy

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.

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?
Implement a Start for Life (SfL) and Family Hubs (FH) model, using 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 support for families in local areas, plus a designated family hub site in each of the seven district council areas. There will be sites in Norwich, King's Lynn, Great Yarmouth/Gorleston, and Thetford where 37% of Norfolk's overall population reside and include the most deprived areas in Norfolk. 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 advice and guidance to families at the earliest opportunity when families engage with FHs. This will also include the signposting to self-care resources, and the opportunity to link with others for mutual support.

How are we going to afford to do this?
There is circa £1.9m of DHSC funding, for perinatal mental health and parent-infant relationship support, to be effectively utilised to deliver the programme's minimum expectations by March 2025.

The funding required to develop and implement a SfL and FH approach in Norfolk is secured through an overall grant of approximately £6m paid to the host agency, Norfolk County Council.

There is an added requirement for Partners (resource expertise) across the 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 2023 – Sep 2023**
  - Commission enhanced support for families who have suffered pregnancy loss
  - Four phase one family hub sites operational
  - Family hub virtual offer operational
  - Level one Perinatal Mental Health and Parent and Infant Relationship (PAIR) 'awareness' training delivered to the core family hub workforce
- **Year 1 Oct 2023 – March 2024**
  - Enhanced 0-4 Parent Infant Mental Health Service, with additionality aligned to family hubs
  - Enhanced Wellbeing (Talking Therapies) Service, with additionality aligned to family hubs
  - Three phase two family hub sites operational
- **Year 2 April 2024 – Sep 2024**
  - Specific deliverables to be defined for this period
- **Year 2 Oct 2024 – March 2025**
  - Full family hub approach embedded across Norfolk
- **Year 3 to Year 5 deliverables are not yet known.**

How will we know we are achieving our objective?
The programme team is currently working with the DfE/DHSC to develop an evaluation process for the national FH and SfL programme. In addition, at a local level a performance measurement dashboard will be developed to track the identified KPI's across the programme and for each individual work strand, 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. Recruitment of an additional 70 peer support volunteers recording families receiving support and recruitment numbers by 2025/26.
5. Aim 250 of families supported via Every Relationship Matters reduce parental conflict on children
6. Families receiving help to manage financial challenges (measured through Department of Work & Pensions advisors embedded in Family Hubs)
7. Families accessing non funded services
8. 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.
9. Families with SEND receive early support reducing escalation measured through reduction in Education Health and Care Plan (EHCP) and needing access alternative provision.
10. 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: 3 year delivery plan which sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families.

Our LMNS equity and equality action plan Norfolk and Waveney Maternity Equity and Equality action plan 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 do it?
The LMNS will align with the wider work to develop Family Hubs (implementation of Family Hubs is an objective within this ambition) to ensure that safe, healthy pregnancy and childbirth is embedded into the Start for Life approach Start for Life.

We will:

- improve equity and equality in accessibility of services.
- offer a 'one stop shop' for care to all pregnant women and people.
- improve maternity safety and outcomes.
- improve maternal and staff satisfaction.
- reduce footfall through hospitals

We will develop a workforce improvement plan to reduce our vacancies for maternity staff. The plan will include:

- implementation of consistent job roles across the system,
- systemwide recruitment of midwifery students,
- deliver systemwide training and learning events,
- support our hospital trusts to have current and robust digital maternity strategies, forming the basis for digital integration in maternity services.

We will make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury.

LMNS will 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 this ambition. 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.

How are we going to afford to do this?
6 March 2023 funding allocation letter received detailing available funding for delivery of the three year delivery plan across the system. There will also be an expectation that existing funding within the system is utilised to continue to deliver the quality, safety and transformation requirements that will be detailed in the three-year delivery plan.

What are the key dates for delivery?

- **Year 1 April 2023 – Sep 2023**
  - Culture Workshop held
  - Publication of LMNS Data Dashboard to automatically report KPIs to LMNS board.
  - Review of LMNS governance and reporting
- **Year 1 Oct 2023 – March 2024**
  - MNVP action plan produced and published.
  - Review of MNVP function supported by national and regional guidance by Jan 24
- **Year 2 April 2024 – Sep 2024**
  - Revised MNVP approved and ready for implementation.
  - LMNS governance and reporting reviewed, refreshed and updated.
- **Year 2 Oct 2024 – March 2025**
  - Pelvic Health Prevention Service is embedded.
- **Year 3 (April 2025) – Year 5 (March 2028)**
  - We will continue to embed the learning, upskill the workforce, continue to hear the service user voice and drive continued quality and safety measures as part of our usual business.

How will we know we are achieving our objective?

We will see the maternity workforce vacancies reduce and retention improve, with clear evidence of future leaders ready to drive forward maternity improvement. As at May 2023 the vacancy rate is 9% which will be our baseline position to measure improvement against.

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

What are we going to do?
We will establish clinically led professional networks who will work together to implement the recommendations of two bundles of care – Asthma (which has been published here: Fingertips Indicators) and Epilepsy (expected June 2023).

Over the next two years, we will increase access to psychological support for those affected by asthma and epilepsy, raise awareness of the conditions, and improve support available to children and families.

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?
Clinical networks will be rolled out involving stakeholders across Norfolk and Waveney to support consistency in clinical pathways, identify and raise gaps in provision and areas for improvement to ensure we improve the quality of care for children with long-term conditions such as these. This will be achieved though sharing best clinical practice, supporting the integration of paediatric skills across services and specific quality improvement projects.

Our public participation group has developed a CYP Mental Health Charter, which details what is important to CYP and their families in the delivery of services and our governance structure enables CYP to hold us to account.

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

How are we going to afford to do this?
Regional funding of £115k per annum is allocated to Norfolk and Waveney to progress plans. Local systems are able to submit expressions of interest for linked innovation schemes.

What are the key dates for delivery?

- **Year 1 April 2023 – Sep 2023**
  - Establish system wide clinical networks.
  - Map the pathway of care for CYP with asthma through primary, secondary, and tertiary care.
  - Development and implementation of plans to deliver the national asthma bundle
  - Agree baseline and set trajectory for improvement.
  - Increase the reach into communities of CYP and families who are seldom heard.
- **Year 1 Oct 2023 – March 2024**
  - Work with regional teams to develop and implement plans to deliver improvements in the four areas of focus for epilepsy improvements
  - Agree baseline and set trajectory for improvement.
- **Year 2 April 2024 – Sep 2024**
  - Design and implement new model of care with psychological support.
  - Evaluate impact of Asthma deliverables achieved
- **Year 2 Oct 2024 – March 2025**
  - Increase access to training from VCSE and extend new model of care with psychological support.
- **Year 3 April 2025 – March 2026**
  - To be defined by the local networks
- **Year 4 April 2026 – March 2027**
  - To be defined by the local networks
- **Year 5 April 2027 – March 2028**
  - To be defined by the local networks

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
Link for indicators is here: https://fingertips.phe.org.uk/indicator-list/view/paGkBr8vy0#page/1/gid/1/pat/15/ati/167/are/E38000239/iid/93136/age/288/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

Objective 3d Develop an improved and appropriate offer for Children's Occupational Therapy

What are we going to do?

Norfolk and Waveney are piloting the impact of integrating children's occupational therapy services. Regardless of where you live, the aim is that access to specialist support should be consistent and high quality, able to meet the needs of CYP.

This programme will deliver:

- Increased and expanded skill mix of the clinical workforce.
- Increased access to advice, support, and training for universal services (these are services that are offered to all families)
- Publication of a joint commissioning strategy involving Norfolk and Suffolk local authorities
- Increased levels of investment to expand the workforce to meet need.

How are we going to do it?
We will improve independence to self-manage conditions and provide access to skilled high-quality advice and support to reduce the need for specialist interventions.

We will explore the viability of shared care records across the footprint through a single point of contact, meaning you will only have to tell your story once.

We will ensure that children with sensory needs can access clinical support through an NHS pathway.

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

Within a joint commissioning strategy, teams will be working to a consistent set of requirements across the Norfolk and Suffolk local authorities.

We will reduce the number of children who require exceptional treatment options by providing training for school staff, parents, and carers to create inclusive school and home environments. This will free up specialist support for those who most need it. Children with complex needs will be supported sooner through a graduated model of support.

Access to a digital offer of support and training will enable universal services to provide better support to children and young people.

How are we going to afford to do this?
External funding for this programme is available until March 2025. Work during 2024/25 will include recommendations to Norfolk and Waveney ICS how a new workforce model can be sustained.

The joint commissioning strategy will include local authority funded provision, assuming a reduction in independently funded packages of care.

Engagement with services and families has strengthened, and integrated commissioning is an established approach. A four-year occupational therapy transformation programme is underway that will provide a valuable blueprint for the future, across both Norfolk and Suffolk.

What are the key dates for delivery?

- **Year 1 April 2023 – Sep 2023**
  - Establish a clinical working group.
  - Co-design the resources for the website and handbooks for schools
  - Co-design training packages for professionals.
- **Year 1 Oct 2023 – March 2024**
  - Accelerate co-production with parents and carers.
  - Publish the parent page.
  - Commence recruitment of additional therapists
- **Year 2 April 2024 – Sep 2024**
  - Finalise joint commissioning strategy
  - Commence joint funding arrangements with the local authorities.
- **Year 2 Oct 2024 – March 2025**
  - Evaluate the impact of deliverables achieved
  - Refresh the joint commissioning strategy and expand the blueprint for joint commissioning priorities.
- **Year 3 April 2025 – March 2026**
  - Implementation of revised plans
- **Year 4 April 2026 – March 2027**
  - Use the evaluation and learning to develop the future service.
- **Year 5 April 2027 – March 2028**
  - TBC

How will we know we are achieving our objective?

Improved patient experience evidenced through feedback with families and a reduction in inappropriate referrals to specialist services.

Outcomes

- 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 specialist training by clinical professionals
- Improved access to universal training for non-clinical professionals and parents/carers

This programme will be evaluated by Ipsos Mori with outcomes expected by 2024/25

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".

Dr Ardyn Ross,
Clinical Mental Health Lead, N&W ICB

"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?

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.

The development of a Resilience Framework will provide our workforce, people and communities with the tools to increase and maintain wellbeing. This framework will focus on 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 will coproduce a refreshed five-year 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. While this work is underway, 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.

How are we going to afford to do this?
We will explore opportunities to use existing resources to deliver this provision. 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?

There are three priority activities with the following milestones:

Year 1 April 2023 – Sep 2023
- Explore opportunities to introduce a mental health literacy framework to the system.

Year 1 Oct 2023 – March 2024
- Publish a co-developed refreshed suicide prevention strategy, with agreed monitoring.
- Agree on a system approach for delivery of the mental health literacy framework.
- Develop a trajectory for improvements, against agreed baseline Measures (below).

Year 2 April 2024 – Sep 2024
- Begin implementation of the targeted workstreams in the action plan of the refreshed suicide prevention strategy.
- Ensure monitoring is established.

Year 2 Oct 2024 – March 2025
- Co-produce and promote a system wide resilience framework for and with communities.
- Launch implementation of the mental health literacy framework

Year 3 April 2025 – March 2026
- Year 3 and 4 - Implement the resilience framework and deliver initiatives i.e., impact of sleep and tools to improve sleep quality

Year 4 April 2026 – March 2027
Year 5 April 2027 – March 2028
- Review the suicide prevention strategy.

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.

Suicide Prevention

- 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?
Establish an adult Mental Health (MH) system collaborative and a Children and Young People (CYP) system Collaborative and participate in the Suffolk Mental Health Collaborative 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.

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.

What are the key dates for delivery?

Year 1 April 2023 – Sep 2023

- Adult MH System Collaborative and CYP System Collaborative Core Executive groups and associated delivery groups launched.
- Rolling programme of engagement/co-production established (to inform the specific work of the collaboratives as they seek to redesign clinical pathways).
- Establish delivery groups drawn from the wider membership to develop and implement the redesign agreed by the core executive; considering available data, information, and insights to understand enablers i.e., workforce, and identify and agree resource.

Year 1 Oct 2023 – March 2024

- Gaining commitment of individual organisations to work together to achieve the new ways of working
- Achieving tangible action; setting an action plan and agreeing local metrics to measure impact
- Review arrangements

Year 2 April 24 onwards

- Building and strengthening on the Year 1 foundation activity; expanding goals as the programme progresses, recognising success and reflecting on lessons learned.
- Continued checking back with older people and their families living with dementia, delirium and depression and children, young people and families with emotional wellbeing, mental and physical health needs that the transformed services are meeting their needs.

How will we know we are achieving our Objective?

Access to support is streamlined, responsive and coordinated for:

- Older people and their families living with dementia, delirium, and depression
- Children or Young Person with emotional wellbeing, mental and physical health needs.

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.

Objective 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.

What are we going to do?
We are launching an Integrated Front Door (IFD) to support Children and Young People (CYP) aged 0-25 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. 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 IFD 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.

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.

How are we going to afford to do this?
The IFD programme is fully resourced through identified mental health service development funding (SDF) and is factored into medium term financial plans. Any efficiencies gained through implementation of the IFD will be re-invested into enhancing the range of emotional wellbeing and mental health service offers and capacity available.

What are the key dates for delivery?

Year 1 April 2023 – Sep 2023
- Launch interim arrangement for mild-moderate emotional wellbeing and mental health requests for support
- Coproduce and launch a health and wellbeing website specifically aimed at young people

Year 1 Oct 2023 – March 2024
- Launch the Integrated Front Door to include all emotional wellbeing and mental health pathways (0-25 years) of support (except crisis, which will continue to be accessed through 111 mental health option)

Year 2 April 2024 – Sep 2024
- Launch the Professional Therapeutic Pathway through the IFD
- Refine data and reporting processes (including real-time reporting on system waits and coding) to ensure an improved experience for service users and professionals

Year 2 Oct 2024 – March 2025
- Develop and embed Artificial Intelligence (AI) and machine learning solutions to improve efficiencies across the IFD

Year 3 April 2025 – March 2026
- Work with system partners to scope additional CYP and family support services that could be accessed via the IFD and plan for implementation

Year 4 April 2026 – March 2027
Year 5 April 2027 – March 2028

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. Implementation of Complex Emotional Needs (CEN) Strategy, 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 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 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 CEN strategy and pathway, and assist system partners to work collaboratively to support people with dual diagnosis.

The Mental Health Integrated Community Interface (MHICI) will join system partners up in a new way of working to provide this function, helping to improve the experience of people with complex needs.

How are we going to afford to do this?
We will seek to identify what can be achieved through improved partnership working within existing resource, and/or scope where additional resource would improve delivery further.

What are the key dates for delivery?

Year 1 (first half) April 2023 – Sep 2023
Complex Emotional Needs:

- Deliver workshops to map pathways, develop, and integrate the CEN pathway
- Integrate new mental health roles within Primary Care Networks
- Continue to develop the evidence-based therapy offer within place-based communities and secondary care.
- Widen the availability of multi-agency training to system partners
- Agree baseline measures (below).

Dual Diagnosis:

- Establish multiagency pathway leadership and working group
- Engage people with lived experience
- Increase the joint working of mental health and substance misuse teams
- Map and gap analysis of existing provision, considering and exploring digital health initiatives (e.g., virtual consultations)
- Carry out a training audit
- Develop a trajectory so that an increased number of referrals is accepted via the dual diagnosis pathway, against agreed baseline measures (below).

Year 1 (second half) Oct 2023 – March 2024

Complex Emotional Needs:

- Establish regular pathway integration meetings
- Provide a tiered offer of therapeutic interventions for CEN within Primary care.
- Widen the availability of formulation and supported psycho-education workbook training, to system partners.
- Integration of senior clinical roles into the MHICI
- Planning the provision of therapeutic interventions of CEN within primary care and VCSE partners, based on analysis of unmet needs

Dual Diagnosis:

- Establish protocol for local data collection
- Draft a NSFT and Change Grow Live pathway, with formal agreement

Year 2 (first half) April 2024 – Sep 2024

Complex Emotional Needs:

- Identify therapy providers and upskill existing staff to meet therapy gaps
- Pilot the use of new roles such as the Clinical Associate Psychologists to meet therapy needs in primary care

Dual Diagnosis:

- Pathway implementation within financial constraints and/or develop funding proposals, should additional national funding become available

Year 2 (second half) Oct 2024 – March 2025

Complex Emotional Needs:

- Start to deliver therapy appointments closer to home in primary care and close gaps in care provision
- Implementation of CEN Strategy completed.
- Launch psychological therapies at Place level

Dual Diagnosis:

- Explore further pathway work on wider elements of provision

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

Dual Diagnosis

- Achieve an increased number of referrals (as per Y1 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

Case Study

Working together to reduce unnecessary hospital admission

John is a 46-year-old man with cerebral palsy and epilepsy who called 999 with a head injury after a fall. John was assessed through the 999-triage process as requiring a category 3 response. This is a lower acuity response with a target response time of 2 hours.

Within the Ambulance Control Room, this case was discussed with partner organisations – 999, Community Teams and the Clinical Assessment Service (CAS) – to determine whether a 999 response would be best, or whether a different service could respond to John in the allocated time.

John lives with his mum and both John and his mum were testing positive for COVID-19 at the time of the call. The Community team had resources available in the area who could visit John and his mum at home. A Community Matron called John prior to visiting to explain it would be the community team who would visit, not an ambulance. John's mum was relieved by this as she said she hadn't wanted to call an ambulance but wasn't sure what she should do instead.

The Community Matron arrived at John's home within two hours and carried out an assessment. A clinical assessment was completed for the head injury, as well as wounds and bruises to the body that were caused during the fall. The Matron was able to dress the wounds and complete a chest examination and COVID-19 assessment. John was found to have no clinical red flags that would be a reason for a hospital admission. The cause of the fall was also assessed and found to be caused be COVID-19 symptoms exacerbating John's existing mobility difficulties. Mobility aids and equipment options were discussed, and equipment from community stores was collected and loaned. Medication advice was given to help with COVID-19 symptoms and some pain from the bruising.

Image kindly supplied by: Norfolk Community Health and Care

John was able to stay at home, which both he and his mum were relived about, as they were concerned about John having to go alone to hospital while his mum was also covid positive. The Matron have advice for what to do and who to contract if the situation deteriorated and a follow up later that week confirmed that John was back to his usual level of mobility, his wounds and bruising was healing and he had no further concerns.

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 Frankie Swords
Executive Medical Director,
NHS Norfolk and Waveney

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

Zena Aldridge
Specialty Advisor for Older People, Frailty and Dementia, NHS Norfolk and Waveney

Our objectives

a) To develop a shared vision and strategy with older people that will help us to transform our services to be easy to access and designed and wrapped around the needs of older people.

What would you like to see in our five-year plan for health and care services? What matters to you most?
Recent JFP consultation feedback: "Support for social care for older people to reduce acute admissions". "Access to the right care pathway and improved social care for dementia and Alzheimer's." "Tackling dementia care". "Older/frail people kept well at home"

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. Current services are often confusing or complicated to access meaning that people don't always get the help they need until far too late. So, we want to design our services with our older residents.

We want to make it easy for older people to access support as soon as they need it, whether that support is for social, care or health needs. We want to simplify and join up all of our different services, so they are wrapped around our residents, 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 support older people to maintain their independence and preserve their quality of life.

Objective 5a: To develop a shared vision and strategy with older people

What are we going to do?
Develop a shared vision and strategy with older people, that will help us to transform our services to be easy to access and designed and wrapped around the needs of older people. We will then work together to deliver that strategy, to improve people's health, wellbeing, clinical outcomes and experiences of using and being supported by our services in their later lives. This will be known as our Ageing Well Strategy.

How are we going to do it?
Bring together members of our older population with colleagues from health, local government, the care sector and voluntary and community services to agree what the ideal service would look like for older people.

Work backwards from that to identify what needs to be in place to achieve that vision, using population health data and evidence based best practice to identify where and how this should be delivered. Map our current services to identify gaps and overlaps between the current and desired future state. Identify what new services or projects we need, and which current services need to change, expand or stop to best achieve this.

Establish an Ageing Well Programme Board to develop and then oversee the delivery of this strategy over the next 3 - 5 years.

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 divert funding toward reablement and care at home, reducing costs associated with long term complex care packages and residential care. Co-ordinating services using a system-wide perspective to deliver more integrated, high-quality cost-effective care from multiple sectors so reducing waste and duplication so saving cost for our system.

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

What are the key dates for delivery?

April - Sept 2023:
- Identify partners from across the ICS; including people in later life, to engage and co-produce the vision.
- Map the 'as is' position of existing services and support. Identify gaps, overlaps and opportunities.
- Agree a system wide definition and assessment tool for frailty to be used across all providers
- Begin to develop a strategy and 3-year plan to achieve the vision. Test this with a wide range of people in later life, carers, VCSE and other health and care professionals

Oct 2023 – March 2024:
- Develop a detailed road map to identify changes to services, commissioning, and communication of the future state.
- Continued coalition building; gaining commitment of individual organisations to work together to achieve the new ways of supporting people as they age to live well.
- Set up working groups to lead on the workplan, set and monitor metrics to measure impact.

April 24 – March 2025: Maintaining the momentum and effort
- Resetting goals and metrics to measure effectiveness of programme, changing the plan to ensure it is delivering as needed
- Recognising success and reflecting on lessons learned.
- Continued checking back with people in later life and carers that the transformed services are meeting their needs.

How will we know we are achieving our objective?
Publication of an Ageing Well strategy by December 2023, and a detailed road map for implementation plans by March 2024.

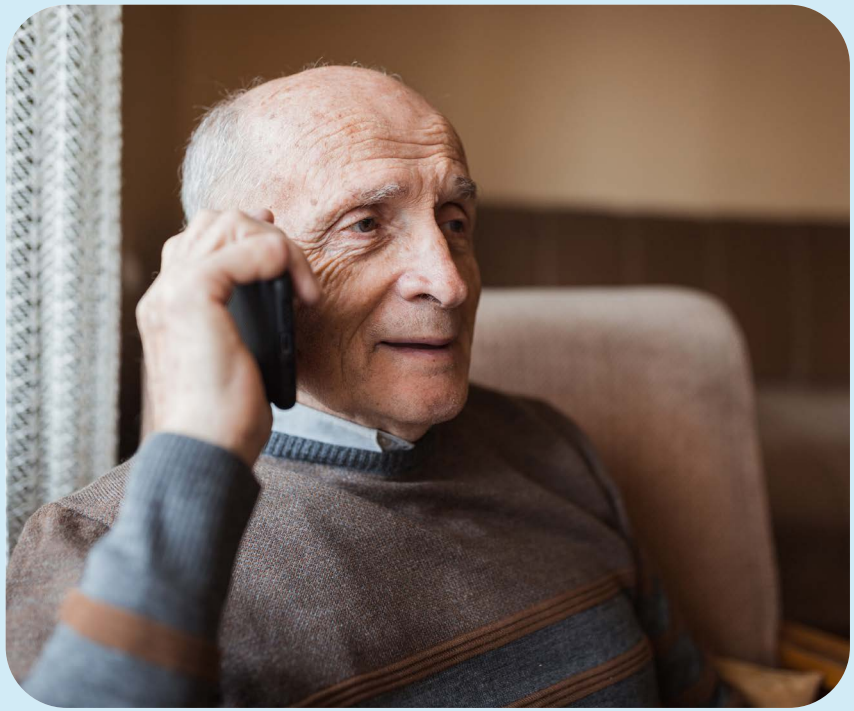
Case Study

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, at the right time. 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)"

Dr Lindy-Lee Folscher,
ICB specialty advisor for UEC

Our objectives

a) Improve emergency ambulance response times

b) Expand virtual ward services

c) Delivery of the Improving Lives Together programme to 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?

Recent 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 when 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, take 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.
The COVID-19 pandemic response enabled lots of our teams to integrate and work closer together however, we still have more to do. The Life Course Infographic in section 3.3 illustrates that for our older people who have a heart attack or stroke and our younger children, further work is required to improve admission to hospital where this is clinically necessary.

Pre-pandemic, Boston Consulting Group worked with the Norfolk and Waveney system to analyse demand and capacity across health and care. The report identified mismatches in demand and capacity, which if not addressed would result in a bed deficit position. The recommendations highlighted that these challenges could not be overcome by a single provider but only by the entire health and care system working collectively behind a single vision for urgent and emergency care services and going further with integration. Our three priorities for urgent and emergency care take the next step in collaborative working across organisations to respond to patients when a need arises.

Objective 6a Improve emergency ambulance response times

What are we going to do?
We will work with the ambulance service and community teams to improve how quickly emergency ambulances can respond to our most unwell patients. To do this, we will support community teams to respond to urgent care needs which are not life threatening but cannot wait, 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 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. 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 unscheduled care hubs which will bring together existing community services into a single point of access.

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

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

Leaders from partner organisations will determine how this will be modelled and delivered to meet the needs of the local population. This 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 will result in 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.

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?

Year 1 April 2023 – Sep 2023
- Existing programme of improvement.

Year 1 Oct 2023 – March 2024
- Deliver Category 2 30-minute mean response time by the end of March 2024.
- Maintain consistent 70% 2-hour UCR performance throughout 2023/24.
- Identify appropriate urgent calls for transfer to community response.
- Establish the unplanned care hubs and access routes
- Consolidate community urgent care service access points under the unplanned care hub.

Year 2 April 2024 – March 2025
- Further review and expansion of the type of urgent calls suitable for transfer from 999.
- Review how community capacity can be expanded through continued integration at place level.

Year 3 April 2025 –Year 5 March 2028
- Continued integration of urgent and emergency care provision, further collaboration across system partners, including VCSE to increase the support available.

How will we know we are achieving our objective?

- Confirm a Category 2 30-minute mean response time by the end of March 2024

National description of C2:
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 allow patients to get the care they need at home safely and conveniently, rather than being in a hospital setting. Support can include remote monitoring using digital technology, wearable medical devices such as pulse oximeters and face to face care provided by multi-disciplinary teams in the community.

Where patients can leave hospital earlier with remote monitoring support, we refer to this as step down. All three of our hospitals have a Step-Down Virtual Ward in place.

Step up virtual wards are an alternative to admission in a hospital setting, where patients can safely receive the same level of clinical care at home.

We will do this by:

- Building a new ICS collaborative partnership to promote joint working, innovation and new ways of working, instead of more traditional approaches of specifying and buying services
- Ensuring strong clinical leadership is in place to support collaboration. This will move towards an integrated model of care that uses resources across the system rather than in individual organisations.
- Developing a common digital solution with one dashboard for clinical teams to access.
- Expanding the conditions that a virtual ward can support to include respiratory, frailty and heart failure provision, as well as pioneering new, locally driven models of care.
- Develop a system wide step-up model which will play a key role in managing urgent care demand and building capability in the community to safely support people at home outside of a hospital setting.
- We will work with the whole provider community -Primary, Community and Acute care, 999 and 111 (CAS) all need to be part of developing, supporting and using the additional capability that the virtual ward creates, to deliver better outcomes for patients
- Integrate and embed virtual ward in the care system. As well as pioneering new ways of working, there is a huge opportunity to link all pre-hospital initiatives into one overall integrated urgent care 'pre-hospital' model with enhanced clinical oversight that allows the community teams to do more to safely support patients outside of hospital.

How are we going to do it?
Virtual Ward will work across the whole health and care system. We will identify referral routes in and out of virtual ward for equal service provision across Norfolk and Waveney. We will make sure there are automated, digital referral routes and the ability to transfer patient details electronically, so patients only have to tell their story once.

Local teams will design the new models of care and supporting processes that will form the Virtual Ward face to face response. These need to be joined up with existing services and offer staff opportunities to work across different organisations to enable better integration and use of skills.

How are we going to afford to do this?
Virtual Ward has an allocation of national funding that is to be used to maintain and expand services. In the longer term it is expected that local areas will need to fund virtual ward services.

As virtual ward expands, we anticipate there will be corresponding changes in where urgent care activity is managed – increasingly outside of hospital settings.

What are the key dates for delivery?

Year 1 April 2023 – Sep 2023
- Current virtual ward provision

Year 1 Oct 2023 – March 2024
- Put in place a single platform across the ICS to ensure consistent ways of working, reporting and viewing capacity are available.
- Launch of the community step up virtual wards across Norfolk and Waveney
- Establish consistent tracking against targets to inform the Partnership and aid decision making and risk mitigation
- Evaluate virtual wards and use the findings to be at the centre of service transformation.

Year 2 April 2024 – March 2025
- Use findings from the evaluation to refine and improve the service.
- Agree an ICS wide approach to medicine administration and point of care testing, based on two trials currently under consideration.
- Continue to expand the specialties Virtual Ward can support.

Year 3 April 2025 – March 2026
- Use outcomes from the evaluation report to further develop virtual wards.
- Continue integration of virtual wards with urgent and emergency care services
- Extend Virtual Ward service to enhance multiple long term condition management to reduce inpatient demand and improve outcomes.

Year 4 and 5 April 2026 –March 2028
- Further evaluation and monitoring to continuously improve the service.

How will we know we are achieving our objective?

Trajectories

- By April 2024 we will have 368 virtual ward beds.

Objective 6c: Delivery of the Improving Lives Together Programme to reduce length of stay (LOS) in hospitals

What are we going to do?
We want to improve discharge planning and processes, so that you can take the next step in your recovery and rehabilitation after a period of illness, quickly and safely, in a place where you can be as active and independent as possible and stay connected with the people and activities that matter most to you.

The 'home first' principle is important to us when we start your discharge planning. We want to make sure that you can return to your home, if this is the right place for you, and meets your needs. If things have changed while you have been in hospital, and home is no longer the right place for you to live, then we can work together to plan what that will look like.

The date and time for your discharge home will be agreed with you in advance, to allow you to make plans with carers, loved ones and/or family members and we will make sure you have a supply of medication and a discharge letter to share with your GP so that they know what help and support you may need once you arrive home.

Better discharge planning helps to reduce your length of stay in hospital, and reduces deconditioning and the need for readmission, which also helps us to bring people into hospital more quickly when they need emergency or planned care because we have more space and resources. It's about getting you to the right place, for the right care and support, at the right time.

How are we going to do it?
The Improving Lives Together Programme will bring system partners together to lead and deliver improved discharge planning and reduced hospital length of stay, across Norfolk & Waveney. There are two timelines for the delivery of discharge improvement, which will happen alongside each other. We will focus on process-based improvement to be delivered in the first 6 months and a programme of wider transformational improvement with a longer term 18-month timescale. The immediate priorities over the next 3 months will be:

1. Mobilise a digital solution (Optica) for managing patients through their discharge pathway more efficiently.
2. Focus on early discharge planning, embed the SAFER flow care bundle, and increase the number of Pathway 0 discharges and weekend discharges for people who do not need additional care and support to go home.
3. Build an Integrated Transfer of Care (ITOC) Team at each Place, which will bring together hospital, community, voluntary, therapy, transport and pharmacy resources around the patient and deliver more seamless support.
4. Continue to develop collaborative leadership, with a clear and consistent governance structure to support delivery. Include the needs of people who are being discharged from Mental Health settings into the improvement journey.

The ICS Discharge Board has agreed these priorities and will oversee improvement and delivery of metrics. Principles and outcomes agreed at system level will help ensure consistency while delivery will be driven at Place-level with support from the NHSE improvement team. In the longer term, the system will create a stable and sustainable model of care for discharge support across the board, but particularly for discharge Pathways 1 to 3, which are pathways for patients who require support following a hospital stay.

Data and Digital
Data is a significant issue and risk for all partners due to the digital immaturity of the Norfolk and Waveney system, however, this highlights the importance of a digital solution to help us monitor, track and report on the discharge position and impact of our interventions and improvements. New national guidance will be issued in 2023 and NHSE will report more discharge data publicly; this will be addressed with current workarounds until Optica is fully operational.

How are we going to afford to do this?
Reducing length of stay for patients improves quality outcomes and offers opportunity for savings to be realised or re-invested. Maintaining people's independence will enable funding to be diverted toward reablement and care at home, reducing costs associated with long term complex care packages and residential care. Reduced length of stay will reduce the risk of patients deconditioning and needing a higher level of care and support, in the longer term.

As part of this ambition, we need to develop a sustainable financing model. To do this we will need system-wide partner financial and operational engagement, to determine how we can resource changes in activity across organisations and develop workforce models that allow organisations to create the right capacity to meet demand, while also ensuring we meet our system's financial targets.

How will we know we are making a difference?

- Reduction in length of stay is the key outcome metric of this programme.
- We can see a reduction in the average length of stay in acute and community beds and an overall reduction in use of intermediate care beds.
- See improved outcomes for patients following discharge, and better experiences for their carers. Deconditioning and readmission rates will fall.
- We can see an increase in our daily numbers of patients discharged.
- Can stop using surge and escalation beds to manage day to day pressures.

What are the key dates for delivery?

First 6 Months: April 2023 to September 2023

- Beginning of Optica phased rollout and real-time tracking of patients through discharge, reducing then eliminating manual Transfer of Care form. Early sight of patient by hubs to start planning complex discharge needs.
- Embed SAFER flow bundle and 'red to green' management system.
- Focus on early discharge planning for P0 patients and increase P0 discharges through criteria lead discharge and weekend discharge activity.
- Voluntary sector integration and utilisation by Wards and Discharge Teams.
- Agree ITOC system principles, aligning goals and purpose with Place-based delivery and improving communication.
- Increase Trusted assessor model.
- Improve multidisciplinary working to support complex discharge planning for service users awaiting discharge from mental health settings.
- Review the ICS Discharge Board and system-level governance. Set and monitor metrics, agreeing principles and outcomes at a system level to ensure consistency.
- Reduction of deconditioning so that patients can leave on the most appropriate pathway.

October 2023 to March 2024

- Continue to map and amend pathways and services to support discharge across the system. Develop and establish the ITOC process at each Place.
- Fully onboard Mental Health into the improvement journey with digital and collaborative leadership.
- Robust oversight of discharge plans to ensure that they are meeting patient needs.
- Reduction in the requirement for intermediate beds and complex long term care packages.

April 2024 to March 2025

- Fully embed Optica digital tool.
- Create comprehensive evidence-based Place-level Discharge Demand and Capacity Plans.
- Evaluation of the programme's effectiveness; review the evidence base and celebrate and share successes.
- Review and reset goals and metrics to measure effectiveness and to evidence continuous improvement.

April 2025 to 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.

April 2027 to March 2028

- Digital maturity fully embedded.
- A model of care that meets demand.

How will we know we are achieving our objective?

Achieving or exceeding the national target to reduce hospital occupancy to 92% or less.

Case Study

Lung health checks launched in a drive to save more lives

Past and current smokers in Great Yarmouth are being invited to an NHS lung health check in a drive to improve earlier diagnosis of lung cancer and save more lives.

With one of the highest mortality rates for lung cancer in England, Great Yarmouth is one of 43 places across the country to launch the Targeted Lung Health Check programme.

The initiative means around 13,750 past and current smokers aged 55 to 74 years of age in Great Yarmouth are being invited to a lung health check by their GP. This will identify lung cancer earlier than it would have been otherwise.

People diagnosed with lung cancer at the earliest stage are nearly 20 times more likely to survive for five years than those whose cancer is caught late.

A patient who has had a lung health check, said: *"This is an excellent scheme and I was so pleased to be invited to attend this check up. Prevention is always better than the cure and this is a great example of the NHS, working together to help identify cancer much earlier. I am so grateful."*

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"

Joanne Segasby
CEO JPUH 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?
Recent 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.

There are increasing numbers of new cancer cases being diagnosed and we know that early diagnosis is key to saving lives so it is essential that we continue to ensure patients can be offered alternative locations for their care and are seen in the right place, at the right time, by the right person.

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 narrow 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
Norfolk and Waveney have developed plans and business cases for multiple Community Diagnostic Centres (CDCs) and are waiting for confirmation of national investment to proceed.

- Our plan is to invest in state-of-the-art diagnostic equipment across our geography, new diagnostic centres at acute hospital sites and in the community setting to offer a suite of multiple diagnostic tests in 'one stop' closer to where you live.
- Streamlined access for Primary Care colleagues to enable direct access to diagnostic tests and clinical guidance across the health services to meet the needs of the individual.
- Tackle health inequalities by creating better access to diagnostic testing in our deprived areas.
- We will optimise what we do and share best practice to standardise procedures, processes and pathways to increase productivity, efficiencies and clinical quality.

We will deliver more elective care

- '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).
- We will build additional theatre capacity at our acute hospital sites. (i.e. Elective hubs)
- We will more readily share best practice between the acute trusts thereby appropriately increasing standardisation of procedures, pathways and support functions.
- This will increase productivity where patients need to be treated in a hospital theatre and contribute to increased planned care treatments in Hospital Outpatient clinical areas, GP practices and Community care settings.

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 ensure that where appropriate Norfolk and Waveney residents are able to fully benefit from 'Day Case Care' for planned care procedures.
- We can release more beds and prevent cancellations of planned care procedures which need overnight stay(s) in hospital.

Reducing cancer backlogs

- We will use evidence and audit to co-produce pathways with primary and secondary care, standardising pathways and ensuring appropriate safety netting where possible.
- Continue to embed system-wide nationally defined Best Practice Timed Pathways (BPTP) for cancer, and vague symptoms pathways to improve efficiency, diagnosis, and patient experience

- We will build on our current projects using PHM approaches to identify people who are at a higher risk of cancer, and those with inequitable access to cancer services, so we can apply these methodologies to cancer backlogs in the future. This will form part of the development of our ICS PHM strategy.
- Provide additional workforce capacity to support clearance of the waiting list
- Ongoing work to raise awareness of cancer guidance within primary care to reduce the variation in quality of referrals

Reducing unnecessary outpatient follow up appointments

- One of key approaches is called PIFU (Patient Initiated Follow Ups) to prevent clinically unnecessary appointments and to ensure that any appointment is booked by the patient at a date, time and location which is convenient to them.
- Clinicians will discuss with patients what and when is expected post intervention and, unless recovery is different from the discussed recovery pathway, the patient will not attend an Outpatient Follow Up appointment.
- We will ensure there are opportunities for the patient to request (or initiate) a Follow Up appointment if they are unhappy or worried in anyway and details how to do this will be given to patients.
- Patients will notice they have more involvement and/or choice of whether to have Follow Up appointments. This will save patients time and transport costs, whilst at the same time releasing clinician time to other priority areas.

How are we going to afford to do this?

National capital funding (TIF) has been requested through the development of local plans and business cases to support Elective Hubs, Community Diagnostic Centres and Diagnostic Access Centres. We await final funding decisions before we can move forward with these initiatives.

What are the key dates for delivery?

Year 1 April 2023 – March 2024

- Mutual Aid rolled out across specific specialties and patient groups.
- PIFU rolled out across specific specialties.
- Norfolk and Norwich Orthopaedic Centre opened
- James Paget Hospital Elective Surgery Hub opened
- There will be additional diagnostic capacity across Norfolk and Waveney (national funding dependent)
- Continue to support Primary Care in the delivery of the Earlier Cancer Diagnosis PCN DES
- Continue to support the hospitals to implement the Best Practice Timed Pathways for Cancer
- Implementation of a clinical decision support tool for cancer in primary care
- Share the learning from improving access to cancer services for people living with learning difficulties project

Year 2 April 2024 - March 2025

- Mutual Aid rolled out across all specialties and all patient groups.
- Patient Initiated Follow Ups rolled out across all specialties.
- Norfolk and Norwich hospital Elective Hub opened
- A further increase in diagnostic capacity across Norfolk and Waveney (national funding dependent)
- Develop an approach to fixed term posts funded through cancer transformation funding to improve sustainability
- Develop career pathways for cancer nursing and therapeutic radiography to support recruitment and retention

Year 3 April 2025 – March 2026

Expand collaborative working with Public Health, social care and VCSE partners.

Years 4 and 5 Apr 2026 – March 2028

We will review the benefits and explore further opportunities to enhance Elective Recovery & improvement including our digital technology which will inform our strategic direction for years 4 and 5.

How will we know we are achieving our objective?
Waiting time will reduce for patients:

Elective

- Patients will not wait any longer than 65 weeks for their planned care treatment by March 2024 and 52 weeks by March 2025.

Diagnostics

- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%

Cancer

- Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.
- Continue to reduce the number of patients waiting over 62 days.
- Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028.

Objective 7b Implement digital technology to enable elective recovery

What are we going to do?
We will implement digital technology and initiatives to support our ambition for elective recovery and improvement.

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. A single waiting list for all three hospitals is stated within our Digital Transformation Strategic Plan and Roadmap as a priority.

- **Peri-operative care** - Digital initiatives will be rolled out in peri-operative care which will allow patients to complete important personal health and lifestyle questionnaires online to streamline the process.
- This will help ensure patients are 'fit and ready' for their planned care/ treatment which will reduce cancellations, reduce length of stay and improve recovery.
- We can identify and support patients to "wait well" and prioritise patients at risk of potential harm while waiting.
- We will ensure non-digital options will also be available for those who do not have access to, or cannot use, IT and those who prefer not to.
- **Single Waiting List -** We will have one waiting list across our three hospitals to ensure patients waiting for treatment at any of our hospitals will receive the same levels of access to care (i.e. waiting times for treatment) and we will proactively offer patients an alternative location to receive their treatment if they could be seen more quickly.
- We want to ensure everyone on the waiting list has 'equity of access' This is important as we have pledged to work to actively reduce health inequalities in Norfolk and Waveney.

How are we going to do it?

- Online Peri-operative care is being tested in Trauma and Orthopaedics first as this is a speciality which has large numbers of patients waiting for treatment.
- The next phase of testing with be specialities such as Ear, Nose and Throat and Gynaecology as these also have large waiting lists.
- The intention is roll out across all specialities in two of the three hospitals by March 2024. The final hospital intends to roll out online Peri-operative across its specialities by March 2025.
- To implement the single waiting list, a new piece of IT Software has been purchased and is currently being implemented in specific areas of care such as Trauma and Orthopaedic and Cancer to test that it is working properly. It is anticipated the testing stage should be completed before the summer of 2023.
- Next, we will expand the testing to other areas of care such as Ophthalmology, Vascular and Endoscopy, it is anticipated this will be completed by the autumn of 2023.
- Our intention is for all three hospital trusts to be using the single waiting list by March 2024.
- This will enable us to actively manage our single patient waiting list to support patients to 'wait well' and identify and manage those at greater risk of harm.

How are we going to afford to do this?
We have purchased the software and hardware necessary for both the Peri-Operative Care and single waiting list initiatives. Future costs have been identified and agreed as part of approving the Peri-Operative Care business case.

With regards to the single waiting list there will be some costs associated with training although the 'Train the Trainer' model should keep costs to a minimum.

What are the key dates for delivery?

- **Year 1 April 2023 – March 2024**
  - Online Peri-Operative Care testing complete and rolled out in two of the three hospital trusts.
  - Single waiting list testing phase for Trauma and Orthopaedic, Cancer, Ophthalmology, Vascular and Endoscopy complete.
  - Single waiting list in operation at all three hospitals by March 2024 for selected specialities
- **Year 2 April 2024 – March 2025**
  - Online Peri-Operative Care implemented in all hospitals.
  - All hospitals using the single waiting list across all services.
  - All patients at the point of referral to have the choice of the waiting list management to be predicated on the place of care or the timeliness of their care.
- **Year 3 April 2025 – March 2026**
  Increased levels of data quality assurance routinely seen across all three hospitals waiting lists.
- **Year 4 and 5 April 2026 – March 2028**
  Throughout the phases of this objective, we will review the benefits and explore further opportunities to enhance our digital technology will inform our strategic direction for years 4 and 5.

How will we know we are achieving our objective?

We will measure

- how many patients have been offered mutual aid
- how many patients chose a different hospital
- how many chose to wait at their preferred treatment location.

Case Study

Shared Care Record sets to transform care in Norfolk and Waveney

The Shared Care Record is a way of bringing together the most important records from the different organisations involved in the health and care of our people and communities in Norfolk and Waveney.

These records are then visible to frontline health and social care professionals, at the point of care, in a read-only view. Our aim is to help our frontline health and care services by providing important information about you and your care, from your interactions with the following professional care services:

- GP
- NHS 111/out of hours service
- community services
- emergency department
- outpatient appointment
- hospital stays
- maternity service
- mental health practitioner or care practitioners

Patients' information will only be made available when needed at the point of care and will only be used by staff members with a legitimate basis to do so. The Norfolk and Waveney Shared Care Record helps meet this aim by reducing the time needed to learn about important health and care information, particularly in a time sensitive situation.

This can be particularly helpful when patients, their families and carers may not be able to answer specific health and care questions.

Ambition 8: Improving Productivity & Efficiency

Ambition 8 Improving Productivity & Efficiency

"Our ambition is to change how we work with partners across the Norfolk and Waveney ICS to look at 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 not simply about saving money but also about delivering better services and outcomes for our patients and local communities."

Andrew Palmer
Director of Performance, Transformation and Strategy
NHS Norfolk & Waveney ICB

Our objectives

a) Improve the services we provide by enhancing productivity and value for money, delivering services together where it makes sense to do so.

What would you like to see in our five-year plan for health and care services? What matters to you most?
The focus of this ambition is to systematically review data about our services and compare how we perform with other systems nationally, seeking out opportunities to work more effectively and efficiently for the benefit of our population.

We will work together in partnership to ensure we achieve value for money, ensuring we use our resources as wisely as possible for the benefit of our population.

Why we chose these objectives
Deciding where to look to improve productivity and efficiency has been driven by the data and in discussion with our staff. All partners are looking at their own internal efficiencies as a constant process.

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

We look at examples of good practice across the local system, regionally and nationally, and use our Health Intelligence data to determine where to focus.

Objective 8a Improve the services we provide by enhancing productivity and value for money, embracing digital innovation and delivering services together where it makes sense to do so.

What are we going to do?
Our organisations have established improvement programmes examining a range of areas in which to increase productivity and value for money. We have already brought together some administrative functions to improve value for money.

Existing improvement programmes include a focus on Procurement, Estates and Medicines Management opportunities.

Our two areas of focus for year one and two are:

a) Organisations will continue to improve their operational efficiency across a range of areas of spend including procurement, estates, workforce and prescribing.

b) Work together to enhance outcomes, productivity and value for money through our new Improving Lives Together Programme.

How are we going to do it?
We have established our Improving Lives Together programme, an ambitious improvement programme, drawing together partners from across our system to work together to improve the services that we provide.

We will assess opportunities based on evidence and benchmarking of data through sources including the Model Health System.

The initial focus of this work is on Digital and Workforce services, and we have already undertaken a detailed assessment of how we currently deliver these services to see how we can make improvements. Options are being developed that will help us to reduce duplication, improve outcomes and make best use of every pound we spend as an ICS.

How are we going to afford to do this?
This programme of work will deliver enhanced productivity and value for money and is not anticipated to increase overall costs in our system.

Options will be carefully assessed as part of approving the cases for change for individual service areas.

What are the key dates for delivery?

Year 1
- By July 2023 our Improving Lives Together programme will develop cases for change for improvements in Digital and Workforce services. These proposals will then be considered by partners in our ICS, and individual projects will be set up to deliver the agreed changes beginning, where possible, in the second half of 2023/24.

Year 2
- 2024/25 will see the full roll out and effect of any changes to Digital and Workforce services, and our Improving Lives Together programme will continue to assess further service areas for wider opportunities to improve.

Years 3 - 5
- Our Improving Lives Together programme will continue to support review and improvements in services as part of our continuous service improvement approach.

How will we know we are achieving our objective?

- We will undertake post implementation reviews for changes led through our Improving Lives Together programme to formally assess that we have successfully delivered the operational and financial improvements.
- We will use national benchmarking data drawn from the Model Health System to measure our improvement relative to national benchmarks and other ICSs.

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.

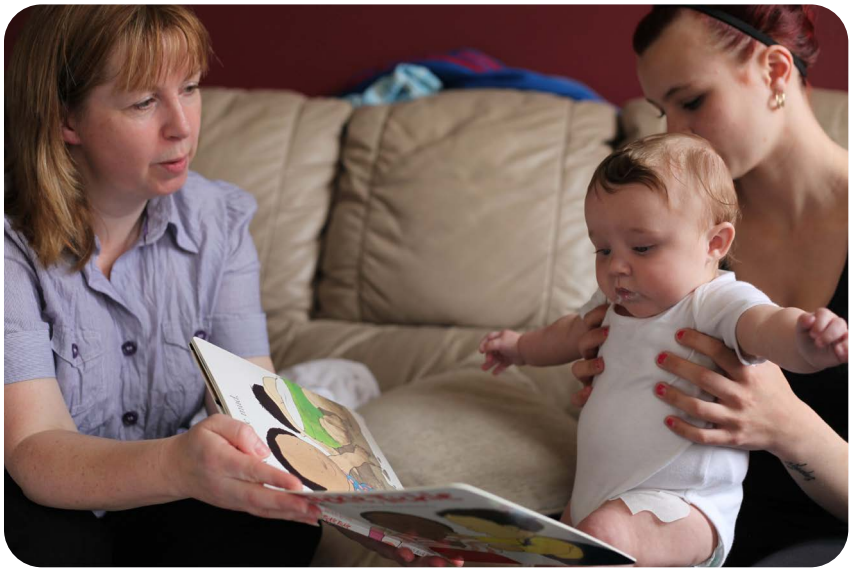
5.0 When we expect to deliver

5.0 When we expect to deliver

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

To show how the overall profile of work looks for our key objectives, we have split Years 1 and 2 into six-monthly timeframes to provide more detail and then we have included our longer-term planning years 3-5.

This provides a programme summary, which will be developed in more detail as our JFP evolves and responds to need and is shown in Figure 8.



Ambition	Ambition Objective	Timeline for delivery						
		Year 1		Year 2		Year 3	Year 4	Year 5
		1st	2nd	1st	2nd			
1	**PHM, Reducing Inequalities & Supporting Prevention**							
1a	Development and delivery of two strategies: A Population Health Management Strategy, and a Norfolk and Waveney Health Inequalities Strategy to deliver the "Core20PLUS5" approach.	■	■		■	■		
1b	Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people.	■	■	■	■			
1c	Early Cancer Diagnosis – Targeted Lung Health check 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 a wider range of services closer to home, 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 Occupational Therapy.		■			■		
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 develop a shared vision and strategy with older people that will help us to transform our services to be easy to access and designed and wrapped around the needs of older people.	■	■	■	■	■	■	■
6	**Improving UEC**							
6a	Improve emergency ambulance repsonse times.		■	■				
6b	Expand virtual ward services.		■	■	■	■		
6c	Delivery of the Improving Lives Together programme to 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	Improve the services we provide by enhancing productivity and value for money, and delivering services together where it makes sense to do so.	■	■	■	■	■	■	■

Figure 8 – 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 transitional Integrated Care Strategy and Joint Health and Wellbeing Strategy, Clinical, Digital, Quality, Estates 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. **Empowering and working with the Voluntary, Community, and Social Enterprise (VCSE)** sector differently and 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.

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 Well-Being Partnerships (HWPs) shown on the map below in Figure 9. The Place Boards and HWPs have complementary roles, which are aligned.

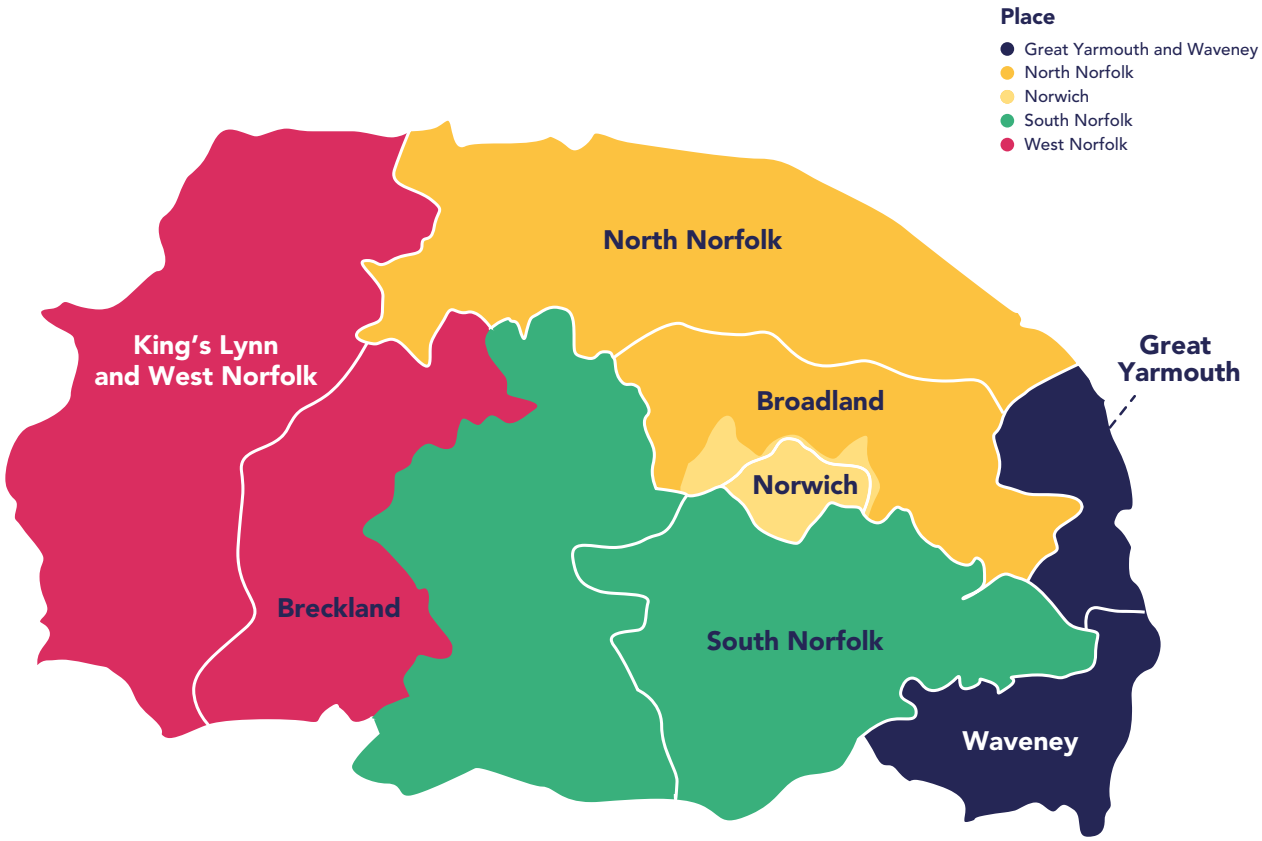


Figure 9 – Five Place Boards and eight Health and Wellbeing Partnerships map

- **Place Boards** bring together colleagues from health and care to integrate services, with a focus on effective operational delivery and improving people's care. They also work with the VCSE and there is a VCSE Place based lead aligned to each Place Board.
- **HWPs** seek to address the wider determinants of health and wellbeing, through collaboration and in line with evidence-based practice, using this planning toolkit to support and develop their work: Toolkit. The HWPs are particularly well placed to deliver against both the Norfolk and the Suffolk Joint Health and Wellbeing Strategies' overall themes of integration, connected, thriving and resilient communities, addressing and reducing inequalities, and prioritising prevention.

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. The Place Boards would plan services and then seek approval from a new system committee who would approve the plans and release the funding, as long as they met the agreed principles.

In 2023/2024, our Place Boards will be primarily focused on delivering against two of our ambitions: urgent and emergency care, and primary care resilience and transformation, particularly moving care closer to home. Other ambitions have Place Boards as key partners too, but it is acknowledged that more needs to happen to confirm details and resourcing. This approach sets out an intent and a signal that if we can deliver locally in our communities we will.

The responsibility map in Figure 10 supports our principles and overall direction of travel.

The HWPs are working on a strategy for each area across a two to five-year time period. Action plans are in development as part of strategy work for each HWPs, which will identify timelines and milestones for delivery in 2023. Future plans will be determined through place-based Health and Wellbeing strategies for the 2023-25 period and beyond, developed with reference to key strategic priorities from the District they serve and the ICS vision.

Current priorities are set out in Figure 11 and all of them can be linked to at least one of the ambitions in the JFP. The HWPs have some resources allocated to them through some funding from the Covid Recovery Fund, Better Care Fund and Active Now. 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 Level
- 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
- Bottom-up input from local needs assessments / intelligence about health inequalities

Securing Services

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

Regional level
- Commissioning of specialised services

ICS level
- Commissioning of services, e.g. planned care, urgent and emergency care, primary care, community services
- 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 level
- Co-ordinating recovery plans
- Enabling functions and joining things-up 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 level
- Performance Committee
- Evidence and evaluation hub
- Quality Management Approach and faculty

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

Assurance

(Assuring quality, safety and governance)

Regional level
- ICB Performance committee and System Oversight Framework level 4 exit

ICS level
- ICB Board underpinned by Tier 2 ICB committee, e.g. Audit and Risk, Remuneration, People and Culture, Patients and Communities, Finance, Clinical Quality and Safety

Figure 10 - Responsibility Map

Partnership	Priorities
Breckland	Overarching Priority - Inequalities • Mental Health (all ages) • Alcohol (targeted - geographies) • CVD (Prevention)
Broadland	• Long Term Conditions: Musculoskeletal (MSK) problems • Lifestyle: Alcohol • Lifestyle and Long-Term Conditions: Diabetes and Cardiovascular disease
Great Yarmouth	• Health & wellbeing - focussing on inequalities: Increasing healthy eating and physical inactivity • Attainment, skills & aspirations: Increasing employment opportunities • Vulnerability & exploitation: Toxic trio: mental health, domestic abuse, substance misuse • Loneliness, isolation & social exclusion: Connecting residents, building community capacity
KLWN	• Mental Health • Weight Management • Alcohol Consumption
Norwich	• Health Inequalities • Mental Health • Domestic Abuse
North Norfolk	• Aging population • Mental health • Inequalities
South Norfolk	• Long Term Conditions: Musculoskeletal (MSK) problems • Older People: Dementia A) Children, Early Years & Young People: Unintentional injuries in children (0-14 years) B) Lifestyle and Long-Term Conditions: Diabetes and Cardiovascular disease
Waveney	• Tackling Inequalities - including cost of living programme • Addressing poor mental health • Reducing loneliness and social isolation • Focused efforts to tackle childhood obesity, particularly for Lowestoft

Figure 11 – 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 both the Joint Health and Wellbeing Strategies and the eight ambitions in the JFP, but we cannot do everything at once. We are pulling in the same direction and aiming for the same things, whilst ensuring the place-based approach can respond to local needs. After an initial set up phase and a lot of hard work, the focus is on evaluating what has worked well and re-setting for the future.

6.2 Provider collaboration

This is about 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 Kings Lynn NHS Foundation Trust, the Norfolk and Norwich University Hospital NHS Foundation Trust and the James Paget University Hospitals NHS Trust. The aim of the N&WAHC is to improve health outcomes for all through:

- Enhancing clinical effectiveness and patient experience and,
- Reducing known inequities in health outcomes and access to services.

These aims are consistent with the JFP through the ambitions focused on prevention and reducing health inequalities.

The N&WAHC has identified a number of pivotal programmes of work it will be focusing on, which will make a real difference to our local population by doing them together:

The first is **implementation of a single acute Electronic Patient Record (EPR)**

This is a joint digital solution that enables clinical and operational processes to run seamlessly and efficiently on one platform across the three acute trusts bringing tangible benefits around reduced clinical risk, efficient use of clinician time, improved decision-making, patient care and experience. It will also provide a platform to transform integrated acute pathways and services.

The second is the **development of a joint Acute Clinical Strategy**

The joint clinical strategy will align directly to the clinical objectives set out in the ICS clinical strategy and it will also support the individual acute hospital trusts' clinical strategies by identifying the specific opportunities where clinical collaboration can improve the way we deliver services for our patients. The objective of the strategy is to ensure right sized and stable inpatient capacity that responds to long-term population health and demand. Underpinning this are design principles of onsite acute care only where true clinical value is added and vertical and horizontal integration of services, teams, and pathways. This is referenced in the place-based approach as we focus on care closer to home as an initial priority, and the development of neighbourhood teams.

The third programme is about **Unblocking delayed discharges; creating stronger, consistent support for frail, older people**

With an existing population demographic weighted towards people living longer into later life the collaborative will prioritise resource and capacity to configure and integrate services, teams, and pathways to reduce the unnecessarily long inpatient stays and the deconditioning of patients. This will be a critical enabler to transforming care in later life and improving urgent and emergency care where we have a focus on length of stay in hospitals.

The fourth programme is about **Improving productivity across the acutes and the wider system**

N&WAHC will be working more closely together, identifying areas to align support and corporate functions with a focus on doing things once and at scale. This is consistent with improving productivity and efficiency as the three hospitals collectively account for the majority of the NHS Norfolk and Waveney budget.

The fifth programme is about **Major acute capital projects.**

N&WAHC is collectively working on plans for three Diagnostic Access Centres (DACs), one at each hospital, which will significantly improve access to diagnostic services and reduce waiting times for treatment, especially for a cancer diagnosis. This aligns with elective recovery and improvement to create additional capacity so more patients can be treated and waiting lists reduced.

Mental health partner collaboration
Collaboration across mental health (MH) in Norfolk and Waveney is relatively well established and has been a focus for several years. In 2019 both the adult, and children and young people's (CYP) MH strategies placed integration and collaboration at the heart of their service models moving forward.

Our ambition is to establish an adult mental health system collaborative and a children and young people (CYP) system collaborative. This will support our plans for transition services (18-25 years) which will be led by one of the collaboratives and will converge over time. In developing these proposals Norfolk and Waveney ICS and Suffolk and North East Essex ICS have worked very closely together to ensure we have consistent delivery arrangements for integrated children's services in Waveney because these will be delivered on a county based model.

Whilst both collaboratives are prioritising mental health services, we want to include physical health outcomes and a focus on the wider determinants of health aligned to the ICS Clinical Strategy objective of seeing me as a whole person.

Initially the adult mental health collaborative will focus on:

a. Building the 'case for change' for dementia provision, inclusive of delirium and depression.

b. Identifying national best practice and best definitions.

c. Given the breadth of the pathway, using a. and b. to advise on which element/s of provision are addressed first.

This links directly to the transforming care in later life ambition, acknowledging that dementia can span all-age – albeit in smaller numbers.

Initially the CYP MH collaborative will focus on development of a model of prevention and intervention with an initial focus on the redesign of community-based services covering mental health services; the Special Educational Needs and Disabilities (SEND) redesign of the operating model and neurodevelopmental pathways.

Such is the importance of this enabler, that we have included the development of these two MH collaboratives as one of the key objectives within the Transforming MH services ambition.

Community services collaboration
Prior to the formation of NHS Norfolk and Waveney, community services were commissioned differently across our geography. As a single organisation have an opportunity to undertake a comprehensive review of community services in the summer of 2023.

This will be our first step to the transformation of services and an opportunity for us to address some of our historic challenges to ensure that people receive timely care and the support they need, in the most appropriate setting, helping them live independent lives for as long as is possible. We will to deliver on some commitments made in the Norfolk and Waveney clinical strategy, in terms of moving health and care pathways into the community and the Fuller Stocktake, recommending integrated community teams supporting general practice.

As part of our review, we will engage with organisations, stakeholders, VCSE sector and wider partners and we expect to produce a report in the autumn to inform the wider transformation of community services across Norfolk and Waveney. We will engage fully with the people and communities of Norfolk and Waveney once the report is published and seek your views using these to your ideas to improve and strengthen community health and care of the future.

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, and this section shows how we are doing this by making connections between different pieces of work. 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.

Partners' plans

It is only by working together we can build system resources to address our ambitions and objectives in section 4 to overcome some of the biggest barriers we face, achieve improvements in productivity and efficiency and the deliver our ambitions across every organisation and every service. Local Authorities play a central role in providing local leadership for health improvement, arranging public health services locally, and influencing local action to address the wider determinants of health and health inequalities for both physical and mental health. The alignment in our shared ambitions is demonstrated below.

Norfolk County Council's Better Together for Norfolk highlights the need to work collaboratively and aims to ensure our residents are living healthy, fulfilling, independent lives with a focus on prevention, early help and levelling up health through provision of better local services. Improving access and integration also aligns with the aim of the core ambitions for Adult Social Services and the Public Health Strategic Plan. Flourishing in Norfolk: A Children and Young People Partnership Strategy – Norfolk County Council supports our work to embed the Thrive model and ensure resources work around the child, with the child at the centre, enabling them to Flourish.

Suffolk County Council's Corporate Strategy 2022-26 addresses their work with the NHS, district and borough councils, and other partners to prioritise the physical and mental health of all people in Suffolk to enable residents to lead healthier, active lives and address health inequalities, including working to combat isolation and loneliness and tackling obesity. Preparing for the Future supports the prioritisation of vulnerable children and young people, including delivery of further improvements in services for children and young people with SEND in Waveney.

Norfolk and Norwich University Hospital NHS Foundation Trust's Caring with PRIDE centres around multiple work programmes to deliver equitable patient access and experience, engagement and co-production, workforce development, integrated working with local providers, service transformation, estates and facilities.

James Paget University Hospitals NHS Foundation Trust's JPUH-Trust-Strategy-2023-28 focuses on empowering patient choice and reducing health inequalities, promoting compassion and staff wellbeing, effective partnership working and ensuring services and finances are sustainable.

Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust's Queen Elizabeth Hospital strategy is focused on equity of access and provision of timely care with an initial focus on emergency care, cancer services and elective recovery alongside a commitment to become a centre of excellence within the specialties of frailty and stroke.

Norfolk and Suffolk NHS Foundation Trust's Our Trust Strategy | Norfolk and Suffolk NHS (nsft.nhs.uk) centres on collaboration within our local system, early intervention to reduce inequalities and improve outcomes and experiences of patients alongside an ongoing improvement programme.

East Of England Ambulance Service NHS Trust's East of England Ambulance Service NHS Trust strategy is consistent with our hospitals' shared objective of care closer to home and will collaborate with primary care networks to ensure provision of care at home or in the community where possible, avoiding unnecessary admissions to hospital achieved through integrated partnership working and finding innovative ways to deliver the best possible care.

Norfolk Community Health and Care NHS Hospital Trust's NCH&C strategy aims to deliver seamless health and social care that creates healthier futures for everyone by developing partner integration, attracting and developing brilliant and fulfilled teams, continually improving standards of excellence and advancing the use of data and technology.

East Coast Community Healthcare's (ECCH) vision and strategy ECCH strategy proactively contribute to the delivery of the three ICS goals. ECCH has six ambitions that underpin service delivery, quality improvement and transformation activity which are informed, and driven, by the eight ambitions as we work in partnership at place and at system level.

We also evidence how the eight ambitions are supported by published ICS strategies. These provide enabling infrastructure to support the transformation.

Our Health and Wellbeing Strategies and our Integrated Care Strategy

Norfolk Joint Health and Wellbeing Strategy and the Integrated Care Strategy for Norfolk and Waveney Norfolk's Joint Health and Wellbeing Strategy focuses on:

Driving Integration by mobilising MH collaboratives and the delivery of people-centred care; by working together as a system to ensure people receive the right care, in the right place, at the right time and reducing LoS; by using and sharing data and evidence to inform planning; by working in partnership to ensure people age well.

Prioritising Prevention with a MH collaborative and shared resources, supporting people to be resilient throughout life; by early diagnosis and reducing waiting times therefore preventing, reducing and delaying need; by delivering the three prevention objectives in ambition 6 and promoting healthy lifestyles; through a systematic approach to preventing ill health from birth through early years and a focus on early intervention and prevention.

Addressing inequalities by improving accessibility and reducing ambulance wait times; by providing support for those who are most vulnerable using a collaborative approach to develop pathways; targeting interventions to those that need it the most and by improving care for people most at risk of falls.

Enabling Resilient Communities by supporting people with complex needs to remain independent whenever possible through promotion of early support and recovery; by supporting people to return back to their communities by reducing LoS and expanding virtual ward services; by supporting the population to live independent healthy lives in their communities for as long as possible, and by building a local resilient multi-skilled professional workforce.

Suffolk transitional Joint Health and Wellbeing Strategy 2022-23, Preparing for the Future Suffolk's Joint Health and Wellbeing Strategy champions greater collaboration, system-working, developing shared priorities and power resource sharing including:

Strengthen protective public factors and lessen the impact of factors that adversely impact mental health, such as unemployment, loneliness, social isolation, crime, migration, unsafe environments, and poor housing. Promote healthy workplaces, listen to the voices coming from employers, have conversations that support mental health and wellbeing.

Ensure that children and young people in Suffolk have the best start in life, enjoy good mental health, are resilient and productive, enjoy positive and happy relationships, and achieve their full potential, tackle the impacts of child poverty; to ensure equal access to education and other opportunities; and to ensure that children's and young people's interests are recognised in the decisions that affect their lives.

A good quality of life for **Suffolk's older people** is a priority. Working with partners to tackle loneliness and isolation, promote active participation in daily life, support greater opportunities for volunteering, and support the development of healthy and sustainable communities where people can live their best lives.

Reducing inequalities is a cross-cutting theme, with actions aiming to improve people's access to good jobs, raising incomes, and tackling the effects of poverty on families and children.

Our existing ICS strategies

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' are developing, particularly the role of digital, workforce and estates.

Digital Transformation Strategic Plan and Roadmap
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 will 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.

This strategy will enable electronic patient records across health and care settings, delivery of a single waiting list, sharing information and deliver the technology to support patient preparation for their planned treatment and operations and enable delivery of virtual wards.

Across primary care there will be integrated infrastructure such as wi-fi connectivity and cloud telephony. Digital workforce tools and fully integrated infrastructure and connectivity will have a direct benefit to productivity as they are linked to the HR/People and Digital changes that we intend to make through the Improving Lives Together change programme. Artificial Intelligence and automation will also increase productivity. Our PHM, HI and prevention ambitions will be underpinned by a specific PHM data-driven approach so we can undertake work in a targeted way, much earlier.

You can read the Digital Transformation Strategic Plan and Roadmap here

People Plan
Our People Plan is being refreshed and we know that our local workforce and our volunteers are a critical enabler as we adapt and change to deliver our services.

We are developing the workforce to integrate new MH roles such as MH Practitioners, Pharmacists, and recovery workers into GP practices which will make services more accessible. We will continue to build psychological therapy skills in our workforce recognising the importance of giving people the resources they need to recover from poor mental health and build the skills and insights to maintain recovery. In Primary Care, we will support workforce planning, recruitment, and retention, providing opportunities to all for education, training, and development of the whole workforce. Several programmes are being delivered to improve efficiency and productivity across the system. Our 'One-Workforce' programme is looking at how to streamline back-office HR and workforce functions to reduce duplication. A reduction in agency spend is required to meet national efficiency targets and integrated workforce plans across providers and working with the VCSE sectors will be developed at system level to align with the JFP ambitions. Multi professional educational and training investment plans with sufficient clinical placement capacity are required to maintain education and training pipelines.

You can read the People Plan here

Estates
In order to provide integrated 'out-of-hospital care,' with a focus on prevention, self-care and supporting people to live well at home for longer, our community-based providers are working with PCNs to develop their integrated service models and PCN estate strategies, influencing the size and type of wider community estate. Our community providers will relocate service activity to primary care, or proposed community care located in hub and spoke models, retaining core estate to provide more specialist and focussed care. We are investing in health hubs, formed from new and existing community-located assets across the area, which will have modern technologies. As demand increases post-pandemic our estates strategy recognises that more support is needed for communities, focussed on children and young people in the areas of prevention, early help, and health inequalities to promote healthier lifestyles and emotional wellbeing, and this is part of our JFP.

Development of ICS estate aligns with the expected increase in an ageing population, and we liaise with developers to identify schemes that deliver stronger health outcomes to our residents. At the same time, we are implementing interventions to decarbonise our estate and reduce carbon emissions from our buildings, infrastructure, and services. Significant investment in new hospital sites will enable us to care for our population in modern and well-equipped environments, securing better health outcomes and this includes supporting mobile service provision.

You can read the Estates strategy here

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
- Developing Family hubs
- Primary Care Hub projects
- Community Diagnostic Centres
- An expanding virtual ward service enabling patients to recover and be monitored at home

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.

You can read the Net Zero Green Plan here

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.

You can read the Quality Strategy here

Clinical Strategy
Each of the clinical strategy objectives can be clearly mapped against the JFP ambitions and we have adopted this approach to maximise inter-dependencies. The ICS clinical strategy, digital roadmap, the Estates strategy and Net Zero Green Plan are equally inter-dependent and refer to each other which gives the JFP a good foundation to build upon. The six clinical strategy objectives weave their way into the ambitions and objectives through 'seeing me as a whole person'. Delivery of high-quality resilient and reliable services relates to our ambition of Improving Productivity and Efficiency, there are direct links between reducing long waiting times and the ambition around Elective Recovery and Improvement. Acting early to improve health supports several of our prevention objectives, and the objective of tackling health inequalities is supported through the commitment to develop a HI strategy.

You can read the Clinical Strategy here

Research and Innovation
Our recently published Research and Innovation (R&I) strategy has four principles

Principle 1 - will be focused on our communities. By working with our population, we can understand needs and identify gaps to target research and innovation to improve experience of care, quality of services and health outcomes. For example, we can drive the development of research which addresses the needs of people in later life and identify innovations which could enable more personalised care.

Principle 2 - will be driven by a confident and capable workforce by equipping our workforce with the skills and confidence to identify where an innovation could help to reduce waiting lists.

Principle 3 - will be collaborative and co-ordinated by working together as a system we can make sure that R&I is championed and embedded across primary care. We can ensure new research projects are designed with people at the centre, so more research takes place closer to home.

Principle 4 - will embed everything we do using evidence from across our system when designing services, evaluating innovation and new ways of working, for example the impact of unplanned care hubs.

R&I 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. 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.

You can read the Research and Innovation Strategy here

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 are working on a collective system culture of compassion and inclusion to develop leaders and teams, with all 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 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 have Social Care and VCSE representation forming part of the CCP Assembly membership and we have established one other consultative forum: The VCSE Assembly, alongside a new Patients and Citizens Assembly due to be set up during 2023/2024. Work to align the forward plans of all three Assemblies is currently underway and this will be aligned to the JFP.

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 are also developing 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.

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 12):

Figure 12 spectrum of participation

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:

- A Norfolk and Waveney ICS Communications and Engagement (ICS C&E) group was established in September 2021 to work as a system on a variety of local priorities, such as communications campaigns, participation and co-production and to act as a learning network. Membership includes representatives from Norfolk and Suffolk - 8 NHS provider trusts, 2 county councils, 2 Healthwatch's, 8 district councils, Norfolk Police, 2 Chambers of Commerce, Out of Hours/111 provider, Active Norfolk, Norfolk Older People's Strategic Partnership, 4 VCSE organisations and representatives from housing associations.
- Each Place Board has a C&E lead to support activity for Place Boards and HWP's. 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. We learnt during the COVID-19 pandemic that we need to get better at listening to what really matters to our people and communities, especially if we are going to address health inequalities, which is one of our eight ambitions. A really effective way to do that is to use trusted communicators, people who are part of the local community – 'people like me'. This approach is being developed through Norfolk and Waveney Community Voices.

Another key area of support centres around the patient voice in primary care. We asked Healthwatch Norfolk to engage with local practices and Patient Participation Groups (PPG's) to find out what support would be most useful. The ICB is now working to deliver the key recommendations from the report. A PPG webpage features case studies including examples that promote different models of patient engagement. There is also other information and links to resources including a toolkit produced by Healthwatch Norfolk following the period of engagement which aims to give Doctor's Practices and PPGs a step-by-step guide.

Communications and engagement work, at a very local level, is key to developing on-going 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 will be developing further 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 for lived experience to effectively influence ICS mental health transformation, services and support.
- Being a part of the Norfolk Making It Real (MiR) steering group which promotes co-production particularly for people with lived experience of physical and learning disabilities.
- Supporting various NHS England funded initiatives in Norfolk and Waveney such as a series of co-production projects across the ICS around Quality Improvement
- Developing a Rewards and Recognition Policy that includes a threshold for when participation becomes co-production, and details how we can offer effective support for our people and communities through the whole spectrum of participation methods.

6.7 Working differently with the VCSE

We are empowering and working with the Voluntary Community and Social Enterprise (VCSE) sector differently and integrating provision into our design and delivery models for services.

Norfolk and Waveney enjoy a broad and diverse VCSE sector, in which there are 3645 registered charities, 220 community interest companies and 124 registered societies with their registered offices in Norfolk and Waveney. Many of these organisations have been born of local communities of interest or geography, responding to specialist need to provide not for profit services and support. Many of these organisations will focus on early intervention and preventative services, from lived experience, which empower their communities to build resilience and maintain control of their own lives.

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 strong voice across the decision-making process, adopting the principles of an agreed Memorandum of Understanding. VCSE representatives sit across our five place boards and eight health and wellbeing partnership boards, providing a vehicle for engagement of local organisations across our eight ambitions and other emerging local priorities.

The VCSE sector in Norfolk and Waveney is facing a 'perfect storm' of rising running costs and reduced fundraising income as supporters tighten their belts. Set against a backdrop of increasing demand for services more sector leaders are currently facing tough decisions as they try to maintain their public benefit mission. With the establishment of our Assembly we have an opportunity for ICS partnership and strategic alignment across the early intervention and prevention ambition specifically. This could this start to shift demand away from more acute interventions 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; listening to and seeking to involve any, and every, VCSE organisation providing health and care support for the benefit of their communities. The graphic on the next page (Figure 14) 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.

N&W ICS will build effective relationships with the VCSE sector. This will be achieved through 3 core ICS programmes, described below.

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 13 – building effective partnerships with the VCSE sector

As our place-based approach takes shape the work of the Assembly will focus across the following three priorities over the coming months;

1. **Agree next steps for development of a VCSE commissioning strategy.** We have a number of key commissioning arrangements in place with VCSE organisations working across our system. Our next steps will be to focus on how we can partner across a broader range of organisations, many of whom will work on a smaller scale and at a local level. Our strategy will be informed through relevant stakeholder engagement to help us build shared understanding across three key areas;
   - Impact of preventative and early interventions across our communities; what is our shared understanding of value and how can we measure it?
   - The added social value brought through strategic VCSE sector partnering; financial value, community value, and the value of long term strategic partnering.
   - The importance of building empowering practice into everything that we do, of supporting every individual to understand what behaviour change might mean for the health and wellbeing of themselves and their loved ones.
2. **Support the ICS health inequalities agenda.** Our Place-based Assembly representatives were appointed on the basis of their connectivity to, and insight across, the inequality priorities for each place. These representatives will look to connect relevant VCSE into our emerging ambitions and priorities, helping to build the relationships and partnerships that will facilitate the VCSE sector to engage with places at a strategic and operational level.
3. **Create a 'road map' for VCSE Assembly development.** The road map will consolidate our learning and make recommendations for the next phase of our VCSE Assembly in Norfolk and Waveney, considering the following areas in particular but not exclusively;
   - Improving communications and direct engagement opportunities between the Assembly and our VCSE constituency
   - Reviewing how we best connect relevant VCSE organisations with the place-based approach and the work happening locally
   - Ensuring Assembly board membership remains relevant to our evolving agenda
   - Ensuring Assembly operations are sustainably resourced and facilitated

7.0 Commitment to achievable, measurable and impactful improvements

7.0 Commitment to achievable, measurable and impactful improvements

The improvements we make will be quantitatively and qualitatively measured through system Programme Boards, reported in annual plans and key metrics will be included in our Integrated Performance Report (IPR). A summary of key metrics is shown in Figure 14.

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	Development and delivery of two strategies: A Population Health Management Strategy, and a Norfolk and Waveney Health Inequalities Strategy to deliver the "Core20PLUS5" approach.	Publication of a system wide Population Health Management Strategy by end March 2024. Publication of a system wide Health Inequalities Strategy by end of March 2024.
1b	Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people.	Reduction in the percentage of women in Norfolk and Waveney who are smoking at time of delivery, from 12% towards 9% over the next 3 years, and to 6% by the end of year 5.
1c	Early Cancer Diagnosis – Targeted Lung Health Check Programme.	Roll out TLHC's to people between the ages of 55 and 74 who are current or former smokers, tracking the number of invitations, uptake and CT scans against the agreed trajectory.
1d	Cardiovascular disease Prevention – develop a programme of population health management interventions targeting High Blood Pressure and Cholesterol.	Identify and offer high risk patients low intensity statins, aiming for 5% improvement in hypertension metrics.
2	**Primary Care Resilience & Transformation**	
2a	Developing our vision for providing a wider range of services closer to home, improving patient outcomes and experience.	Publication of our overarching vision and our strategy for general practice by March 2024.
2b	Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.	Publication of our overarching vision and our strategy for dentistry by March 2024.
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.	Evaluation process being developed and 10 local key performance indicators identified.
3b	Continued development of our Local Maternity and Neonatal System (LMNS), including the Three Year Maternity Delivery Plan.	Maternity workforce vacancies reduce and retention improves against the current vacancy rate of 9%.
3c	Implementation of asthma and epilepsy recommendations, for Children and Young People.	Decreased hospital admissions for asthma for young people aged 10-18 Decreased hospital admissions for epilepsy for children and young people aged 0-19.
3d	Develop an improved and appropriate offer for Children's Occupational Therapy.	Improved patient experience evidenced through feedback with families and a reduction in inappropriate referrals to specialist services. This programme will be evaluated by Ipsos Mori.
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.	Self-reporting mental wellbeing – the number of people reporting high anxiety, low happiness and low worthwhile scores will reduce Suicide Prevention – Rates of suicide and self-harm will reduce.

Figure 14 final metric summary

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.	Qualitative feedback from people, families, and professional's feedback before and after any change that is implemented.
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.	Increase in the number of children and young people accessing the right support to meet their emotional wellbeing and mental health needs. Measure 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 specific approaches • Increase in numbers of service users able to access a psychologically informed intervention outside of the NHS talking therapies and secondary care offer **Dual Diagnosis** • An increase in number of referrals into services 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 develop a shared vision and strategy with older people that will help us to transform our services to be easy to access and designed and wrapped around the needs of older people.	Publication of an Ageing Well strategy by December 2023, and a detailed roadmap for implementation plans by March 2024
6	**Improving UEC**	
6a	Improve emergency ambulance repsonse times.	Achieve a category 2 30-minute mean response time by the end of March 2024.
6b	Expand virtual ward services.	By April 2024 we will have 368 virtual ward beds.
6c	Delivery of the Improving Lives Together programme to reduce length of stay (LoS) in hospitals.	Achieve or exceed the national target to reduce hospital occupancy to 92% or less.
7	**Elective Recovery & Improvement**	
7a	Effectively utilise capacity across all Health System Partners.	Waiting times will reduce for patients and cancers will be diagnosed earlier in line with trajectory.
7b	Implement digital technology to enable elective recovery.	We will measure: • how many patients have been offered mutual aid • how many patients chose a different hospital • how many patients chose to wait at their preferred treatment location
8	**Improving Productivity & Efficiency**	
8a	Improve the services we provide by enhancing productivity and value for money, and delivering services together where it makes sense to do so.	Formally assess the operational and financial improvements Use national benchmarking data to measure our relative improvement compared to other ICSs.

Figure 14 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: https://www.nomisweb.co.uk/

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