Improving lives **together**
Norfolk and Waveney Integrated Care System

Transitional Integrated Care Strategy and Joint Health and Wellbeing Strategy

Setting the agenda for our new Integrated Care System across Norfolk and Waveney

2022-23

Welcome

Every local area must have a Joint Health and Wellbeing Strategy setting out priorities, identified in the Joint Strategic Needs Assessment (JSNA), that partners will deliver together to improve health and wellbeing outcomes. The Health and Wellbeing Boards for Norfolk and Suffolk have their own strategies aimed at highlighting the need for collective responsibility for health and wellbeing. The Boards have a proven history of holding partners to account and enhancing everyone's responsibility to improve the health and care of their counties.

The recent changes under the Health Act 2022, has created a new Integrated Care System (ICS) which has formally brought together a wide range of organisations and stakeholders to improve services and provide more joined-up health and care for our residents. Our ICS is comprised of Norfolk with the addition of Waveney.

It also created an Integrated Care Partnership which key organisations – including health, care, local authority, Healthwatch, and voluntary sector from across Norfolk and Waveney – are part of. This partnership must produce an Integrated Care Strategy which is the key document for all ICS partners to develop their strategies and plans from, and sets out the challenges and opportunities we face that can only be addressed by partnership working and joint approaches.

As there is a clear cross-over between an Integrated Care Strategy and a Health and Wellbeing Strategy, this creates an opportunity to work together as a collective ICS around shared high-level health and wellbeing priorities. We have already achieved a lot by working in partnership, this has been strengthened through our collaborative response to the COVID-19 pandemic. The past three years have seen unprecedented challenges, but also incredible stories of communities and providers working together to ensure the people of Norfolk and Waveney have the support and care they need.

We want to build on the learnings from the pandemic to enhance our integrated working within the new Integrated Care System structure, but this will take time to do.

This Strategy builds on that collaborative mandate – our vision is working as a single sustainable system that enables us to achieve our overarching mission to **help the people of Norfolk and Waveney to live longer, healthier, and happier lives.** To do this, we are evolving our longer-term priorities from our previous Joint Health and Wellbeing Strategy to help us face the challenges of the future.

Prevention and early intervention are critical to the long- term sustainability of our health and wellbeing system – stopping ill health and care needs happening in the first place and targeting high risk groups, as well as preventing things from getting worse through systematic planning and proactive management.

For us to achieve our goals, we have developed these priorities which are reliant on everyone taking a collective and collaborative approach:

Rather than duplicate and replicate work being undertaken at place-level, it makes sense to coordinate an integrated approach for the whole System. This document acts as a transitional strategy which encompasses both the Integrated Care Strategy for Norfolk and Waveney and the Joint Health and Wellbeing Strategy for Norfolk.

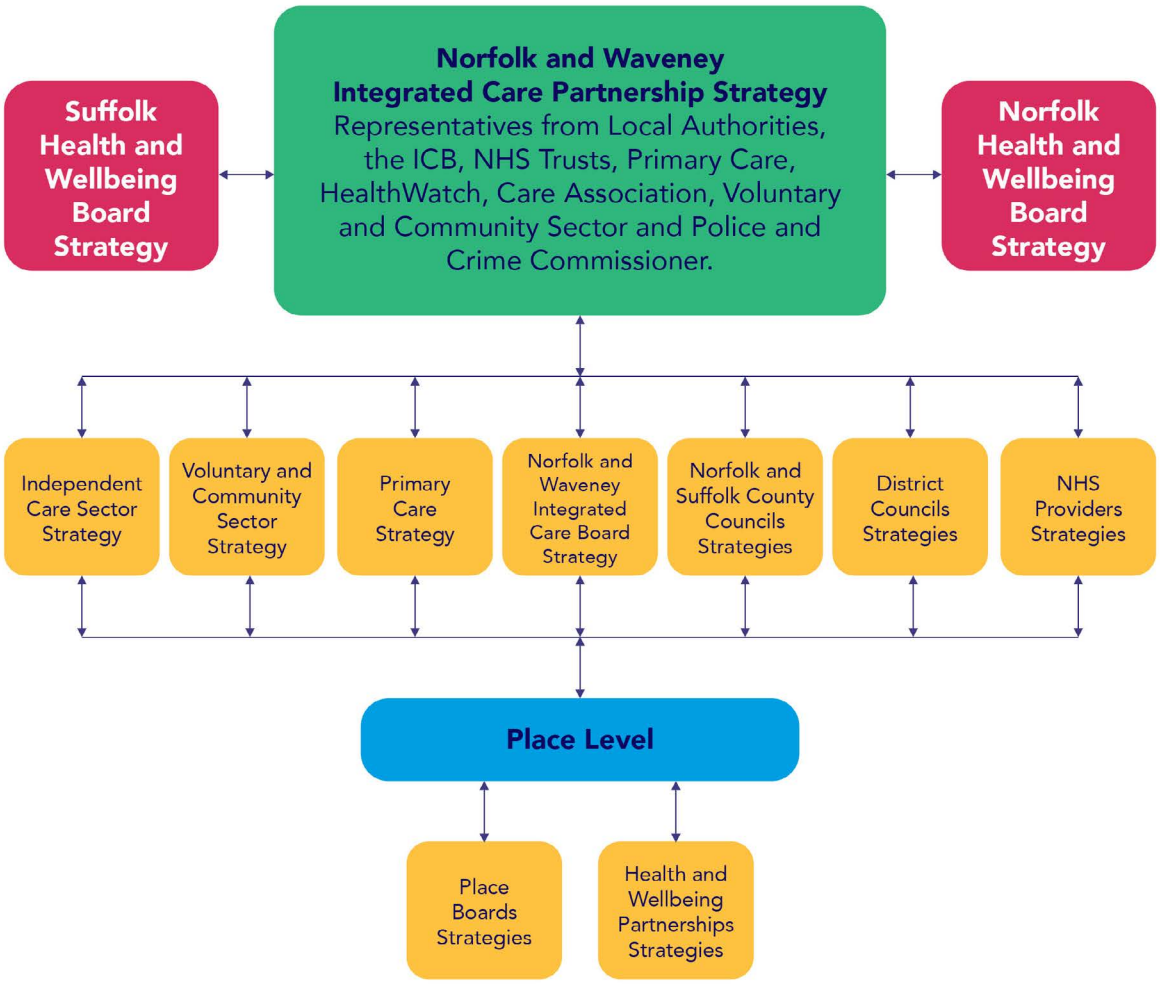
Over the course of 2023, we will be engaging with people, communities, and partners across our System to find out how our Integrated Care Strategy can work for us all. This engagement will be targeted and accessible to ensure those with quieter and overlooked voices are heard and listened to. We will engage with a wide range of communities, including those who are harder to reach and more rural.

This transitional period will allow time for emerging partnerships within the new ICS to establish themselves, for partners to assess the latest information from the JSNA and the impact the coronavirus pandemic has had on our communities, as well as allow time for meaningful engagement to take place. It is a 'living' document that will change and grow as our new collaborative system develops.

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

System and strategy

A key strength of our system is that it is built from the ground-up, meaning that District, City and Borough Councils, grass-roots voluntary and community organisations, NHS partners, providers, and most importantly the communities and people we provide services for all have input. This includes ensuring that strategies and plans across the system work cohesively and collaboratively. The diagram below shows the working relationship between the transitional Integrated Care Strategy and other boards and committee strategies across the ICS, and how we all work together in partnership.



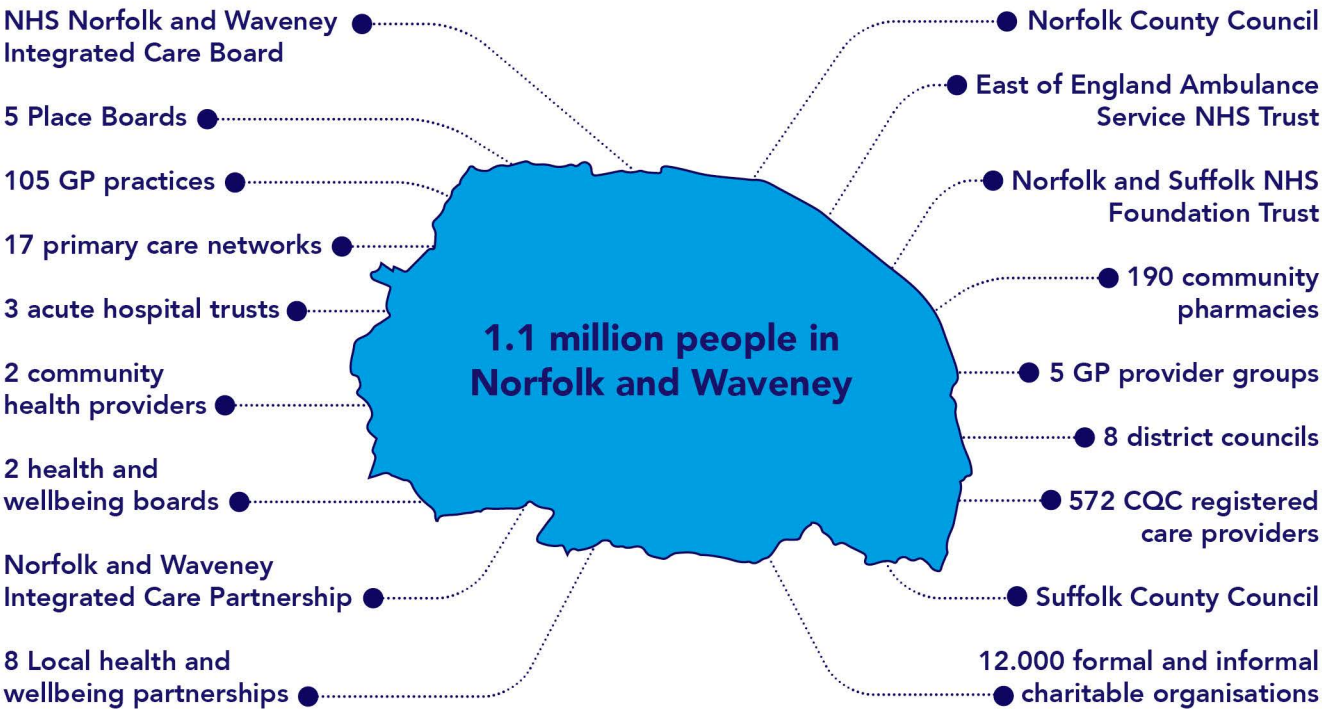
The diagram shows the Norfolk and Waveney Integrated Care Partnership Strategy with arrows alongside connecting this to Norfolk Health and Wellbeing Board strategy and the Suffolk Health and Wellbeing Board strategy. From this level there are double ended arrows down to the Independent Care Sector strategy, the Voluntary and Community Sector strategy, Primary Care strategy, Norfolk and Waveney Integrated Care Board strategy, Norfolk and Suffolk County Councils strategy, District Councils strategies and NHS Providers Strategies. These are also connected together by double ended arrows. The final level of the diagram shows double ended arrows to the Place Board Strategy and Health and Wellbeing Partnerships strategies at place level. The purpose of the diagram is to show how all the strategies in the system link together.

Setting the scene for our system

Norfolk and Waveney consists of over a million residents living in eight districts across rural, urban and coastal geographies. These include Breckland, Broadland, Great Yarmouth, King's Lynn and West Norfolk, North Norfolk, Norwich, South Norfolk, and Waveney.

Our health and wellbeing system is complex and made up of lots of different organisations under the umbrella of the Norfolk and Waveney Integrated Care System, which came into being on 1 July 2022. While we have been working closely together for many years, the new Health and Care Act 2022 will make it easier to bring partners together and push forward collaborative working and a single sustainable system. It offers us the unique opportunity to build on what we already have and take the steps towards a truly integrated model which delivers for everyone across the area.

The map below shows everybody involved in our System supporting health and care for the people who live in Norfolk and Waveney.



Our system mission

As an Integrated Care System, we have developed an overarching mission to **help the people of Norfolk and Waveney to live longer, healthier, and happier lives.**

To fulfil our mission we have three goals, these are:

To make sure that people can live as healthy a life as possible
This means preventing avoidable illness and tackling the root causes of poor health. We know the health and wellbeing of people living in some parts of Norfolk and Waveney is significantly poorer – how healthy you are should not depend on where you live. This is something we must change.

To make sure that you only tell your story once
Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have, which medication they are on. Services have to work better together.

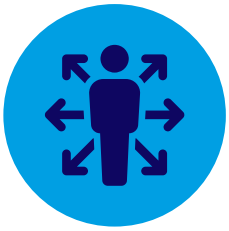
To make Norfolk and Waveney the best place to work in health and care
Having the best staff and supporting them to work well together will improve the working lives of our staff and means you will get high quality personalised and compassionate care.

From these system-wide goals and overarching purpose, we have developed shared guiding principles for the Norfolk and Waveney Integrated Care Partnership. These are designed to drive the cultures and behaviours of the Integrated Care System at a more local level, and to enable everyone to work together to make improvements and address challenges.

Our Integrated Care Partnership Principles are:

Partnership of equals

To find consensus and make decisions including working though difficult issues, where appropriate.



Collective model of accountability

As system leaders, taking collective responsibility for the whole system and partners hold each other mutually accountable for shared and individual organisational contributions to health and wellbeing objectives.

Improving outcomes for communities

Including improving health and wellbeing, supporting people to live more independent lives, reducing health inequalities, and tackling the underlying social determinants. Listening to the public and being transparent about our strategies across all organisations.

Collaboration and integration

Under the umbrella of the Integrated care Partnership and the Health and Wellbeing Board foster a culture of broad collaborations and integration at every level of the system to improve outcomes and reduce duplication and inefficiency. A commitment to joint commissioning and simpler contracting and payment mechanisms.

Co-production and inclusivity

Create a learning system which makes decisions based on evidence and insight. Using data, including the Joint Strategic Needs Assessment to target our work where it can make the most difference - making evidence-based decisions to improve health and wellbeing outcomes.

For us to achieve our mission and goals as a partnership, we have developed these priorities which are reliant on everyone taking a collective and collaborative approach:

Driving integration

Collaborating in the delivery of people-centred care to make sure services are joined-up, consistent and make sense to those who use them.

Prioritising prevention

A shared commitment to supporting people to be healthy, independent, and resilient throughout life. Offering our help early to prevent and reduce demand for specialist services.

Addressing inequalities

Providing support for those who are most vulnerable using resources and assets to address wider factors that impact on health and wellbeing.

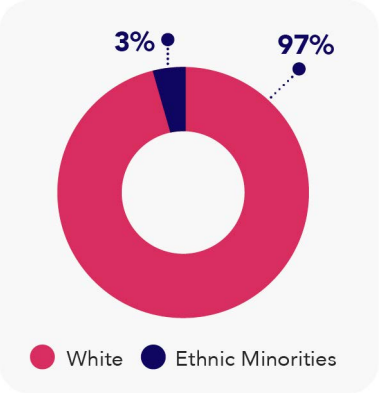
Enabling resilient communities

Supporting people to remain independent whenever possible, through promotion of self-care, early prevention, and digital technology where appropriate.

Living in Norfolk and Waveney: Who we are, and where and how we live

The population in Norfolk and Waveney is generally **older** than the England population. **1 in 4 are over 65.**

Norfolk and Waveney population is expected to **grow** by about **116,500** people between 2020 and 2040, the **largest growth** is expected in the older age groups, with those aged 65+ increasing by **95,000**. This is likely to put extra pressure on the working age population and potentially the availability of staff to deliver services.

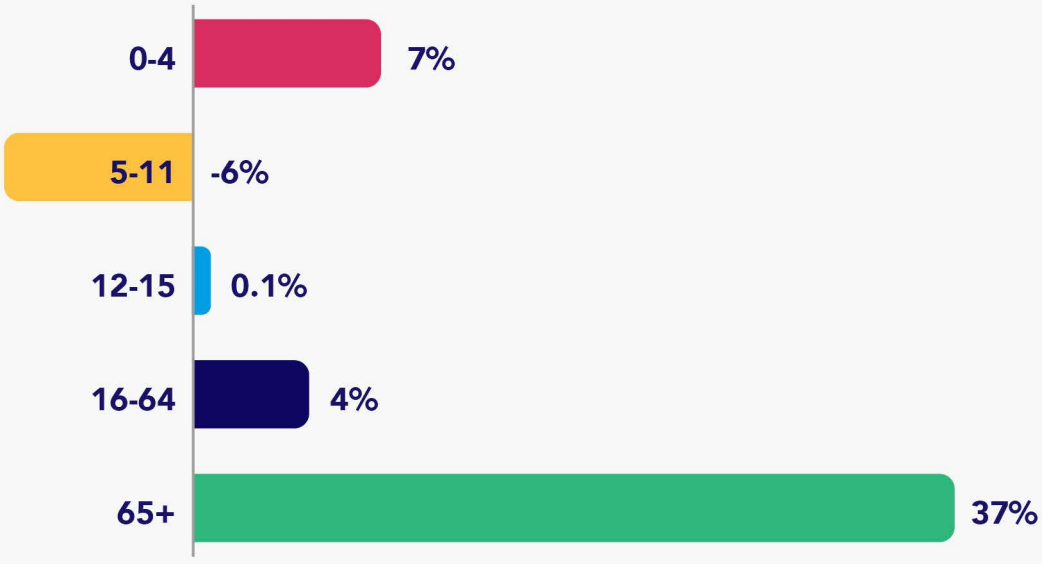


The Norfolk and Waveney population is less ethnically diverse than average in England. The most diverse areas across Norfolk and Waveney are Norwich, Great Yarmouth and Breckland.

There are around **160 languages** spoken in Norfolk & Waveney. English is not the first language of around **12,400** school children.

1.2% of people in Norfolk and Waveney have a disability.

Percentage increase in each of the age groups between 2020 and 2040



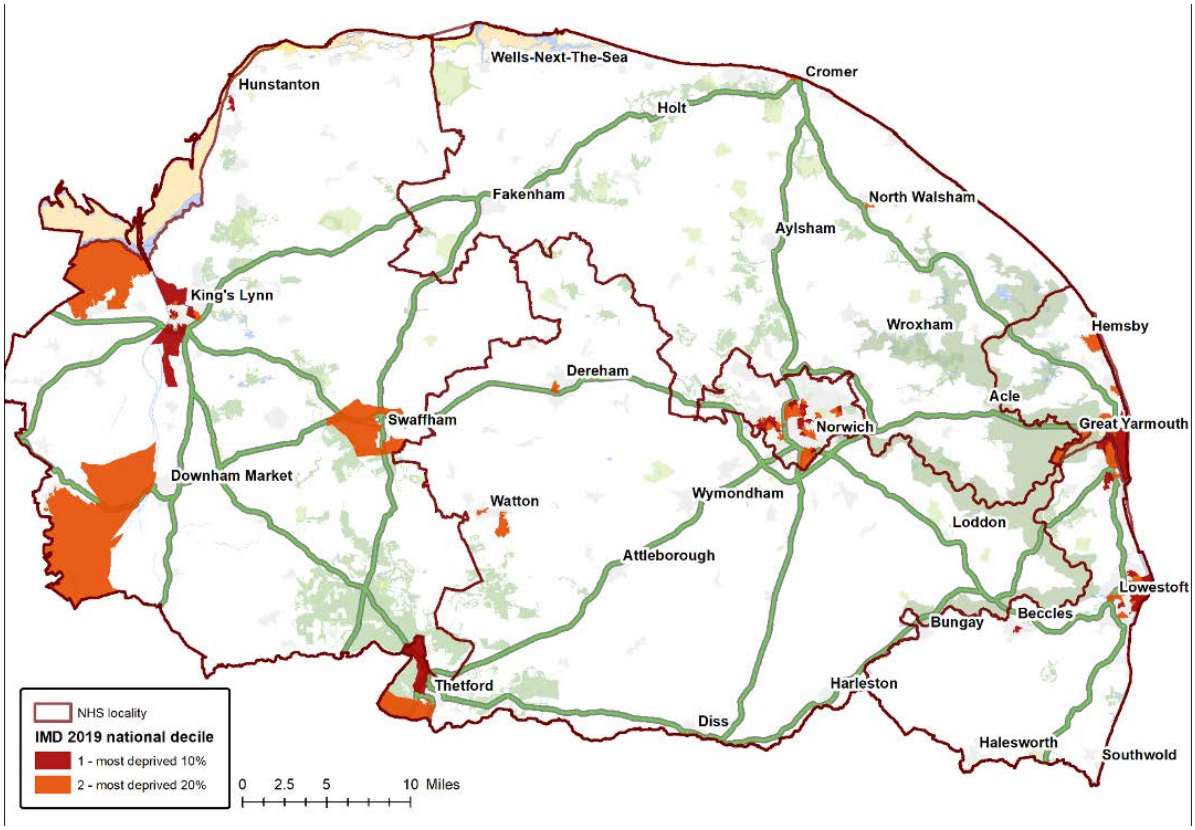
Where we live

There are 42 communities across Norfolk and Waveney where almost 164,000 people live in the 20% of the most deprived areas in England. However, none of these communities are in Broadland or South Norfolk.

The map below shows the most deprived communities are mainly in our urban areas of Great Yarmouth, King's Lynn, Lowestoft, Norwich, and Thetford but there are smaller areas of deprivation in rural areas too. 40% of the populations of Great Yarmouth and Norwich live in the most deprived 20% of areas in England compared to 16% for Norfolk and Waveney as a whole.

The areas shown in red on the map are the most deprived 10% in the Index of Multiple Deprivation (IMD) 2019 National Decile. These are parts of King's Lynn, Thetford, Norwich, Great Yarmouth and Lowestoft.

The areas shown in orange are the most deprived 20% in the IMD 2019 National Decile. These are parts of King's Lynn, Thetford, Norwich, Great Yarmouth, Watton, Downham Market, Dereham, North Walsham, Hemsby, Beccles, Cromer, Hunstanton, Swaffham and Lowestoft.



15% of children live in low-income families

13% of households experience fuel poverty

The built and natural environment is inextricably linked to health across our lifetime. Populations in more deprived areas are more likely to have worse health outcomes, are more likely to be admitted to hospital in an emergency and are more likely to die early.

The design of neighbourhoods can influence physical activity levels, travel patterns, social connectivity, mental and physical health, and wellbeing outcomes. There is a higher occurrence of behavioural risk factors in the more deprived areas in England.

The connection between inappropriate or inadequate housing and poor health, effects everyone from childhood through to the elderly.

In Norfolk and Waveney, we have populations which have historically been excluded or have found our services hard to access. This includes refugees and asylum seekers, those experiencing homelessness or substance misuse, prisoners, sex workers, and those from Roma or traveller communities.

This results in missed opportunities for preventive interventions and further exacerbates existing inequalities. We need to breakdown the difficulties and barriers in engaging with our services to enable better outcomes for those with seldom heard and excluded voices. Our system should provide services that are available to everyone. This will require us to work differently, to include and involve better. By working together our system can bring expertise in hearing the voices of those excluded.

Mortality from respiratory disease is **2 times worse** in people aged 65+ in the most deprived communities compared to the least deprived.

Mortality from all cardiovascular diseases in people under 75 is **3 times worse** in the most deprived communities compared to the least deprived.

Mortality from causes considered preventable i**s 3 times worse** in those under 75 in the most deprived communities compared to the least deprived.

Emergency hospital admissions for unintentional injuries are **1.5 times worse** for children under 5 in the most deprived communities compared to the least deprived.

All-age suicide is **3 times worse** in the most deprived communities compared to the least deprived.

**comparison between the most and least deprived 20% of the population in Norfolk and Waveney.*

How we live

Births in Norfolk and Waveney are declining.

The rate of births to mothers aged 15-44 is lower compared to the rest of England.

1 in 20 children are under 5

9,100 births in 2019

Both Norfolk and Waveney have higher prevalence of smoking at time of delivery compared to the rest of England.

Early years to age 25

Overall health outcomes for children and young people in Norfolk and Waveney are similar to those for the rest of England. There are, however, differences in health outcomes based on where children live and in some groups of children, such as children with Special Educational Needs and Disabilities (SEND) and children in care.

5-11 year olds represent **8%** of our total population

The past couple of years have seen more children and young people accessing our services due to emotional wellbeing and mental health needs and gaps in learning following the pandemic.

More than 2 in 5 children in Year 6 (10-11yrs old) are overweight or obese

Further work is needed across Norfolk and Waveney for children and young people in the areas of prevention, early help, and health inequalities to promote healthier lifestyles and emotional wellbeing.

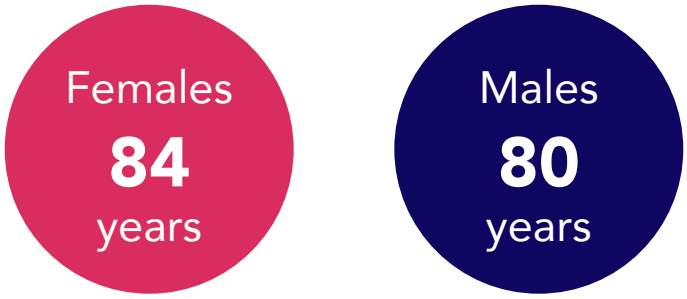
Across Norfolk and Waveney, we already have in place some strategies and operational plans to provide improved outcomes for our early years, children, and young people. Flourishing in Norfolk: A Children and Young People Partnership Strategy, which can be found by visiting the Norfolk County Council website. and, in the Family 2020 Strategy for Waveney which can be found by visiting Suffolk County Council website. The Family 2020 Strategy is currently in the process of being updated.

Life expectancy

Life expectancy is a person's estimated length of life based on age, gender and where they live.

Life expectancy in Norfolk and Waveney has consistently been higher than the national average for both men and women.

A person born in Norfolk and Waveney can expect to live:



Deaths from **circulatory diseases, cancer and respiratory diseases** contribute to most of this life expectancy gap.

Healthy Life expectancy is the average years somebody is expected to live in good health. In Norfolk and Waveney healthy life expectancy is about **63 years for males** and **64 years for females**, lower than England and has decreased over the last few years. This means that the time people spend in ill health is getting longer and is **17 years for males and 20 years for females.**

Inequalities exist from birth to older age (e.g. smoking in pregnancy, obesity, educational outcomes, lifestyle, unemployment). These contribute to a gap in peoples life expectancy of 9 years for men and 7 years for women between the least wealthy and most wealthy areas in Norfolk and Waveney. The life expectancy gap between these communities is mainly due to more people dying at an earlier age of circulatory, cancer and respiratory diseases.

Alcohol consumption is the biggest risk factor of ill health, premature death, and disability for younger adults (aged 15-49 years) in Norfolk and Waveney.

Lifestyle factors

These are the things that have an impact on our life expectancy in Norfolk and Waveney.

1 in 7 adults smoke. That's **100,000+** smokers

1 in 4 adults drink more than 14 units per week. **180,000+** adults drink too much.

3 in 5 adults carry excess weight. That's **475,000** adults that are overweight or obese

1 in 5 adults are inactive. **140,000** adults do not exercise

3 in 5 adults eat the recommended '5-a-day'. **280,000+** adults could eat better

Mental health

As a group of conditions, mental health disorders are a leading cause of ill health. This reflects the fact that most mental health conditions start early in life, some of them are very common (e.g. depression and anxiety) and many have a major impact on quality of life. People with long-term conditions, including diabetes and heart disease, are two to three times more likely to have depression.

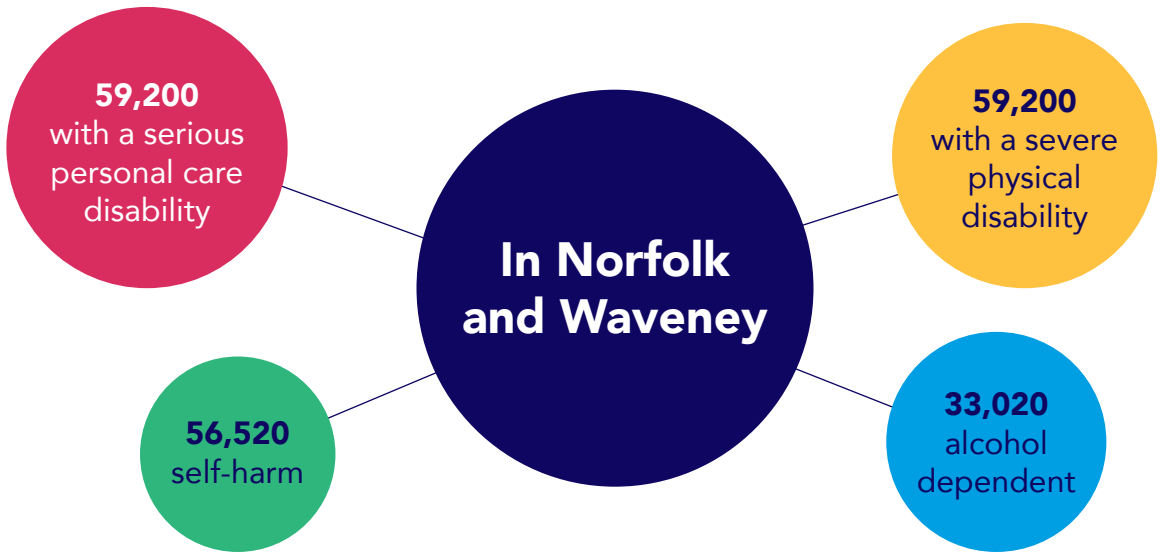
In Norfolk and Waveney, **143,430** people live with a common mental disorder. Suicide rates are higher than the England average, with suicide more common in men, those living in deprived areas, are unemployed, and who live alone.
We have seen an increase in people wanting to access mental health services, especially children and young people.

Care and Carers

A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support. Around **1 in 8 people are carers**, that's 6.5 million people in the UK. According to the 2011 census, there are over 108,000 carers in the Norfolk and Waveney Integrated Care System with a fifth of these being young carers and young adult carers.

Carers UK report "Alone and caring" reveal 8 out of 10 carers have felt lonely or isolated as a result of their caring responsibilities. 57% had lost touch with friends and family, and 38% of carers in full time employment have felt isolated from other people at work.

The health and wellbeing of carers is also reported to be affected by the levels of caring, with carers who care for someone for more than 50 hours a week twice as likely to be in poor health as non-carers.



Safeguarding, its everyday business

Every child, young person and adult has a right to live their life free from abuse and harm. When safeguarding is done well it permeates through every part of our workforce, across our communities and through our voluntary & social enterprise sector. Safeguarding isn't just everyone's business, it's everyday business.

From the start of your career to the end, from frontline to board, in every conversation, in our working lives to our leisure time, we are all responsible. When done effectively we can 'feel' it in all contacts we have an organisation and its people. This feeling is outwardly demonstrated because raising a safeguarding concern is done with total ease and confidence.

We all have a role to play. We are all accountable.

Impact of Covid-19

The impacts of the pandemic are likely to be both short- and long-term, and the ongoing impacts on services and changes to healthy behaviour will have a negative impact on health outcomes for future generations.

Norfolk and Waveney and all district, city and borough areas had death rates lower than the East of England and England averages.

Unequal impacts of Covid-19

Populations in more deprived areas are more likely to have more pre-existing health conditions, which means that reduction in service use during the pandemic will have disproportionately impacted those groups.

The 20% most deprived areas had the highest case rates, the lowest vaccination uptake and the highest death rates once age was taken into consideration.

There were more cases in the female population, but national research shows that males are at a higher risk of dying.

Highest case rates were shown in older children and working-age adults compared to other age groups.

Ethnicity and Covid-19

Highest case rates were seen in:

Long Covid-19

Long Covid is defined as symptoms reported by individuals themselves that last for more than four weeks after a suspected Covid-19 infection. The most common symptoms reported were fatigue, shortness of breath and loss of smell.

Nationally, around 1 in 40 people experience Long Covid. That would mean around **26,000 in Norfolk and Waveney.**

14,000
would have moderate impacts

4,000
would have more severe impacts

Highest rates are in women, people **aged 35-49 and those living in more deprived areas.**

How we end our life

There were about **12,700 deaths** in 2020. All-cause mortality rates are **lower** than England.

Generally, as the population in Norfolk and Waveney increases and ages, the actual number of people dying each year is increasing. Most deaths are in older people, with very few deaths in younger age bands. The increasing age at death means more need for our health and care services.

The leading causes of **death for males and females are:**

Dementia and Alzheimers

Covid-19

Heart disease

Stroke and lung cancer

So, what does this information mean?

Looking at the Norfolk and Waveney picture we have developed these four priorities which are key to achieving our system-wide mission to **support the people of Norfolk and Waveney to live longer, healthier, and happier lives:**

Driving integration

Collaborating in the delivery of people-centred care to make sure services are joined-up, consistent and make sense to those who use them.

Prioritising prevention

A shared commitment to supporting people to be healthy, independent, and resilient throughout life. Offering our help early to prevent and reduce demand for specialist services.

Addressing inequalities

Providing support for those who are most vulnerable using resources and assets to address wider factors that impact on health and wellbeing.

Enabling resilient communities

Supporting people to remain independent whenever possible, through promotion of self-care, early prevention, and digital technology where appropriate.

Driving integration: What's important strategically?

Norfolk and Waveney have an annual budget in excess of £2bn for health and social care services. However, as a system we are seeing increasing demand resulting in budget pressures. Needs are becoming increasingly complex and so our service improvements must be more co-ordinated and effective for the service user and their carer. Services are improved where there is a coordinated, effective, and seamless response.

Interviews with members of Norfolk Health and Wellbeing Board emphasised the collaborative and innovative working during the pandemic. This involved breaking down some of the organisational barriers to support one another and moving resources accordingly. Health and Wellbeing Board members are keen for these changes to continue with collective resources used to their best effect, and duties and responsibilities shared to better support communities.

Our key challenges are:

- Increasing demand on health and care services and post-covid challenges, puts the focus on operational pressures ahead of cultural changes, behaviours, and partnership development.
- Reducing and levelling budgets within a stretched system.
- Recruitment and retention issues with high number of vacancies across health and care.
- Lack of joined up records and information across the system.

Our priority actions are:

- To work as a single sustainable system in the delivery of people centred care, across a complex organisational and service delivery landscape.
- Shift in focus and investment to community based support so that people stay healthier for longer in their own homes and communities.
- Use and share evidence and data intelligently, lived experience and evidence from service users, to help us keep our Strategy and System Plans on track and understand their impact.
- Use partners' existing plans – building on the priorities partners are already working hard to address, identifying the added value that collaboration through this strategy can bring.
- Develop mechanisms such as the sharing of information, pooling of resources and budgets (including Section 75 arrangements), to target health and care where it is needed most.
- Create a joint workforce strategy and long-term plan to include recruitment and retention of health and care staff across Norfolk and Waveney.

We know we will have achieved this when:

- We are all working together as a single system and sharing thinking, planning, funding, opportunities, and challenges – to inform new ways of working and the required transformation.
- We are effectively engaging with, and listening to, staff, residents, and communities to inform our understanding and planning for the future.
- Investment and funding has shifted focus to community provision.
- Someone only has to tell their story once when accessing multiple health and care services.
- We have a resilient and sustainable workforce to meet system need.

Prioritising prevention: What's important strategically?

There is strong evidence that interventions focussed on prevention are both effective and more affordable than just focussing on providing reactive emergency treatment and care. Although the language of prevention is not spontaneously used by people, the concept itself is well understood.

To build a financially sustainable system means we must promote healthy living across a life course, seek to minimise the impact of illness through early intervention, and support recovery, enablement, and independence. This starts with early years and childhood and throughout the life course.

Our research shows primary responsibility for health and wellbeing is seen to fall to individuals, with personal responsibility heightened by the pandemic for most. Despite agreement that health and care partners have some role to play in supporting residents to be healthy and well, there is a lack of understanding of what this role looks like in practice.

Our key challenges are:

- Prevention and Early Help are seen as difficult to do and not everybody's priority.
- Prevention support doesn't always show immediate results.
- Stretched services due to lack of investment and provision in prevention awareness and intervention at an early stage.
- Residents across various age and demographic groups are sometimes unclear what services might be available to help them stay healthy and well.
- The current costs of ill health, providing health and social care and anticipated demographic changes in the next 20 years means it is not sustainable to continue to work as we currently do.

Our priority actions are:

- Review historic practices to develop, in partnership, the opportunities for a systematic approach to preventing ill health from birth through early years to older age and end of life, starting with those areas that need it most
- Funding of prevention services alongside existing services, to shift the system focus to helping people lead healthier lives at the earliest opportunity especially at a younger age.
- Embed prevention and early help across all system and organisational strategies, plans and policies and shift focus to community provision.
- Have joint accountability so that as a system we are preventing, reducing, and delaying need and associated costs.
- Prevent people from becoming ill through promoting healthy lifestyles and mental wellbeing and healthy communities.

We know we will have achieved this when:

- System strategies, budgets, plans and policies reflect a focus on prevention and early help and future proofing for our changing demographics.
- All partners are prioritising prevention and early help both at a policy level and in decision-making that resonates with our communities.
- People and communities are able to independently access prevention help and advice, and activities, with the support of partners if needed.
- A reduction in the gap between life expectancy and years spent in poor health by better outcomes for everybody.

Case study: Age Healthy Norwich

Age Healthy Norwich

About

This project is aimed at 50-65 year olds with high blood pressure and weight concerns, to help prevent further deterioration in their health and wellbeing.

Age Healthy Norwich is a collaboration of VSCE providers who specialise in supporting people aged 50+ with their physical and mental health. The team consists of qualified staff from Age UK Norwich, Exercising People in Communities, Norwich Theatre, and Norwich Door-to-Door.

Two GP surgeries from OneNorwich PCN were involved in a pilot programme, which started in February 2022. 50 individuals from each surgery took part.

Approach

Participants could choose from a diverse range of over 30 activities which were a mixture of one-to-one or group-based and delivered within the home or garden, surgery, parks, community buildings or online.

Everyone received weekly one-to-one coaching sessions over a six-month period. This supported behavioural changes, helped to identify wider determinants of health (such as smoking cessation and healthy diets), accredited advice, hardship and transport subsidies as required.

Results

After six months, a variety of tools were used to evaluate participant goals and progress. These showed frequency of activity remained consistent over the six-months with a positive shift to more vigorous activity and walking. Time spent on physical activity increased from 4 hours-per-week to 5hrs 20 mins-per week, with time spent on vigorous activity trebling in duration.

Participants rated the quality of the service **10/10**

Across all types of feedback, people reported improvements in sleep, anxiety, nutrition, and levels of physical activity – all factors that can impact high blood pressure and overall wellbeing. There was also positive improvement across the majority of factors, including life satisfaction, happiness, physical health, and life purpose, and a significant improvement in mobility and ability to perform activities of daily living.

Although participants received one-to-one coaching in their home, 50% of people were supported to connect to community clubs for ongoing self-care, increasing their levels of social connection, support, and friendships.

Age Healthy Norwich will be continuing this model into 2023. You can find out more by visiting their website at AgeHealthyNorfolk.org.uk.

Addressing inequalities: What's important strategically?

Those living in our most deprived communities experience more difficulties and poorer health outcomes. Health and Wellbeing Board members told us that this was magnified during the pandemic and gaps between communities widened.

We recognise that together, we need to deliver effective interventions, to break the cycle, mobilise communities and ensure the most vulnerable children and adults are protected. To be effective in delivering good population outcomes we need to most help those in most need and intervene by working together at system, place, and community levels to tackle issues reflecting whole system priorities as well as specific concerns at the right scale. Reducing inequalities in health and wellbeing will involve addressing wider issues that affect health, including housing, employment, and crime, with community-based approaches. These need to be driven by partnerships at a place level involving councils, health services, the voluntary sector, police, public sector employers and businesses.

Our key challenges are:

- Deprivation, poverty, and multiple overlapping risk factors for poor health outcomes are found throughout Norfolk and Waveney, and are more concentrated in some areas.
- Seldom heard communities, the most vulnerable and those that are socially excluded experience additional difficulties accessing services.
- Not everyone has a positive experience when accessing and using our services.
- We have pockets of inadequate and poor housing, as well as inappropriate living conditions which are linked to poor health outcomes
- There are differences between some of our rural and urban communities in their levels of need and the support available to them.

Our priority actions are:

- Provide, share, and use the evidence to address needs and inequalities.
- Identify and target collaborative interventions, services and resources to those communities and areas that have more need.
- Plan for the future by joining up development planning and working with those with planning responsibilities.
- Consult and engage with residents, including those from seldom heard and excluded communities, to design and input into our services. This should include a variety of engagement methods and technologies.
- Ensure our services are easily accessible to all and improving accessibility to our services for those who need more support
- Build confidence and trust in everyone who engages with our services and learn from those with lived experience
- Reduce the impact of injuries, accidents and crime in our most deprived areas

We know we will have achieved this when:

- Populations in areas of most need show better health outcomes.
- There is an increase in availability of services in deprived and rural communities.
- We are consistently able to engage and support those in seldom heard communities and those who have previously experienced difficulties in accessing services.
- Our services are shaped by feedback from those with lived experience and everyone can access our services with confidence
- There is a reduction of injuries, accidents, and crime in our most deprived areas.

Case Study: Tricky Friends

Friendships are important and valuable to everyone and have a major impact on our health and wellbeing. Friendships are as important as healthy eating and exercise and support a sense of belonging. Belonging fulfils an important emotional health need and helps decrease feelings of depression and hopelessness.

It is important that people with learning disabilities and autism, those who have cognitive difficulties, and also children and young adults, have positive opportunities to make and maintain friendships. However not everyone who says they are your friend is genuine and some people can be exploited and abused by so called friends.

Over the last few years, Norfolk Safeguarding Adults Board (NSAB) have had discussions with groups and organisations in Norfolk who support people with learning disabilities and autism, about how to raise awareness of issues like exploitation, county lines, cuckooing.

We wanted to help them to do this, to reduce the risk of harm and exploitation in groups who may be less able to recognise the intentions of others. So, working with adults with learning disabilities and autism we have produced a short 3 minute animation called Tricky Friends.

This video can be used with or by anyone - carers, family, organisations, groups, to start conversations about what good friendships look like and what to look out for if something is not right.

Tricky Friends has been adapted for children and young people, and there's now a version in Ukrainian for those working with refugee families and vulnerable adults.

NSAB has shared this resource nationally and now over 35 safeguarding adults boards and other organisations are using it

Enabling resilient communities: What's important strategically?

District, City and Borough Councils work hard with partners to identify areas of increasing concern, poverty and inequality across Norfolk and Waveney. Health and Wellbeing Board Members told us that, through the pandemic, local resilience arrangements were key to providing clear messages and communication with communities, partners, and members.

Communities have the knowledge, assets, skills, and ability to help their residents flourish. Communities and individuals that are able to meet their own needs have better outcomes. It is important that our services support those living in our communities to look after themselves and live an independent life for as long as possible.

Our key challenges are:

- Gaps in support services to enable people to live independent healthy lives in their communities for as long as possible.
- Inconsistencies in our communities with accessing help and support through a variety of means
- Loneliness and social isolation, especially for those with caring responsibilities.
- People and communities including those with lived experience are often not involved in planning and developing their environments and care, as well as shaping the redesign of services and support.

Our priority actions are:

- Support people to live independent healthy lives in their communities for as long as possible, through promotion of self-care, early intervention, and digital technology where appropriate.
- Enable local resources, skills, and expertise to help people, families, and communities to thrive by accessing local support through the use of community assets such as green spaces, village halls, leisure centres etc.
- Build capacity in our voluntary, community and social enterprise, faith groups and third sector.
- Create healthy environments so healthy choices are the easiest choices.
- Improve access and encourage people to use our natural and cultural landscapes to benefit their physical, mental and emotional wellbeing.
- Identify investment and funding opportunities from a variety of sources to develop new initiatives e.g. to combat loneliness and isolation.

We know we will have achieved this when:

- There is increased partnership working and engagement of local authorities, parish councils, the voluntary, community, faith groups and third sector offering.
- There are better health outcomes such as decrease in admissions because of early interventions and more support services in the community.
- More people are independently able to access the support they need by using a variety of methods such as digital tools, apps and websites.
- Personalised advice is helping people to navigate our services and the use of self-directed support, such as new technologies and innovative models of care, are engrained in people's experiences.
- Healthy living environments are created at a local level through good holistic Planning design.

Case study: Lowestoft Rising - The Power of Collaboration

Lowestoft Rising is a multi-agency place partnership set up to take a holistic and asset-based approach to tackling the challenges faced in the town. Just over £500,000 of investment by the Lowestoft Rising funding partners over seven years has generated more than £4m of funding for the town. The funding partners are East Suffolk Council, Suffolk County Council, Great Yarmouth and Waveney ICB and Suffolk Police/Police and Crime Commissioner, but Lowestoft Rising is so much more than funding.

A few of our key achievements include our Mental Health Ambassador role and Positive Mental Health Manifesto, the Lowestoft Interventions process – where we work together to triage and support the most vulnerable, enabling Lowestoft Solutions (the first social prescribing project in Suffolk), our schools mentoring programme, high impact Cultural Education Partnership, work around homelessness and street drinking and our innovative 'Collaboration Academy' to inspire current and future leaders to work across organisational boundaries.

Current priorities are supporting vulnerable people (including financial and food poverty, substance misuse), mental health and wellbeing, and aspiration and achievement in young people. Our emphasis is on maximising the benefits of integration and partnership working for Lowestoft (including through the new Place Board, Waveney Health and Wellbeing Partnership and Waveney Health and Wellbeing Network, as well as the existing Lowestoft and Northern parishes Community Partnership), and inspiring individuals and families to believe in a better future.

Social Prescribing

- Operating in all GP surgeries across the town where patients with long-term conditions can access a holistic package of care within the community, through Solutions Lowestoft.
- Delivered by Citizens Advice North East Suffolk and funded by Better Care Fund, East Suffolk Partnership and the Suffolk Transformation Challenge Fund (plus Kirkley Mill) to March 2021.
- There was an approximately 40% reduction in GP appointments in the six months after support compared to the six months before but, more importantly, much better life outcomes for individuals.

"I am so pleased to have seen the adviser at Solutions because I know they are professional and they aren't going to scam me. I am being taken seriously because they are in the surgery so I know I can trust them".

"After visiting Solutions I feel like everyone is coming together to help me and I am going to be able to sort everything out now. For so long I have been getting bits of advice from 'here and there' and have never resolved anything".

"I felt the appointment with Solutions was really good, the adviser listened to me and took lots of notes. She is going to get some information to send to me so it was 45 minutes well spent".

Food Bank response

- Signpost East-led Food Bank collapsed in November 2017. An interim solution was quickly deployed by Access Community Trust to maintain food bank service across most sites – with 22 tons of food moved by volunteers to a new storage site.
- Lowestoft Community Church launched a new Food Bank in February 2018, with college and church volunteers working together. This provides six-day coverage across Lowestoft, plus an outreach service.
- There is a Free Period Scheme (sanitary products) in schools, colleges, and the library, which is now funded by national government.
- Special homeless persons Food Parcels are allocated by MEAM workers.
- 2 Year celebration event held for the 70+ volunteers who help keep the food bank running and helping to provide on average 750 parcels per month.

How can we make a change?

Working together is an opportunity to achieve joint outcomes, as a partnership we commit to:

- **Identifying the actions** that each Integrated Care and Health and Wellbeing Board partner will take in delivering our strategy, either through their existing plans or new initiatives.
- **Developing a joint system plan** so we can focus on the important things we have agreed to do together.
- **Holding ourselves to account** and be an accountable public forum for the delivery of our priorities.
- **Monitoring our progress** by reviewing data and information that tells us if we are making an impact.
- Reporting on our progress to the Integrated Care Partnership and/or Health and Wellbeing Board and **challenging ourselves** on areas where improvements are needed and supporting action to **bring about change.**
- **Recognise that social exclusion** impacts health outcomes, experiences, and access, and will require us to work different to include and involve better.
- **Developing and promoting a culture** within our system that actively addresses the **prevention of abuse and neglect** across all ages.
- **Keeping our Strategy live** and reflecting the changes as we work together towards a single sustainable system.

Plans for the transitional strategy going forward

The guidance from the Department for Health and Social Care outlines various areas where the Integrated Care Strategy must or should develop to be comprehensively support the health and care of our communities. As this document is a transitional strategy, which encompasses both the Joint Health and Wellbeing Strategy for Norfolk and the Integrated Care Strategy for Norfolk and Waveney, we plan to build on what is here to ensure we meet those requirements.

Over the coming months we will:

- Meaningfully engage with people, services and staff across Norfolk and Waveney.
- Identify areas of unwarranted variation and disparities in health and care outcomes.
- Identify gaps in our knowledge and research.
- Consider whether the needs outlined in the transitional strategy could be more effectively met with an arrangement under section 75 of the NHS Act 2006.
- Continue to work with partners in children and young people's services to highlight the safety and development of early years and transition into adulthood.

Improving lives **together**

Norfolk and Waveney Integrated Care System