North Norfolk Health and Wellbeing Partnership Strategy 2023 - 2026

North Norfolk
Health &
Wellbeing
Partnership

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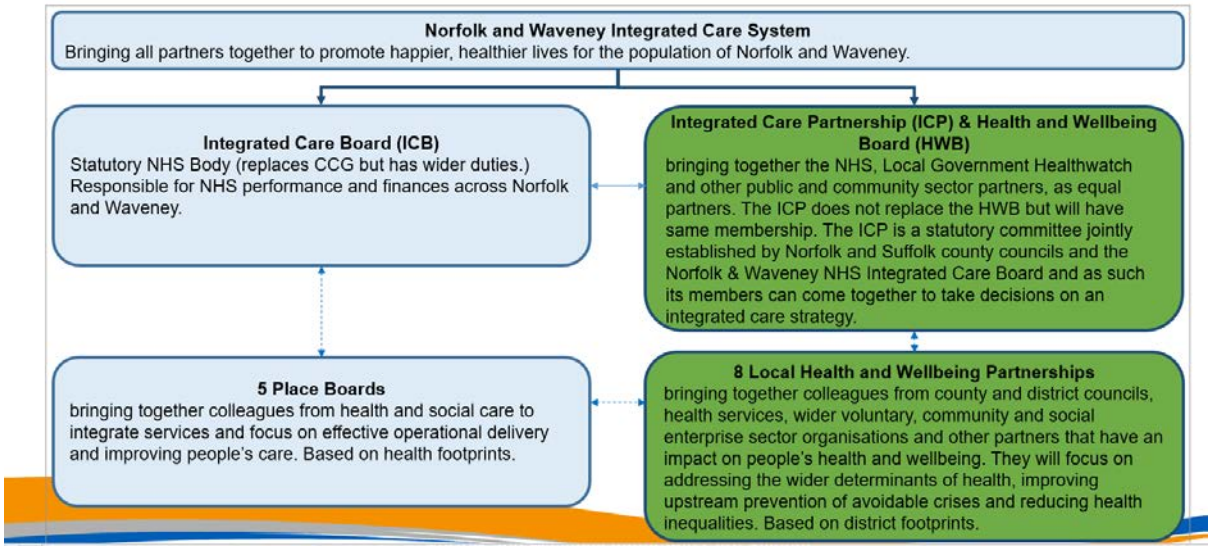
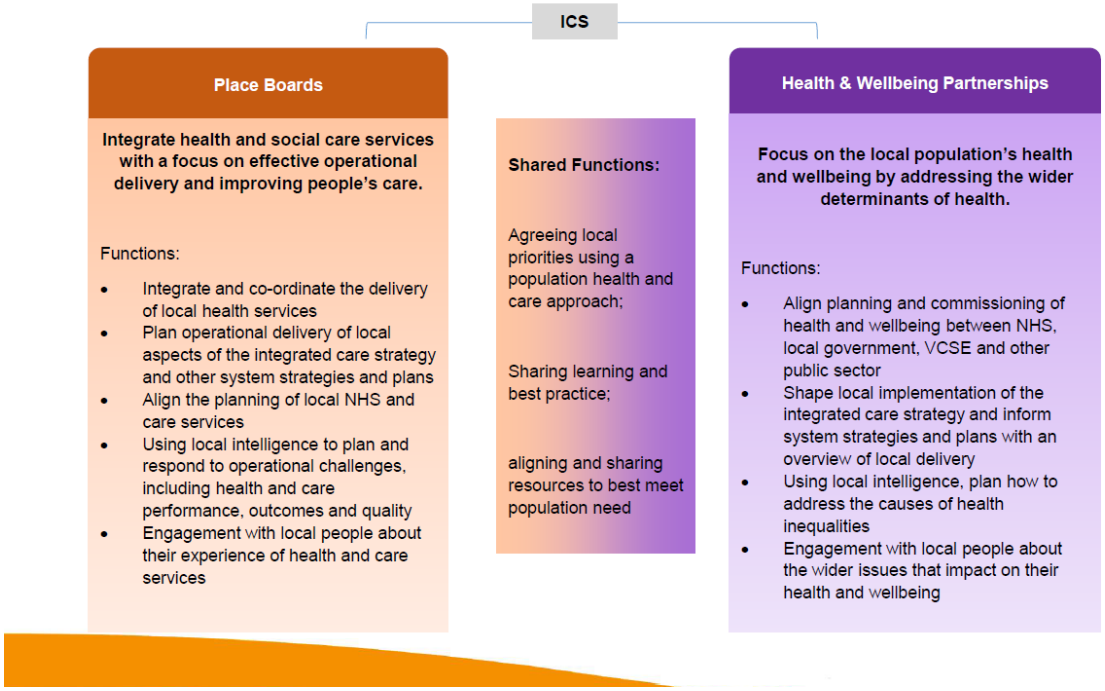
Introduction

Background

The North Norfolk Health and Wellbeing Partnership was formed in July 2022 as part of the new Integrated Care System for Norfolk as per the diagram below.



The partnership operated in shadow form from April 2022. The partnership operates on the footprint of the North Norfolk District Council area and operates alongside the North Norfolk Place Board (which operates on the footprint of the former North Norfolk Clinical Commissioning Group). The roles of the partnership and Place Boards are set out in the diagram below including the areas of overlap.



A list of current partners is included at appendix 1.

The Purpose of the North Norfolk Health and Wellbeing Partnership Strategy

This North Norfolk Health and Wellbeing Partnership Strategy sets out the Partnership's priorities for health and wellbeing over the next 3 years. It also sets out the actions the Partnership intends to take to improve health and wellbeing in the District over this period (appendix 4).

The Strategy takes reference from the Norfolk and Waveney Integrated Care Partnership's **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**.

This strategy adopts an evidence-based approach to identify the priorities for partners operating in the North Norfolk District Council area. Generally health outcomes are better in North Norfolk than the England average but there are a number of areas where health outcomes are much poorer. Health inequalities are masked as a result of small pockets of deprivation sitting alongside areas of affluence.

North Norfolk being a sparsely populated rural area with a significant stretch of coastline presents challenges to commissioners and providers of services in respect of both access and quality. A dearth of services places a greater reliance on personal transport and public transport which exacerbate inequalities for those unable to afford to access these.

The demography of North Norfolk, having the oldest average population in the country, presents additional challenges to commissioners and providers of services. Whilst a focus on older people doesn't necessarily address health inequalities it has significant potential to relieve system pressures on both health and social care freeing up resource to be invested elsewhere in the system.

Partners are keen to address health inequalities and significantly reduce system pressures but in the absence of any significant resource to invest in new or additional services the focus has to be on better utilisation of existing resources under the control of the partners. It is essential therefore that this strategy invests in developing the partnership in order that it can mature and develop trust to build the foundations for increased collaboration, funding alignment and joint commissioning.

The partnership is cognisant that disadvantage accumulates throughout life, hence the need to take a life course perspective and give some priority to ensuring that the residents of North Norfolk get the best start in life. We therefore want to develop a partnership approach to supporting the Early Years agenda.

The partners would also like to embrace the natural assets of North Norfolk, the coast and landscape quality which bring a feel-good factor to so many and consider how these can be utilised to support the delivery of our health and wellbeing outcomes.

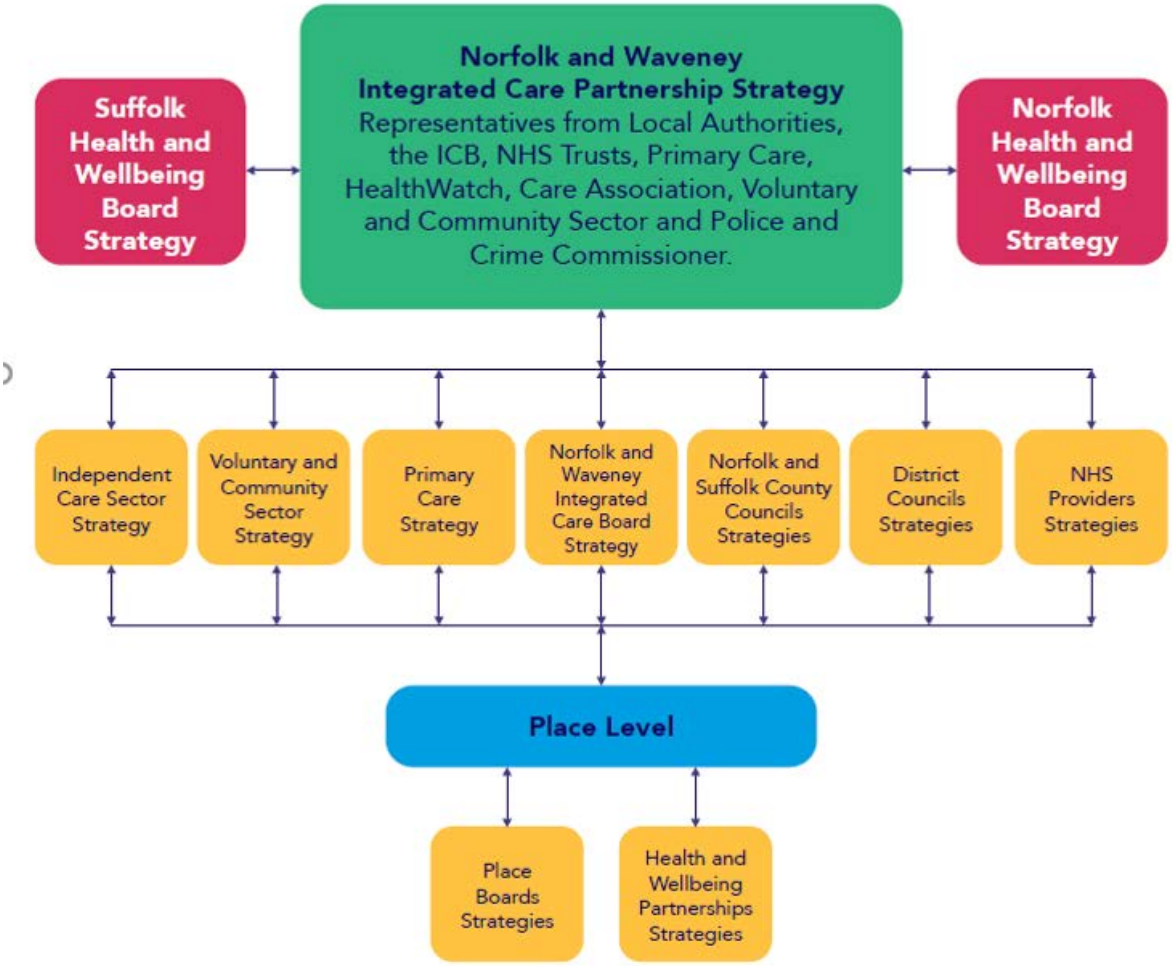
Links to Other Strategies and Policies

The Norfolk and Waveney Integrated Care Partnership has published a **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**.

The vision of the Integrated Care Partnership is to work as a single sustainable system that enables it to achieve its overarching mission **to help the people of Norfolk and Waveney to live longer, healthier and happier lives**.

The Transitional Strategy identifies prevention and early intervention as being critical to the long-term sustainability of the 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.

A key strength of the system is that it is built from the ground-up, meaning that District, City and Borough Councils, grass root 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 the other boards and committee strategies across the ICS and how we all work together in partnership.



The Norfolk and Waveney Integrated Care Partnership has 3 goals;

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.

The integrated Care Partnership has developed a number of shared guiding principles 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.

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.

It has also developed a number of priorities;

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.

Structure of the North Norfolk Health and Wellbeing Partnership Strategy

The North Norfolk Health and Wellbeing Partnership Strategy has two main elements:

1. The process for developing the Strategy and looking at evidence of health and wellbeing and inequalities locally.
2. The proposed actions and intervention which the Partners will undertake. We group these actions by health and wellbeing theme:
    - Older People
    - Mental Health and Wellbeing
    - Health inequalities
    - People and communities
    - Transport and connectivity
    - Covid Response and Recovery
    - Developing the North Norfolk Health and Wellbeing Partnership

Developing the North Norfolk Health and Wellbeing Partnership Strategy

We have developed the North Norfolk Health and Wellbeing Partnership Strategy through:

1. Consideration of the wider determinants of health
2. Analysis of evidence on the needs and challenges in the District which fall under the umbrella of Health and Wellbeing (the North Norfolk Health Profile)
3. Consultation with partners and stakeholders.

The Wider Determinants of Health and Health Inequalities

Our health is determined by a range of factors, these include:

- Age and genetic factors
- Health behaviours
- Socio-economic factors
- The built environment
- Clinical care

The social, economic and environmental factors are known as wider determinants of health. These influence our health more than other factors and many of them may be influenced by the work of the District Council hence the District Council area being the place footprint for the Partnerships. The differences in the care that people receive and the opportunities they have to lead healthy lives, can lead to differences in health outcomes and these are termed health inequalities (appendix 2 – the wider determinants of health).

The Marmot Review

Sir Michael Marmot was asked in 2008 by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England. The final report 'Fair Society Healthy Lives' published in February 2010 concluded that reducing health in equalities would require action on six policy objectives:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention

The Marmot Review describes how the social gradient on health inequalities is reflected in the social gradient on educational attainment, employment, income, quality of neighbourhood and so on. The Marmot Review stresses the importance of taking a life course perspective and recognising that disadvantage accumulates throughout life. It follows that those that do not get the best start in life are less likely to experience a good quality of life.

We therefore need to ensure our approach is designed to address the needs of all; children and young people as well as working age adults and older people.

fair-society-healthy-lives-full-report-pdf.pdf (instituteofhealthequity.org)

The Institute of Health Equity undertook a review in 2020 to mark 10 years from this landmark study. The report highlights that;

- People can expect to spend more of their lives in poor health
- Improvements to life expectancy have stalled and declined for the poorest 10% of women
- The health gap has grown between wealthy and deprived areas
- Place matters and has an impact on life expectancy (hence why the new arrangements for Health and Wellbeing Partnerships are at a district council level).

Health Equity in England: The Marmot Review 10 Years On - The Health Foundation

There have been two major reports in recent months which highlight the need for specific focus on action to reduce the impact of health inequalities on coastal and rural communities – Chris Whitty, Chief Medical Officer's Annual Report 2021, Health in Coastal Communities and the report of the All Party Parliamentary Group, Rural Health and Care, February 2022.

Health in Coastal Communities – Chief Medical Officer's Annual Report 2021

The central argument of this report is that *the health challenges of coastal towns, cities and other communities are serious, and their drivers are more similar than their nearest inland neighbour. This means a national strategy to address the repeated problems of health in coastal communities is needed in addition to local action. If the health problems of coastal communities are not tackled vigorously and systematically there will be a long tail of preventable ill health which will get worse as current populations age.*

The report identifies that *there are many reasons for poor health outcomes in coastal communities. The pleasant environment attracts older, retired citizens to settle, who inevitably have more and increasing health problems. An oversupply of guest housing has led to Houses of Multiple Occupation which lead to concentrations of deprivation and ill health. The sea is a benefit but also a barrier: attracting NHS and social care staff to peripheral areas is harder, catchment areas for health services are artificially foreshortened and transport is often limited, in turn limiting job opportunities. Many coastal communities were created around a single industry such as previous versions of tourism, or fishing, or port work that have since moved on, meaning work can often be scarce or seasonal.*

Given the known high rates of preventable illness in these areas, the lack of available data on the health of coastal communities has been highlighted by the report *with coastal communities having been long neglected and overlooked with limited research on their health and wellbeing. The focus has tended towards inner city or rural areas with too little attention given to the nation's periphery. Data is rarely published at a geographical level granular enough to capture coastal outcomes, with most data only available at local authority or Clinical Commissioning Group (CCG) level. As a result, deprivation and ill health at the coast is hidden by relative affluence just inland which is lumped together. The report explores the experiences of local leaders, along with analysis of what data exist, to help understand the health and wellbeing of coastal communities.*

Coastal communities are not homogenous, and each is shaped by its own unique history and culture. They do, however, share many similar characteristics, which lend to the development of common policy responses. A need has been identified for a national strategy informed by common groups, and underpinned by local actions aligned with a sustained evidence is needed to help tackle health inequalities in these areas.

The report highlights *the significant strengths in coastal communities along with many exemplary and impressive examples of local work taking place to support the health of local citizens. The vulnerability of these communities is not a new revelation, and the economic problems they face have been highlighted in several recent reports including in relation to the impact of COVID-19.*

Chief Medical Officer's Annual Report 2021 - Health in Coastal Communities (publishing.service.gov.uk)

All Party Parliamentary Group (APPG) Rural Health and Care – Parliamentary Inquiry February 2022

The report highlights that *for too long people in rural and coastal areas have experienced poorer access to health and social care services than their counterparts in cities and towns. For many, the prospects of a healthy life are also worse, somewhat at odds with the perceived benefits of living the idyllic rural life.*

It acknowledges that *it is often more difficult to provide services to dispersed populations or those living in more remote coastal communities with provision of services generally being poorer than in more heavily populated parts of the country. Public transport is often a major impediment to accessing health and social care, not just for patients but also for staff travelling to work. Cars have become essential for most people living in sparsely populated communities with many more households owning a car than in urban areas. Ironically, vehicle ownership is often seen as a measure of affluence, rather than a necessity and cars owned in rural settings are on average older and less energy efficient. Similarly, housing is also more expensive (excluding London), often less well maintained and again less energy efficient. Poorer educational provision and facilities for young people, fewer day centres for those of more advanced years, lack lustre digital connectivity, poor housing stock, and economic uncertainty in agricultural and agrarian industries all influence the health and wellbeing of rural residents. It is not just access to healthcare that is compromised, but the very determinants of health itself.*

In essence, rural residents are disadvantaged throughout the life-course compared to their urban counterparts. Access to maternity care is more problematical; the wider community services for children and young people are less accessible; primary and secondary care are less readily available for people of working age, including preventative and screening services; and the provision of both health and social services for the growing proportion of older citizens is increasingly inadequate. We are not offering equal care for all in England, despite the commitment to do so.

Three of the 12 recommendations are particularly relevant to the North Norfolk Health and Wellbeing Partnership in looking to improve health outcomes and address health inequalities;

Recommendation 1: Rurality and its infrastructure must be redefined to allow a better understanding of how it impinges on health outcomes

Recommendation 4: "Rural health" proof housing, transport and technology policy

Recommendation 12: Empower the community and voluntary sector to own prevention and wellbeing

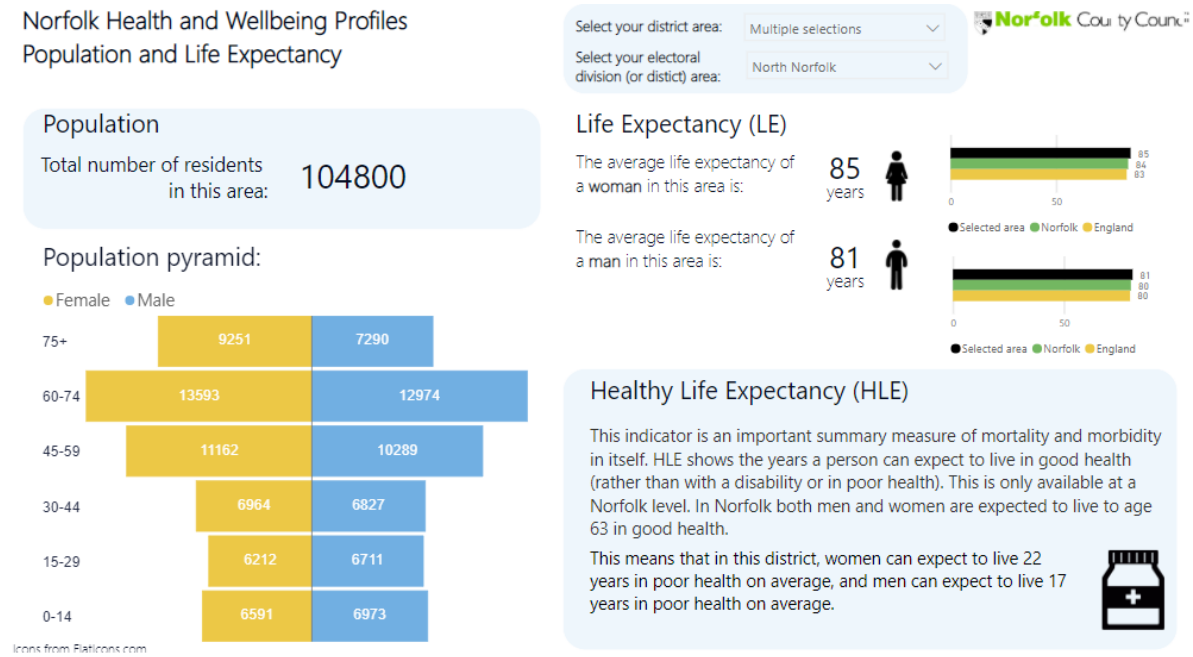
RuralHealthandCareAPPGInquiryRep.pdf (rsnonline.org.uk)

North Norfolk Health Profiles

The Health Profiles for the District produced by Public Health colleagues highlight the areas of concern when comparing the data for North Norfolk (selected area – black bar) compared to Norfolk and England.

[Health & wellbeing profiles - JSNA - Norfolk Insight]

Population and Life Expectancy

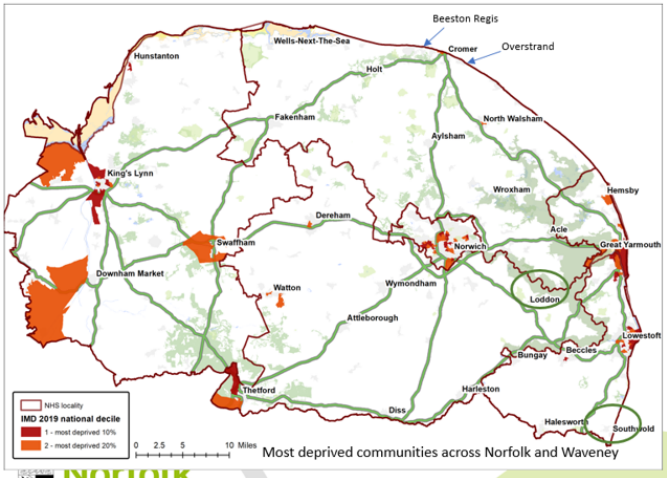


Although life expectancy in the District is better than that of both Norfolk and England, there is concern that these additional years are likely to be spent in poor health and that this will not only reduce the quality of life of the individuals concerned but could reduce the quality of life more generally at a community level as greater pressure is placed on services and in particular health and social care services.

As we know averages mask health inequalities as we can see from looking at the best and worst outcomes for men and women in specific locations in the North Norfolk area.

A male in Overstrand can expect to live to 83.0 years whereas a male in North Walsham can expect to live to 77.3 years.

A female in Beeston Regis can expect to live for 88.3 years whereas a female living in North Walsham can expect to live for 82.9 years.



Most deprived communities across Norfolk and Waveney

Across Norfolk and Waveney the market town life expectancy gap

- 8.2 years for men
- 5.4 years for women

Locality	Male Life Expectancy 2015 to 2019 (years)	Female Life Expectancy 2015 to 2019 (years)
Great Yarmouth	75.1	81.2
King's Lynn	76.7	81.0
Loddon	83.3	85.8
Southwold	82.0	86.4
Norfolk	80.0	83.8
Norfolk and Waveney	80.0	83.8

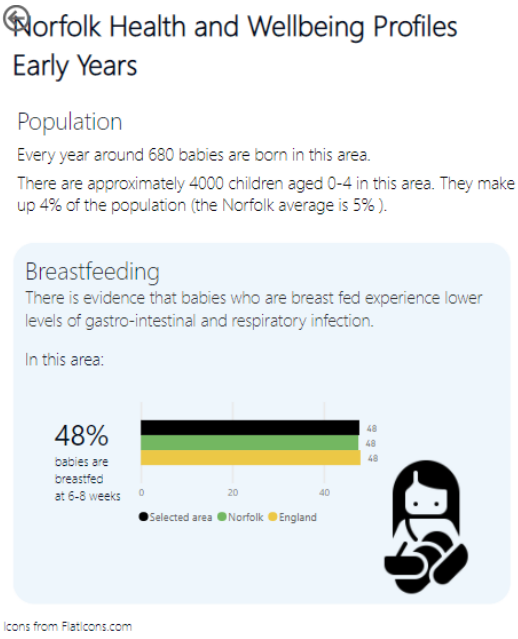
But between the most deprived and least deprived communities it is even wider

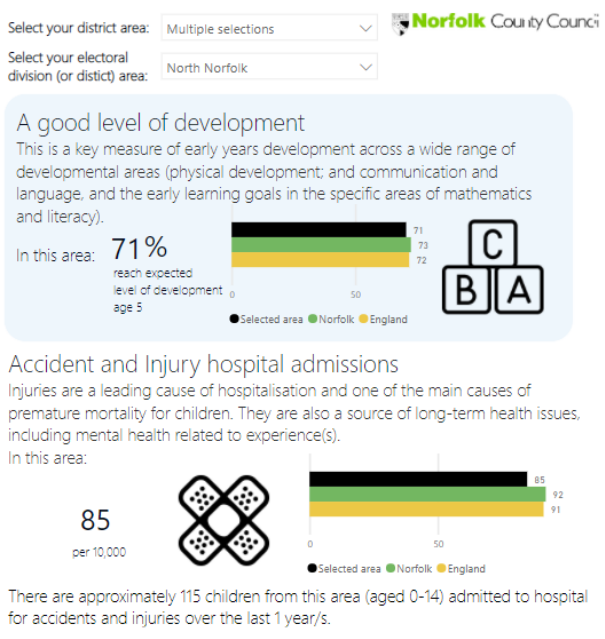
- 9.2 years for men
- 7.2 years for women

North Norfolk men: North Walsham: 77.3 years, Overstrand 83.0 years gap=5.7 years
North Norfolk women: North Walsham: 82.9 years, Beeston Regis, Saxthorpe etc. 88.3 years gap=5.4 years

Early Years

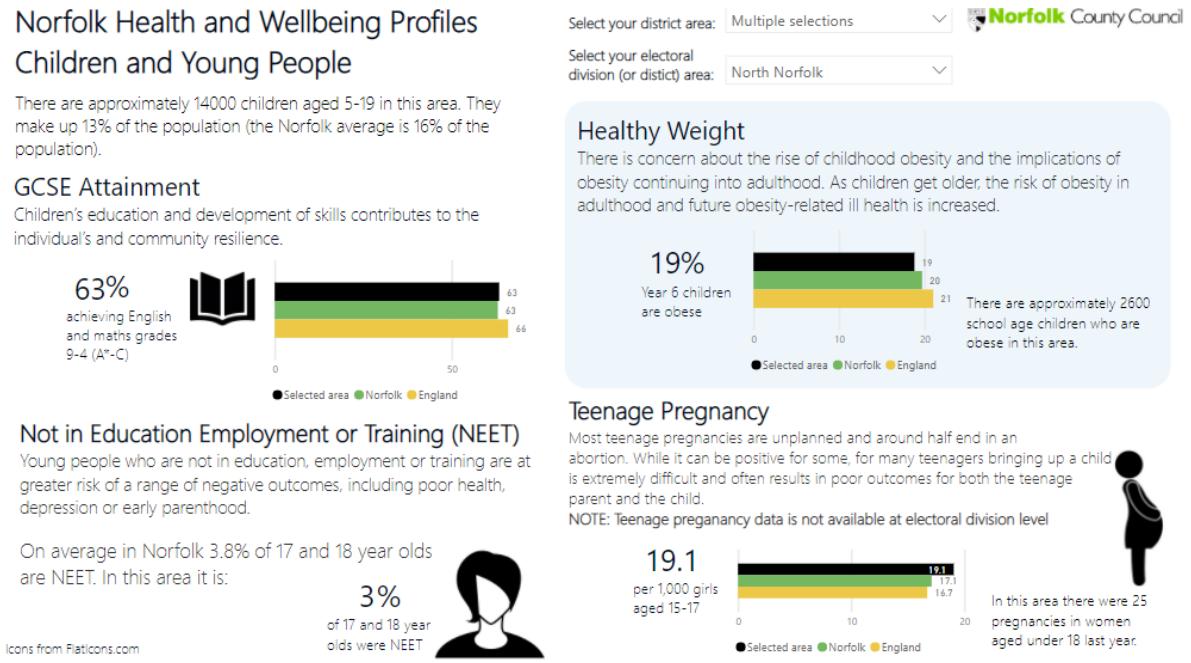
We know how important getting off to a good start in life is. The early years development indicator shows that children in North Norfolk are not getting off to as good a start as those in Norfolk and England and this is likely to affect life opportunities in later years.





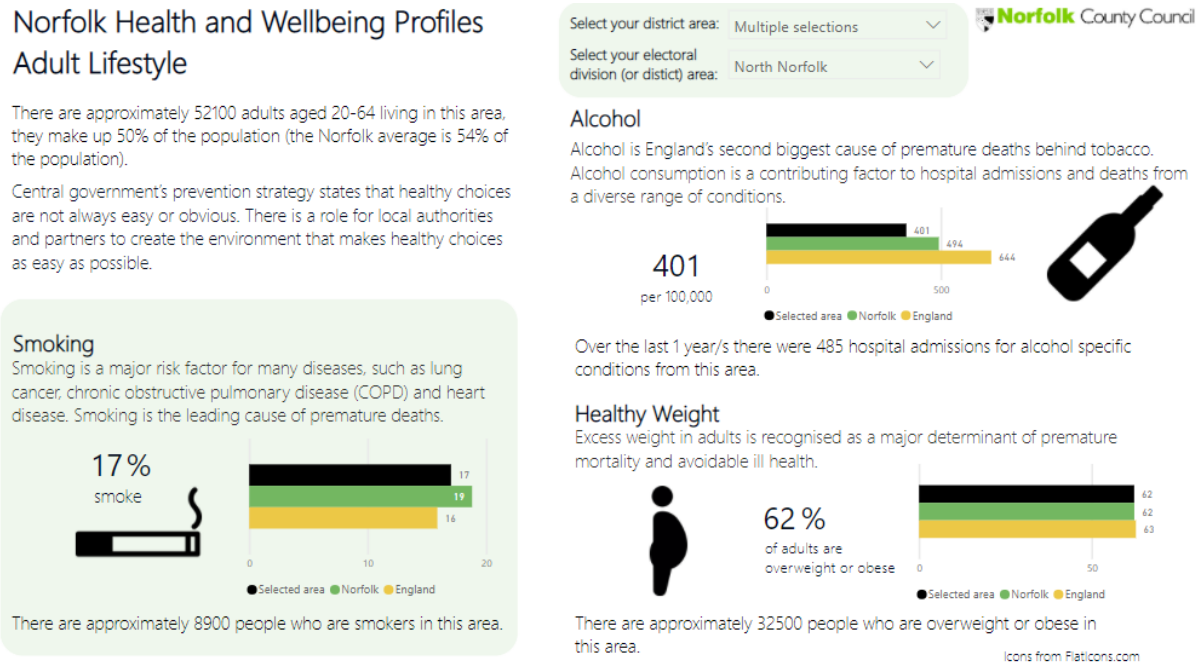
Children and Young People

GCSE attainment is lower than for Norfolk and England and although low in number there is some concern over the number of teenage pregnancies in the District.



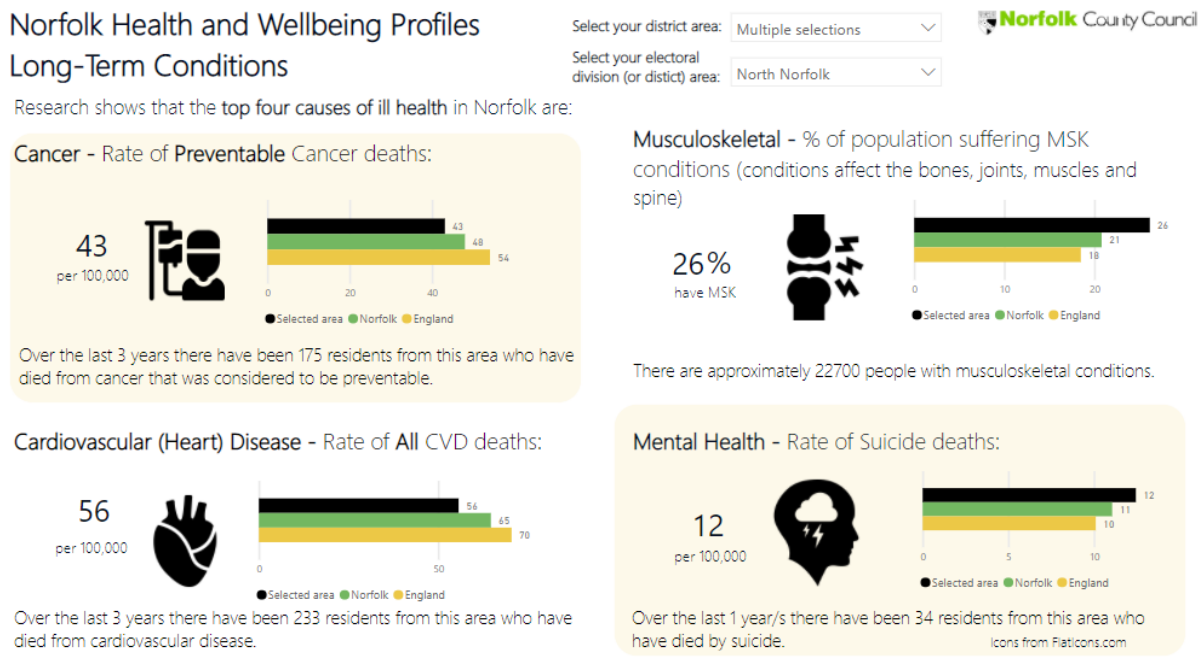
Adult Lifestyles

The percentage of residents in the District who smoke is lower than in Norfolk but higher than in England.



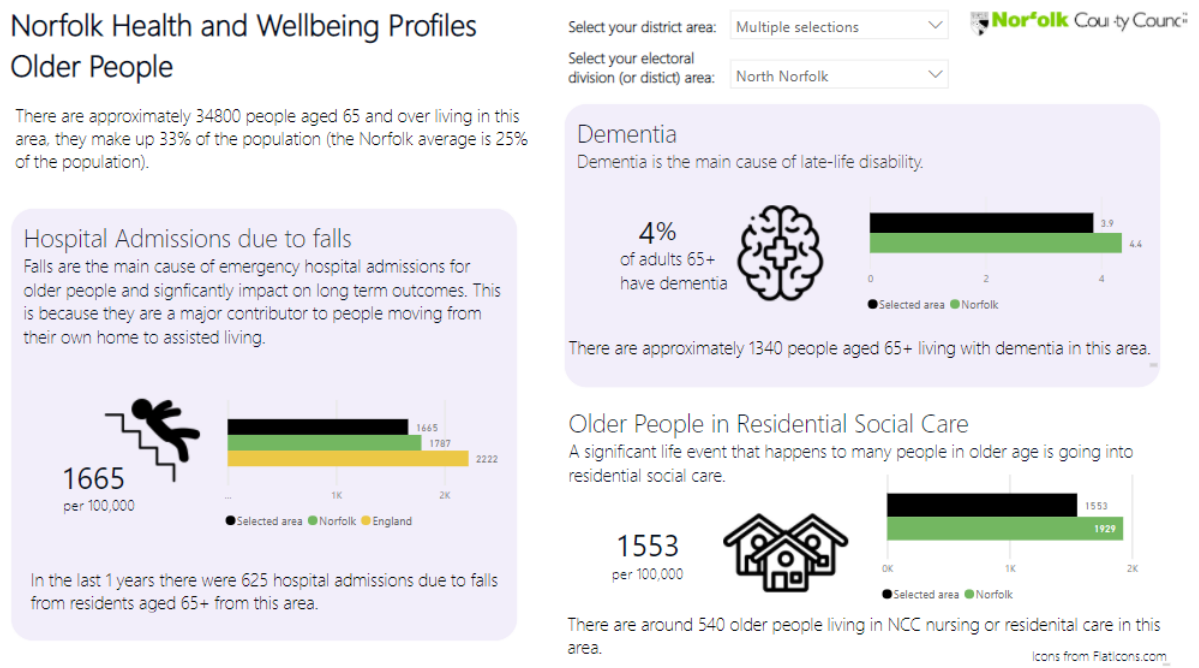
Long term conditions

The percentage of the population in the District suffering from musculoskeletal conditions is significantly higher than in both Norfolk and England. The rate of suicide in the District is also of concern.



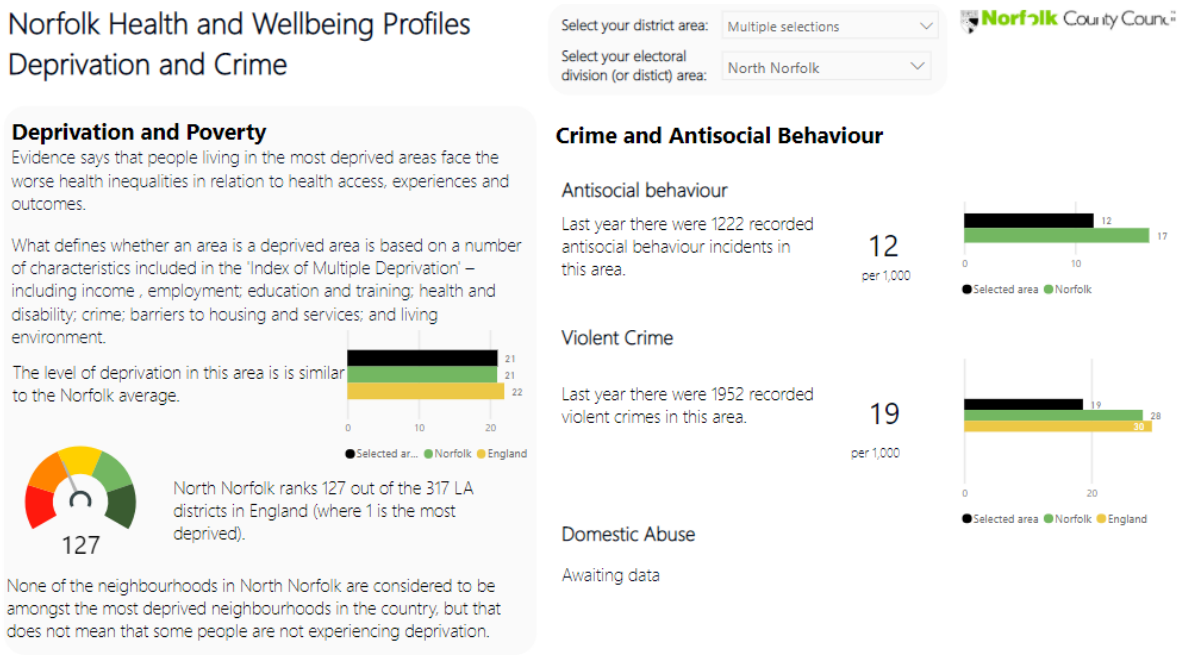
Older People

The proportion of the population aged 65 and over is significantly higher than the Norfolk figure at 33% and 25% respectively.



Deprivation and Crime

Crime levels in the District are lower than in Norfolk.



Health Index

The ONS has created an index that gives every local area in England an overall health score. This is made up of measures in different categories (domains and sub domains). These measures include physical and mental health conditions, social and environmental measures and health behaviours. This can be used to identify priority areas and track changes over time. The index has a baseline score for England of 100 from 2015. A score higher than 100 means that an area has a better health for that measure than was the average in 2015, lower than 100 means worse health than the 2015 average.

For North Norfolk the overall score for 2020 was 106.4. There are a number of sub domains however where we are below the England average which we might seek to prioritise to deliver improvements in health and wellbeing including;

- Access to services
- Mental health (mental health conditions, suicide, self-harm, children's social, emotional and mental health)
- Difficulties in daily life (frailty, disability)
- Physical health (long term conditions, cancer)

https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/articles/howhealthhaschangedinyourlocalarea2015to2020/2022-11-09

Consultation with partners and stakeholders

We have held 3 workshops to inform the development of the strategy; Older People (31 October 2022), Mental Health (29 November 2022) and Inequalities (9 January 2023) attended by Health and Wellbeing Partners and wider stakeholders (appendix 3). In addition, all partners were invited to complete a questionnaire and offered group and individual opportunities to discuss issues and questionnaire responses with officers of the Council leading on the production of the strategy.

The Big Issues for North Norfolk

These are the headline issues identified from the North Norfolk Health Profile along with the current and pressing issues being faced locally and by the nation as we continue our recovery from the Covid pandemic.

Older People

The demography of North Norfolk, having the oldest average population in the country, presents additional challenges to commissioners and providers of services. Whilst a focus on older people doesn't necessarily address health inequalities it has significant potential to relieve system pressures on both health and social care freeing up resource to be invested elsewhere in the system. This is also highlighted in the scores on the sub domains for difficulties in daily life and in particular frailty, disability and long-term conditions.

The incidence of dementia and in particular the likely under diagnosis of dementia overlaps with the second priority for the partnership of mental health. We are particularly concerned that under diagnosis and the lack of services for those with dementia in conjunction with the lack of access to formal domiciliary care is putting enormous pressure on informal carers and impacting on their mental health and wellbeing.

Mental health

There are particular concerns relating to isolation which are in some cases linked to rural isolation and connectivity but which can also be linked to social isolation particularly for older and disabled people and for marginalised and disadvantaged groups. For the majority these will have an impact on an individual's general wellbeing but for others will manifest in severe and enduring mental illness which will then impact on physical health and relationships. There is particular concern about the incidence of suicide.

There is a need to improve access to and pathways for commissioned mental health services but there also needs to be resource invested in developing resilience in communities to prevent escalation to the point of needing formal services and for the development of peer support and self-care.

Health Inequalities

We know that inequalities have been exacerbated by Covid and are likely to be exacerbated even further by the ongoing 'cost of living' crisis. It is essential that we scope out this work as a priority. It is likely that there will be some overlap with the work we will be undertaking in respect of Older People and Mental Health and the work we have commenced to look at managing the needs of High Intensity Users. The partnership focus we will develop for Early Years is also likely to be focused on those living in our most deprived communities.

People and Community

We recognise the need to improve engagement with our residents and service users/patients. A significant amount of the partnership's Covid Recovery Grant was invested in developing a Community Connector Service to support this aspect of the Partnerships role.

The Partnership is committed to utilising co-production for future service development where possible.

Transport and Connectivity

We are aware that many of our residents are reliant on personal transport to access services, take their children to school, travel to work, provide informal care to family members and for socialisation. We accept that for many car-ownership supports personal freedom.

We are also aware however that we need to encourage residents to reduce their reliance on cars, to reduce emissions and pollution, to reduce congestion in our towns and villages and to make our roads safer for pedestrians and cyclists. By doing this we can also encourage our residents to be more active. The costs of driving have increased significantly in recent times and continue to do so and so providing viable alternative options will help residents with managing the costs of daily life and generally increase their quality of life.

We do not have control over the provision of public transport in the area but can use our influence as a partnership and community leaders to highlight the importance of regular bus and train services to our towns and villages. We will look to support the voluntary and community sector to provide more flexible and bespoke options for the more vulnerable members of our communities.

We can be more flexible in how we support our service users/patients by facilitating and encouraging digital transactions where appropriate and explore opportunities to take services to our more vulnerable customers where this is not possible. Ultrafast Broadband connectivity will support this whilst improving access to a wide range of services and opportunities including the ability to work from home thus reducing the need to travel and car usage. Our Customer Service Strategies and Customer Charters will form a key plank of this work.

We are aware that we will not be able to eliminate the use of vehicles and the District Council is therefore supporting the provision of electric vehicle charging points in key locations within the towns in the district to reduce emissions as part of its Environmental Charter.

A key measure in the Thriving Places Index is minimum journey time to key services by car, public transport or walking and cycling – it is unlikely that we will be able to sufficiently influence these to improve performance for North Norfolk.

	North Norfolk	**Norfolk**
Minimum journey time (minutes) to 8 key services by car	17.9	12.9
Minimum journey time (minutes) to 8 key services by public transport or walking	34.1	25.4
Minimum journey time (minutes) to 8 key services by bicycle	35.3	23.8

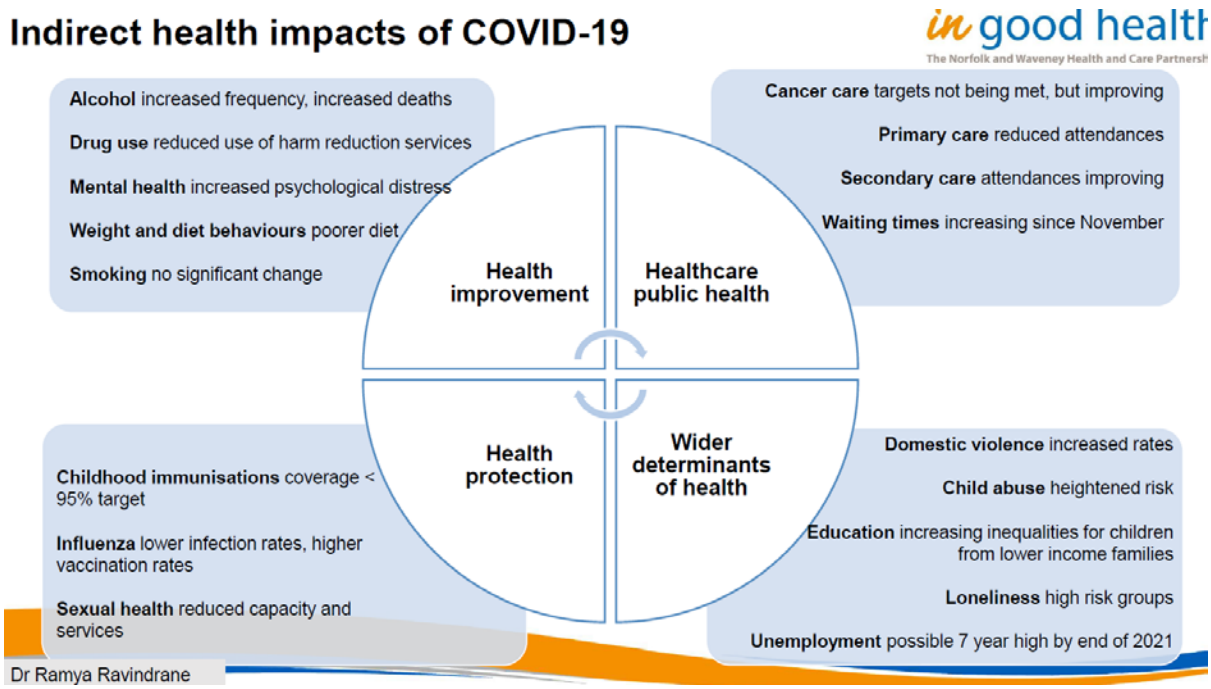
GOV.UK. (n.d.). *Journey time statistics, England: 2019*. [online] Available at:

https://www.gov.uk/government/statistics/journey-time-statistics-england-2019

Covid Recovery

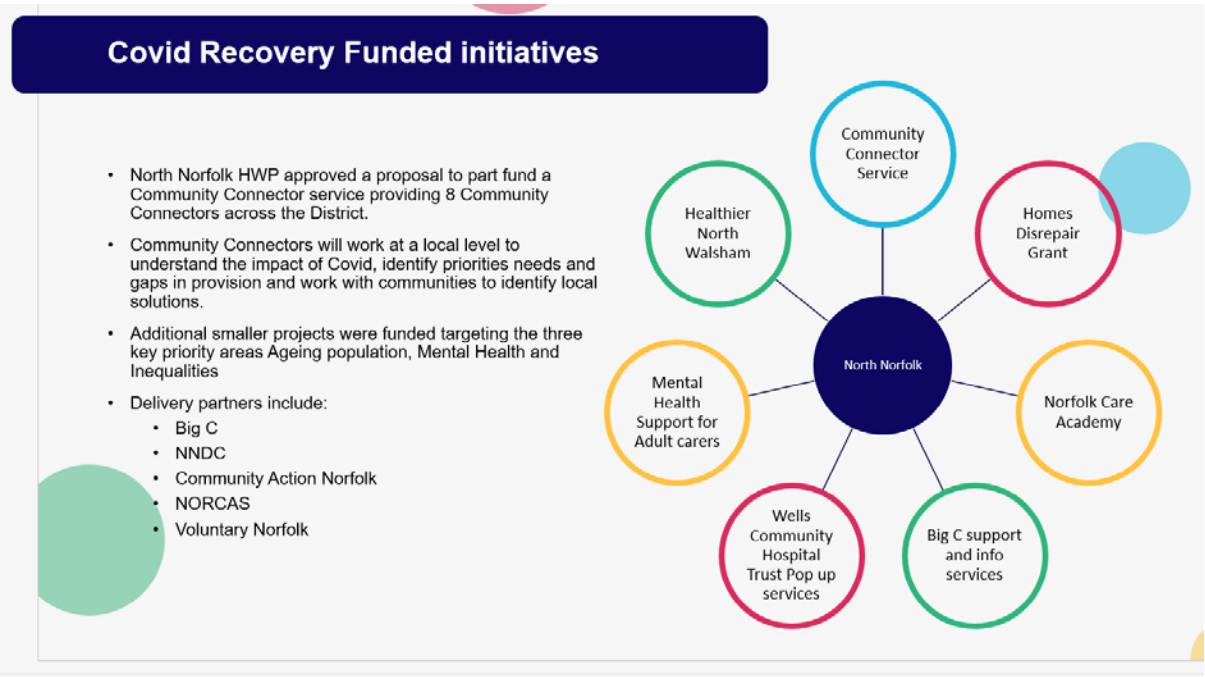
The early indications are that the pandemic has exacerbated health inequalities and we await data to be able to determine the full impact.

For many the pandemic changed the way we lived, worked and were educated; for some these changes might become the new norm as we continue to adjust to a post pandemic world. It has impacted jobs, finance, education, families, caring responsibilities and social life and placed immense pressure on essential workers. Some groups have been affected more than others and moving forward we will need to focus more of our efforts towards those with the greatest needs.



Many people's mental health has been affected due to factors including furlough, job losses, loss of income, reduced social contact and family bereavement. There is now even more demand for what were previously stretched mental health services. Physical health has also been affected due to limited access to primary and secondary health care services including prevention and screening and a hesitancy of patients to access services for fear of contracting Covid. Although most people who contracted Covid did not suffer unduly, some have suffered lasting respiratory and organ-damage and some have developed the long term debilitating Long Covid condition. There is now a significant backlog for most health services. It is fair to say that we will be managing the impacts of the pandemic for years to come.

The Health and Wellbeing Partnerships in Norfolk were each allocated £347,500 to address some of the worst impacts of the pandemic and to assist with Covid recovery. A summary of the projects funded by the North Norfolk Health and Wellbeing Partnership is provided below. These projects have not yet run their full course and will be subject to evaluation to assess the impact they have had and to inform future commissioning decisions.



Developing the Partnership

We are ideally placed to identify and tackle the causes of inequality within the North Norfolk district. In doing so we can improve the health and wellbeing of our residents. We already provide services to our residents through the delivery of both statutory and discretionary services, which have been designed to reflect their needs.

The issues that impact upon a person's health and wellbeing are both varied and complex and whilst, we as individual organisations can address some of these through delivery of the areas we have responsibility for, other elements are firmly within the scope of other partners, such as clinical provision through the NHS and Public Health through the County Council. Due to the complex factors it is often the case that issues cannot be addressed unless partners work together.

In order to be effective and to maximise the effectiveness of the relatively small financial resources available to the partners it will be necessary for us to work collaboratively. Some of the partnerships and joint working arrangements are well established and the Covid pandemic has provided opportunities to both strengthen these existing arrangements and develop new ones.

As well as the statutory organisations, there is a range of community and voluntary groups who provide services and support, either across our district, or on a more local community level. The community and voluntary sectors have similar constraints of limited resource and capacity but play a vital role in health and wellbeing outcomes for those they work with. The impact that can be made on reducing inequalities will be greater if we add value to the work of each other.

Partners are keen to address health inequalities and significantly reduce system pressures but in the absence of any significant resource to invest in new or additional services the focus has to be on better utilisation of existing resources under the control of the partners. It is essential therefore that this strategy invests in developing the partnership in order that it can

mature and develop trust to build the foundations for increased collaboration, funding alignment and joint commissioning.

Conclusions and Further Work

North Norfolk is an outstanding place to live, work, do business and visit. Many people choose to remain living in, move to or visit North Norfolk for the quality of life that it offers. The area is distinctive with large areas of outstanding natural beauty, long stretches of coastline and Broads which are a haven for wildlife and provide many and varied opportunities for leisure and recreation. There are many attractive villages and small market towns with historical and cultural offerings. Yet these things which are valued as integral to health and wellbeing can also bring challenges which can undermine their value for the more disadvantaged and marginalised within our communities.

Our Mission is to tackle these challenges head on to create a fair and welcoming inclusive North Norfolk where everyone can thrive, secure quality homes and good jobs whilst protecting and conserving our environment and delivering a sustainable future.

We know that improving health and wellbeing outcomes and reducing health inequalities will be challenging and that this will in some cases be difficult to measure as some impacts might not be evidenced for years or impact the current generation. We have decided to develop this strategy around some immediate priorities and to review where we are after three years. During this time we will be putting in place robust mechanisms to engage with our communities at a grass roots level such that the next strategy will be informed by the priorities which are being communicated to us by our communities.

Actions for the Health and Wellbeing Partnership Strategy

We have developed a number of actions to deliver against the Big Issues identified in the Strategy. A detailed action plan is included at appendix 4.

We are confident that the actions can be delivered within existing resources. We have identified where we will seek to supplement Partnership resource through bidding for external funding and seeking to align the resources of partners/influencing how partners use their resources.

The action plan will be a living document and progress against our action plan will be monitored on a quarterly basis with a more formal annual review and report on progress. This will enable us to bring in more actions if circumstance and capacity allows. For this reason, we have deliberately included the actions in a separate document rather than detailing them within the strategy document itself.

Appendix 1 - Membership of the North Norfolk Health and Wellbeing Partnership

Community Action Norfolk

Department for Work and Pensions

Healthwatch Norfolk

Norfolk and Norwich University Hospital

Norfolk and Suffolk Foundation Trust

Norfolk and Waveney Integrated Care Board

Norfolk Care and Support (NORCAS)

Norfolk Constabulary

Norfolk County Council - Adult Social Care

Norfolk County Council - Children's Services

Norfolk County Council - Public Health

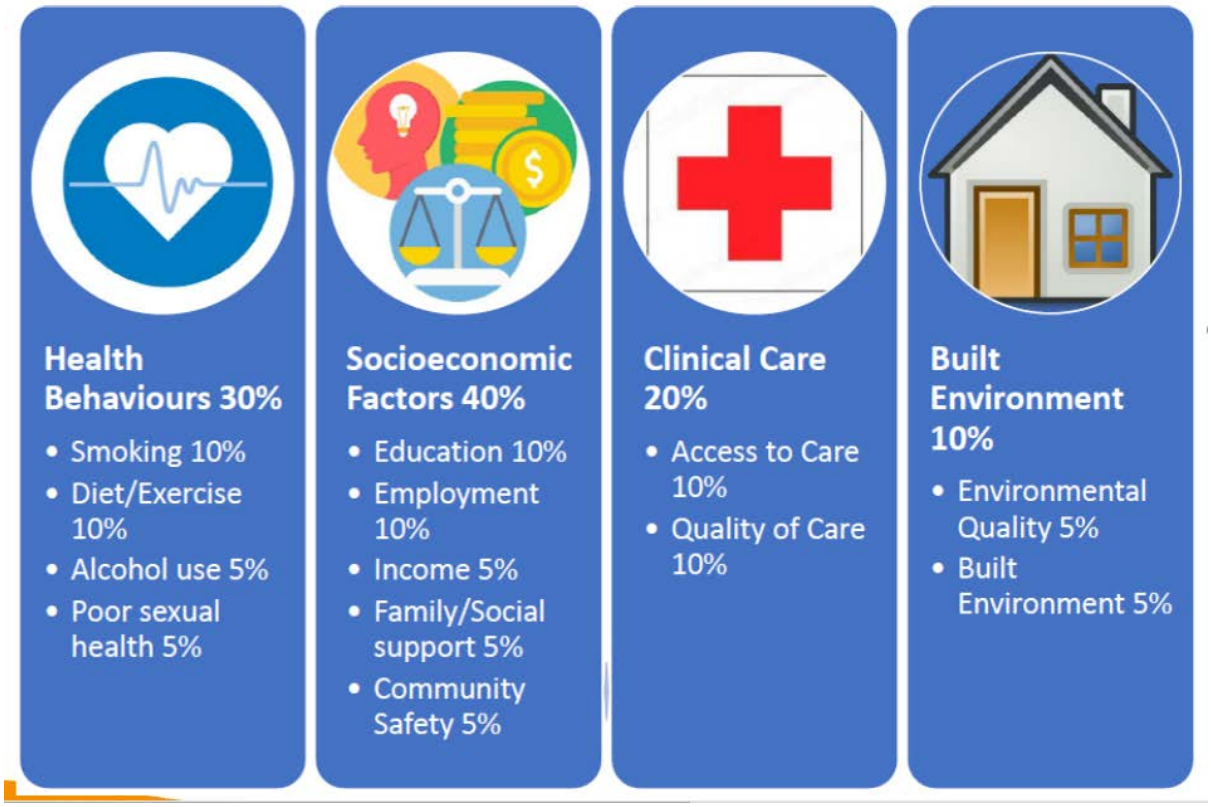
North Norfolk District Council

North Norfolk Primary Care Network

Victory Homes

Voluntary Norfolk

Appendix 2 - Wider Determinants of Health



Appendix 3 - Attendance at Strategy Workshops

Older People Workshop – 31 October 2022

Active Norfolk

Age Concern

Age UK

Caring Together

Community Action Norfolk

Glaven Centre

Healthier Sheringham

Hear for Norfolk

Norfolk and Waveney Integrated Care Board

Norfolk County Council - Adult Social Care

Norfolk Older People's Strategic Partnership

North Norfolk District Council

North Norfolk Primary Care Network

Voluntary Norfolk

Mental Health Workshop – 29 November 2022

Active Norfolk

Community Action Norfolk

Healthier Sheringham

Holt and District Dementia society

Leeway

Matthew Project

MIND

Norfolk and Suffolk Foundation Trust

Norfolk and Waveney Integrated Care Board

Norfolk Constabulary

Norfolk County Council - Adult Social Care

Norfolk County Council - Children's Services

Norfolk County Council Public Health

North Norfolk District Council

Pandora Project

Phoenix Project

Playing for Cake

Victory Homes

Voluntary Norfolk

Inequalities Workshop – 8 January 2023

About with Friends

Benjamin Foundation

Caring Together

Community Action Norfolk

Healthier Sheringham

MIND

Norfolk and Norwich University Hospital

Norfolk and Waveney Integrated Care Board

Norfolk Cancer Alliance

Norfolk Community Health Care

Norfolk County Council - Children's Services

North Norfolk Community Transport

North Norfolk District Council

North Norfolk Youth Advisory Board

Trussell Trust

Voluntary Norfolk

Your Own Place

Appendix 4 –North Norfolk Health and Wellbeing Partnership Strategy 2023 – 2026 Action Plan

Big issue	Action	Reasoning	Responsibility	Resources	Timescale	Outcomes/measures
Older People	Consider using the World Health Organisation process to develop Age Friendly Communities in the area	in recognition of the demography and utilisation of a recognised process to assess where our towns stand and what could be done to improve our towns with the aim of improving the health and wellbeing of residents	All partners	officer time, political buy in, consider options for levering in external funding	2023 – 2026	a decision on whether we should proceed with an application for Age Friendly Communities and if so attaining the status
Older People	Consider ways in which activity can be promoted to older people within main-stream service delivery	to encourage older people to remain active resulting in improvements to their physical and mental wellbeing	All partners	officer time, review of service delivery, funding for activity offers (Active Now)	2023	improvements to the physical and mental wellbeing of older people and relieving system pressures and delivering system savings/ longer term improvements to life expectancy and life in later years being healthier
Older People	Consider ways in which we can increase recruitment and retention in health and social care to relieve system pressures	to support older people to live independently in the community with appropriate domiciliary care	All partners	officer time, workforce planning, consideration of training academies	2023	availability of appropriate domiciliary care enabling residents to choose where they live in later life
Older People and mental health	Promote dementia awareness to increase dementia diagnosis	to reduce the stigma of dementia and to enable those diagnosed and their carers to access appropriate support	All partners	officer time, funding for commissioning of dementia services and support	2023	increased dementia diagnosis and improved services for those with dementia and their carers

Big issue	Action	Reasoning	Responsibility	Resources	Timescale	Outcomes/measures
Mental Health	To consider how pathways into mental health services can be improved and consider how such services could be delivered more locally	to manage demand for mental health services, reducing the waiting time and delivering more effective services which result in better outcomes for those experiencing mental health difficulties	All partners	officer time, review of commissioning of mental health services	2023	a reduction in the waiting time, reduced levels of prescription for anti-depressants, improved outcomes for those accessing commissioned mental health services
Mental Health	To further develop social prescribing, community groups, green care and peer support to support mental wellbeing	to offer an alternative to commissioned mental health services and services that complement commissioned mental health services and services that can support resilience and prevent mental ill health	All partners	officer time, Community Connectors, Social Prescribers, Active Norfolk	2023	a reduction in the waiting time, reduced levels of prescription for anti-depressants, improved outcomes for those accessing commissioned mental health services, increased number of services in the community
Mental Health	Explore opportunities to make our green spaces more accessible for vulnerable households and to support positive parenting through interaction with nature	increase accessibility and utility of our natural assets to improve the health and wellbeing of marginalised groups and to ensure the best start in life for children	North Norfolk District Council	officer time, revenue and possibly capital funding to facilitate transport to and from, consider bidding opportunities by voluntary, charitable and community groups	2023	development of options/funding bids/business case

Big issue	Action	Reasoning	Responsibility	Resources	Timescale	Outcomes/measures
Health Inequalities	Support residents to mitigate the worst impacts of the current cost of living 'crisis'	helping residents to mitigate the worst of the cost of living 'crisis' through implementation of Gov't sponsored schemes, delivery of services, use of funding available and working in partnership	All partners	officer time, administration of Gov't schemes, development of discretionary schemes using funding from Gov't passed down from other agencies, using existing resources working with partners and communities	ongoing depending on funding	successful administration of Government schemes and allocation of funding, development of discretionary schemes with output and where possible outcome measures, co-ordinated working with partners and communities
Health Inequalities	Develop a bespoke cancer screening programme for those identified at being at risk of health inequalities	to improve early diagnosis and improved outcomes for cancer for those at risk of health inequalities	All partners	officer time, changes to cancer screening	2023	increased cancer screening take-up, improved outcomes for those diagnosed with cancer
Health Inequalities	Consider ways in which we can use local data to understand the health inequalities in our most rural and coastal communities to enable targeted approaches to reduce inequality	to commission services using local data in order to reduce health inequalities and deliver better health outcomes	All partners	officer time, data analysis, using data for future commissioning	2023	better understanding of the health needs of residents and the services that will be the most effective to reduce inequalities and deliver better health outcomes
Health Inequalities	Consider ways in which we can support our most vulnerable residents to improve their life chances through education, skills and employment and participation in their local communities	in recognition of the impact of wider determinants of health on health inequalities and health outcomes	All partners	officer time, Community Connectors, DWP, funding for job fairs, opportunities for influencing use of external funding	2023	the delivery of initiatives linked to the wider determinants of health and evaluation of the impact of these initiatives

Big issue	Action	Reasoning	Responsibility	Resources	Timescale	Outcomes/measures
People and Community	Develop and implement a Partnership Community Engagement Plan	to provide a framework for engaging with our residents, communities and key stakeholders to increase the influence they have over decisions that affect them	North Norfolk District Council	mainly officer time with some resources being needed to facilitate engagement activities	April 2023 annually updated	a published Community Engagement Plan/ demonstration of consideration of the most appropriate engagement mechanism for the circumstance/ promotion of engagement opportunities on the Partners websites and how the engagement has affected the decisions being made
People and Community	Engagement with the residents of North Norfolk and communities of interest to determine future priorities for North Norfolk Health and Wellbeing Strategy	to understand the issues faced by our residents and communities of interest and in particular those who are the most disadvantaged and marginalised	North Norfolk District Council	mainly officer time with some resources being needed to facilitate engagement activities	April 2024 and annually	evidence of appropriate engagement which can adequately inform the development of priorities for the refresh of this Strategy
People and Community	Develop and implement a Partnership Equality, Diversity and Inclusion Plan	to ensure that Equality, Diversity and Inclusion are embedded in the decisions made by the Partnership and in service commissioning	North Norfolk District Council	officer time	April 2023	the production of an Equality, Diversity and Inclusion Plan, development of a consistent process for undertaking Impact Assessments as part of decision making processes, a suite of outcome measures, delivery of training for all partners

Big issue	Action	Reasoning	Responsibility	Resources	Timescale	Outcomes/measures
People and Community	Continue to support communities to deliver activities, services and events which increase participation and active engagement	improve health and wellbeing through participation and active engagement	Community Connector Service	officer time	ongoing	demonstration of significant benefit to the health and wellbeing of North Norfolk residents and an active participatory role
People and Community	Review information, advice and guidance produced in relation to health inequalities, health and wellbeing and promotion of healthy lifestyles and consider developing local branding for the partnership to co-ordinate effort and reduce duplication and inconsistency of message	promote a local understanding of the need for adopting healthy lifestyle to gain momentum and support	All partners	officer time, existing budgets	2023	development of a local brand, evidence of community support for adopting healthy lifestyles, reduction in health inequalities and improved health and wellbeing outcomes
People and Community	consider the development of Integrated Neighbourhood Teams with a focus on High Intensity Users	to improve outcomes for High Intensity Users whilst reducing systems pressures and freeing up resource, better collaboration between partners	All partners	officer time, Better Care Funding (2022), Community Transformation Fund	2023	development of Integrated Neighbourhood Teams, a better understanding of the needs of high intensity service users, reduction in service demand from this cohort and better health and wellbeing outcomes

Big issue	Action	Reasoning	Responsibility	Resources	Timescale	Outcomes/measures
Transport and Connectivity	Continue to fund projects that benefit vulnerable, disadvantaged and isolated people of all ages living in rural areas to access the services and facilities through the Community Transport Fund	fund transport solutions to facilitate access to services and facilities for vulnerable, disadvantaged and isolated people of all ages living in rural areas	North Norfolk District Council	officer and member time, Community Transport Fund	ongoing	grant terms and conditions fulfilled, benefit to vulnerable, disadvantaged and isolated people of all ages living in rural areas in accessing services and facilities
Transport and Connectivity	consider ways in which the Council and partners can support and encourage active travel	to reduce use of personal transport and support and encourage active lives	North Norfolk District Council Active Norfolk	officer time, revenue funding to jointly fund work of Active Norfolk	April 2023	monitoring and delivery against service level agreement, increase in activity levels of children and adults
Covid Recovery	To continue to manage risks related to Covid, including preparedness for outbreak management, supporting communities to recovery and develop resilience	to continue to work with partners to protect our communities	All partners	officer time	ongoing	monitoring of community transmission and evidence of recovery and the development of community resilience
Developing the Partnership	Supporting the roll out of Family Hubs and mainstreaming of support for new parents in service delivery to ensure that children get the best start in life	to reduce the accumulation of disadvantage and health inequalities	All	officer time and service review	2023	establishment of Family Hubs supported by partners, service changes, reduction in health inequalities and improved health and wellbeing outcomes

Big issue	Action	Reasoning	Responsibility	Resources	Timescale	Outcomes/measures
Developing the Partnership	Continue to monitor the development of the partnership using the maturity assessment tool and consider what joint training would be useful to build trust to support greater collaboration between partners	to ensure that the North Norfolk Health and Wellbeing Partnership fulfils its role and is effective in tackling health inequality and improving health and wellbeing outcomes and adds value to the work of the individual partners	All partners	Partnership funding	2023	regular well attended meetings with effective governance and clear and effective decision making, evidence of impact against reducing health inequalities and improving health and wellbeing outcomes, use of the maturity assessment tool and evidence of the partnership maturing
Developing the Partnership	Continue to support the work of the Norfolk County Community Safety Partnership	to help to keep our residents safe, engendering trust in statutory services and reducing the fear of crime and harm at both an individual and community level	all	mainly officer time, some budget allocation to support the delivery of local and countywide initiatives	ongoing	attendance at partnership meetings and contribution to local and countywide initiatives, low crime rates and evidence that fear of crime and harm is not increasing
Developing the Partnership	To seek to influence development of local strategies and plans where there are opportunities to improve health and wellbeing/reduce health inequalities	Population Health Management	All	officer time	as part of the Health and Wellbeing Partnership Strategy development and refresh	monitoring of the effectiveness of the Local Plan Policies with specific regard to health and wellbeing and health inequalities

Big issue	Action	Reasoning	Responsibility	Resources	Timescale	Outcomes/measures
Developing the Partnership	Support Data Analysts and Information Governance Leads to find solutions to ease data sharing and to avoid delays in implementing new ways of working supporting by more robust evidence of seeking consent from residents, service users, patients in support of Making Every Contact Count	enable collaboration and partnership working/news ways of working to tackle health inequalities and improving health and wellbeing outcomes	All partners	officer time/sharing best practice	2023	time reduced to implement new ways working, robust information sharing agreements which can be utilised more generally rather than specific to an initiative
Developing the Partnership	Undertake an audit of services on a locality basis to identify gaps in order to inform future decisions on service delivery and commissioning	to ensure that the necessary services are available/accessible to residents and where they are not or where demand exceeds capacity to highlight to commissioners, support community/voluntary sector to support individuals and groups as an alternative to statutory provision	North Norfolk District Council	officer time	2023	development of repository of information at a locality level which can be updated as service provision in an area changes due to services closing or new services being delivered and monitor demand for services against capacity

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