Your Health, Your Community, Your Say!

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Waveney
Health & Wellbeing Partnership

Norfolk and Waveney System

N and W Health and Wellbeing Board / Integrated Care Partnership

N and W Health Integrated Care Body

N and W HWB Board District Sub Group

N and W Health Inequalities Oversight

GY and W Place Board

Community Transformation Fund Steering Group

GY and W Health Inequalities Group

See next slide for acronym meanings

- Waveney VASP
- Waveney HWB Network

Waveney HWB Partnership

BBH CP

CCKS CP

LNP CP

Lowestoft Rising

System

Place

Neighbourhood

Suffolk and North East Essex System

SNEE Integrated Care Body

People and Communities ICB Sub Committee

SNEE Integrated Care Partnership

I & ES Alliance Committee

I & ES Executive Delivery Group

- I & ES Personalised Care Group
- INT and Connect Dev't Group
- I & ES Connect Delivery Group
- I & ES Frailty Steering Group

Suffolk Health and Wellbeing Board

Suffolk HWBB Programme Office

- Reimagining Health Behaviours
- Mental Health T & F Group

Sax & NE INT and Connect

ALSCP

FWMCP

Woodbridge INT and Connect

WMDCP

KMCP

Felixstowe INT and Connect

FPCP

Integrated Care Systems – East Suffolk

East Suffolk is covered by two separate Integrated Care Systems (ICSs) – Norfolk and Waveney ICS and Suffolk and North East Essex ICS. This diagram provides an overview of the three levels of engagement – system, place and neighbourhood

CP = Community Partnership
BBH = Beccles, Bungay, Halesworth
CCKS = Carlton Colville, Kessingland, Southwold
LNP = Lowestoft and Northern Parishes
ALS = Aldeburgh, Leiston and Saxmundham
FMW = Framlingham and Wickham Market
WMD = Woodbridge, Melton and Deben Peninsula
KM = Kesgrave and Martlesham
FP = Felixstowe Peninsula
N and W = Norfolk and Waveney
SNEE = Suffolk and North East Essex
GY and W = Great Yarmouth and Waveney
I & ES = Ipswich and East Suffolk
HWB = Health and Wellbeing
HWBB = Health and Wellbeing Board
T&F = Task and Finish
INT = Integrated Neighbourhood Team
VASP = Voluntary and Statutory Partnership
Sax & NE = Saxmundham and North East
ICS = Integrated Care System

Connect

Community | Local Services | Co-production | Solutions

Follow Connect on Facebook

Integrated Neighbourhood Team (INT) Leadership Team

Health, Social Care and other professionals working together to deliver key health objectives which improve the wellbeing of residents and reduce the demand on services.

Who is involved:

- Integrated Neighbourhood Team Manager
- Adult Social Care
- Primary Care Networks Clinical Directors (GP's)
- Social Prescribing Lead
- District/Borough/County Councils
- Norfolk and Suffolk Foundation Trust (NSFT)

Connect

The voluntary and community sector working collaboratively with statutory services to improve the health and wellbeing of our communities, by identifying localised priorities and solutions.

Who is involved:

- Good Neighbour Schemes
- Faith Groups
- Mental Health Support Groups
- Dementia Services
- Schools
- Community Health
- Community Transport
- Children & Young People Services
- Care Homes
- Libraries
- Police
- Town/Parish Councils

Plus many, many more!

Other Partners and Programmes of Work

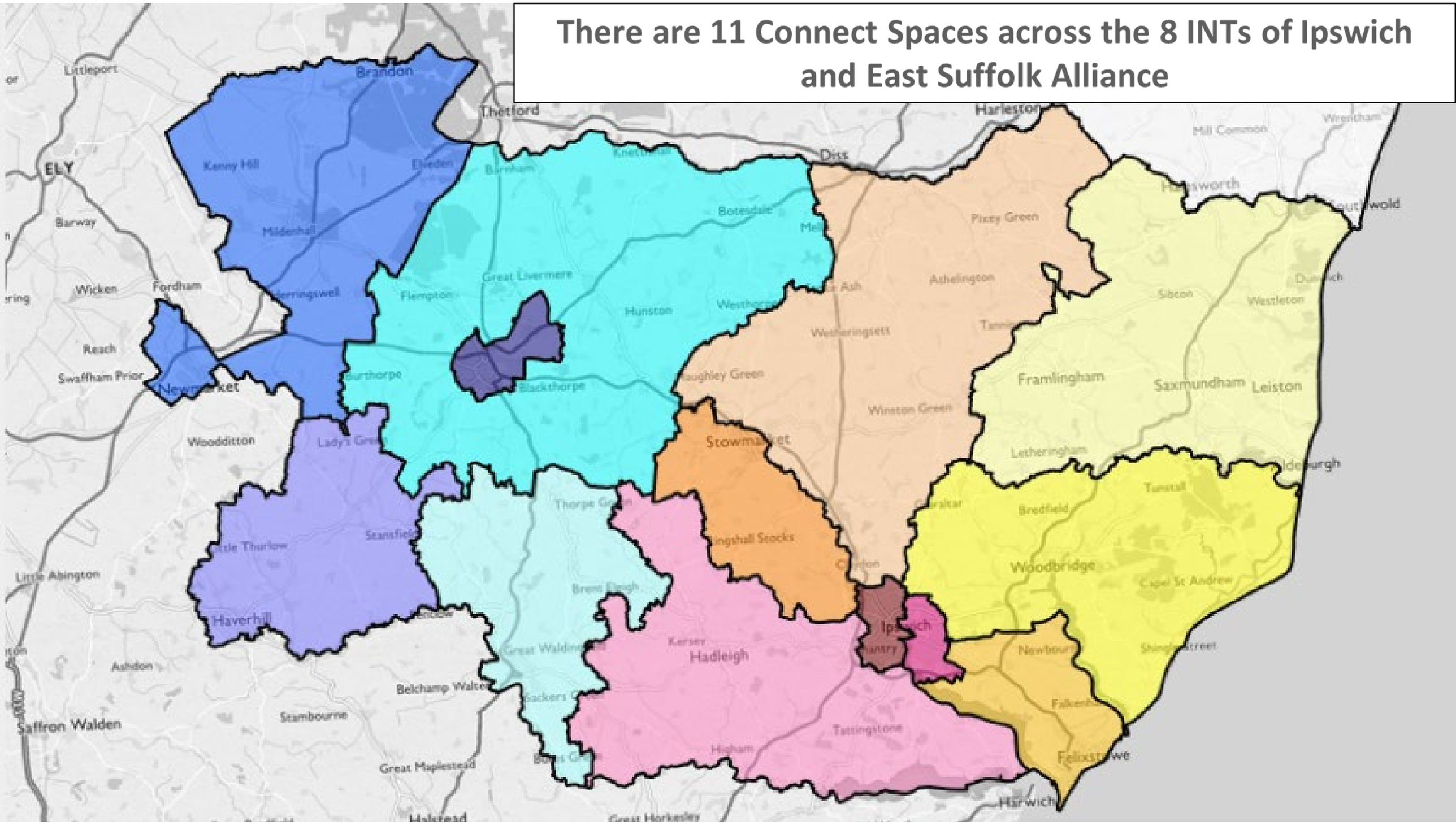
Connect works in partnership with a range of other partners, services and projects to improve the health and wellbeing of residents.

This includes:

- The ICB - Integrated Care Board (formerly Ipswich and East Suffolk Clinical Commissioning Group)
- Connect & Catch-up's (Health themed virtual workshops)
- Connect for Health (Social Prescribing)
- District/Borough Council Communities Teams
- Other District/Borough/County health & community projects/initiatives

Working Together to Improve the Health and Wellbeing of everyone within our Communities!

There are 11 Connect Spaces across the 8 INTs of Ipswich and East Suffolk Alliance



Health Inequalities

CORE20PLUS5

Public Health
& Communities

Suffolk Knowledge

East Suffolk

Profile

Public Health & Communities

Population
Key facts

Total population
248,250

Largest age group
70-74

Smallest age group
85+

Just over
1 in 6
people are aged under 16

17%; national average 19%

More than
1 in 4
people are aged 65+

27%; national average 18%

9,610
people aged 85 or over

3.9% of total population; national average 2.4%

Source: ONS 2018 mid-year population estimates

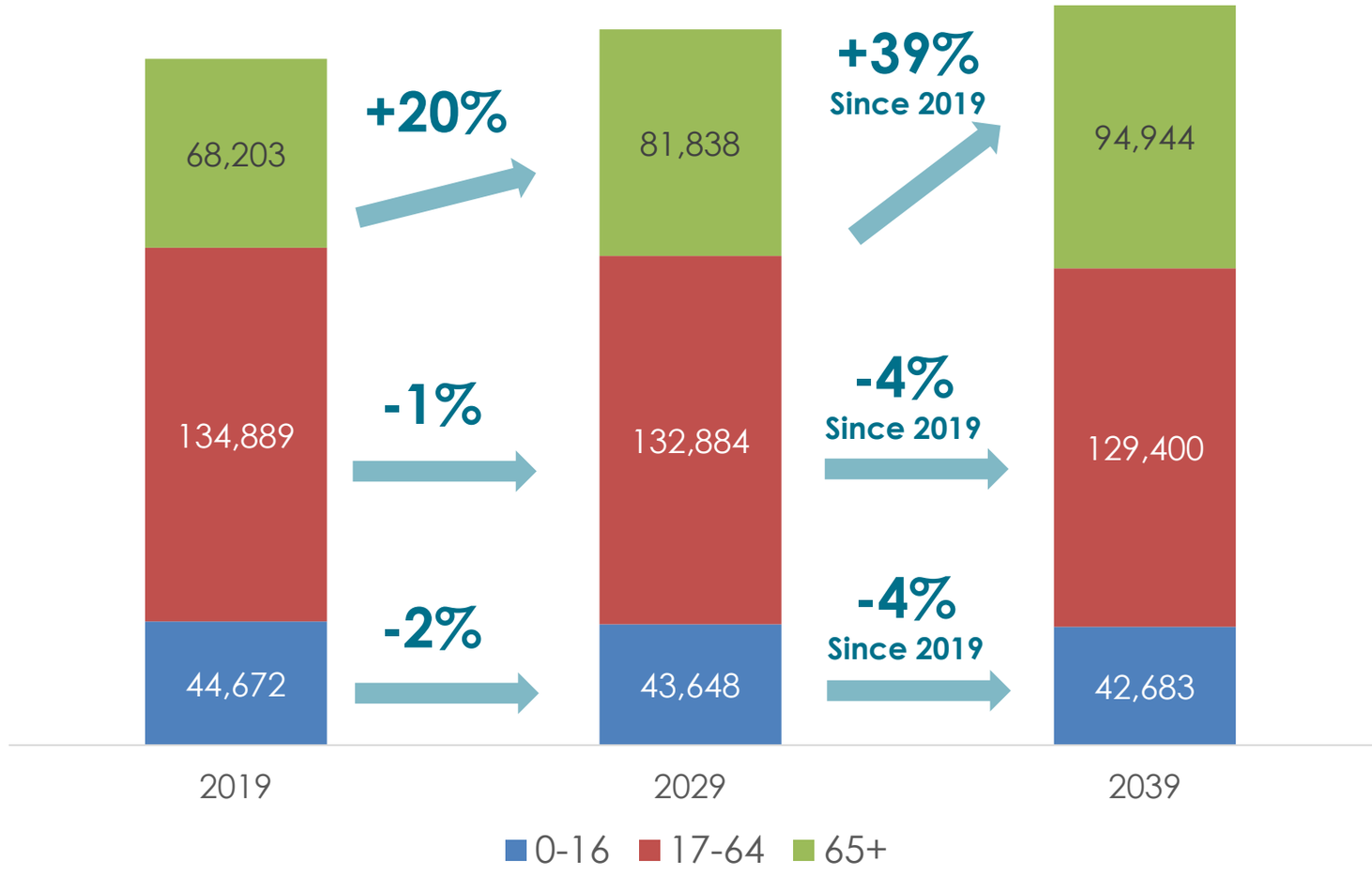
Public Health & Communities

Population Trends

The population of **East Suffolk** has grown by **3.5%** over the past decade

In the same period the **Suffolk** population grew by **5.6%** and the **Great Britain** population by **6.8%**

East Suffolk population projection by children, working-age and elderly age groups



Source: ONS 2016-based population projections

Public Health & Communities

Health and social care
Life expectancy

	Life expectancy at birth for males	Life expectancy at birth for females
Suffolk Coastal	81.7	84.8
Waveney	79.4	82.9
Suffolk	80.8	84.1

Highest and lowest life expectancy in East Suffolk

Deben Ward (Woodbridge CP)	84.4	
Kirton Ward (Felixstowe CP)		93.1
Kirkley Ward (Lowestoft CP)	73.5	78.3

10.9 years
the gap in life expectancy for males between Deben Ward and Kirkley Ward

14.8 years
the gap in life expectancy for females between Kirton Ward and Kirkley Ward

Source: ONS, 2013-2017 data. Accessed via localhealth.org.uk. Data not yet available for the new 2019 East Suffolk wards or East Suffolk District as a whole

Public Health & Communities

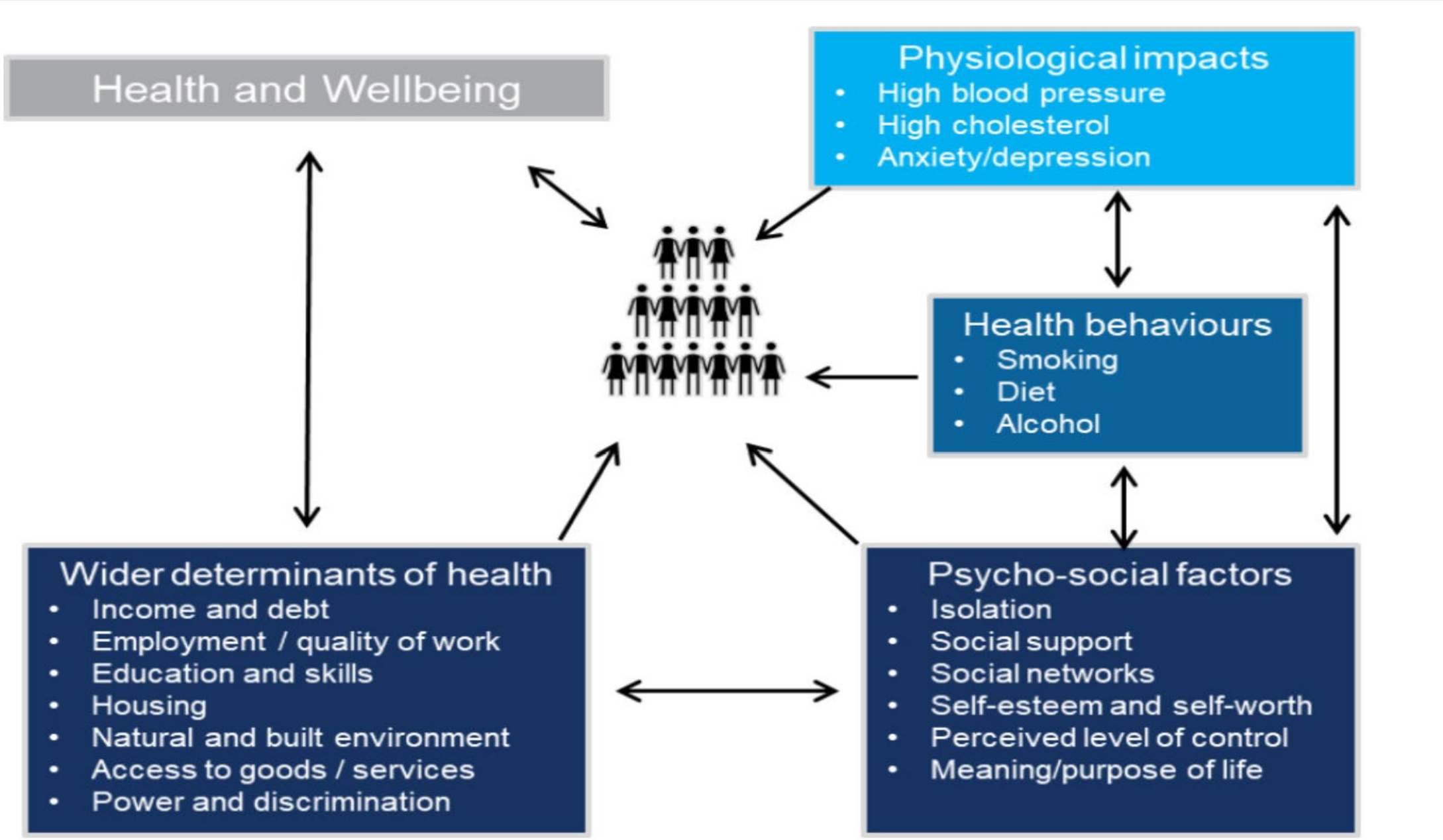


Figure 4. System map of the causes of health inequalities.

REDUCING HEALTHCARE INEQUALITIES

NHS

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement

Target population

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

CORE20 PLUS 5

Key clinical areas of health inequalities

1. **MATERNITY**
ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups

2. **SEVERE MENTAL ILLNESS (SMI)**
ensuring annual health checks for **60%** of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities)

3. **CHRONIC RESPIRATORY DISEASE**
a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

4. **EARLY CANCER DIAGNOSIS**
75% of cases diagnosed at stage 1 or 2 by 2028

5. **HYPERTENSION CASE-FINDING**
and optimal management and lipid optimal management

SMOKING CESSATION
positively impacts all 5 key clinical areas

Public Health & Communities

So what is Core20Plus5?

Core20Plus5 is designed as the NHS contribution to a wider system effort by Local Authorities, communities and the Voluntary, Community and Social Enterprise (VCSE) sector to tackling healthcare inequalities – and aims to complement and enhance existing work in this area.

The aim is that **Core20Plus5** will support ICSs to effectively prioritise energy, attention and resources enabling the biggest possible impact.

Core20Plus5 is not designed to be a new set of priorities but should refine existing NHS Long Term Plan commitments on tackling health inequalities into clear and focused areas which have the biggest opportunities to narrow the health inequality gap.

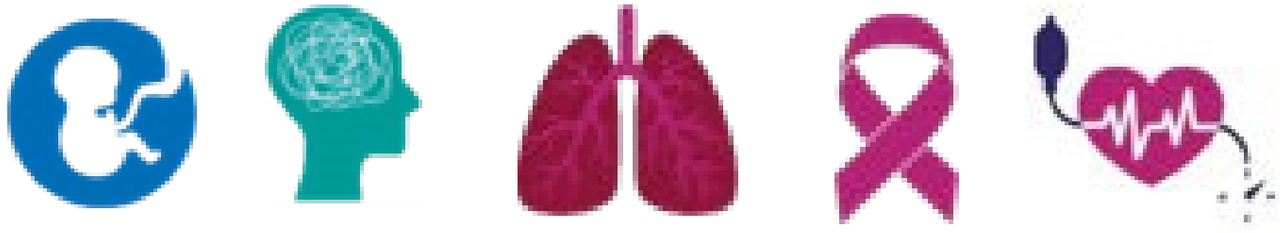
Fundamentally CORE20PLUS5 is an approach to reducing health inequalities

The approach defines a target population cohort:

- The **Core 20%** most deprived population in the area
- **PLUS** ICS chosen cohorts that experience worse than average health experiences, outcomes and/or access
- **5** nationally defined focus clinical areas requiring accelerated improvement, with the addition of smoking cessation as a thread running through the 5 areas.

Source: NHS England

The ‘5’



There are five clinical areas of focus:

1. **Maternity:** ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups.
2. **Severe mental illness (SMI):** ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).
3. **Chronic respiratory disease**: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

Continued…

4. Early cancer diagnosis: 75% of cases to be diagnosed at stage 1 or 2 by 2028.

5. Hypertension case-finding and optimal management and lipid optimal management: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

Whilst not included in the 5, smoking cessation is also included at this level of Core20PLUS5 as a cross cutting theme. This is because stopping smoking has a positive impact in all of the five clinical areas of focus.

Partnership working to address health inequalities

Leiston Wellbeing Hub (Waterloo Centre)

- Idea came from Connect Space – A safe space for all residents!
- INT & Connect working together (supported by Town Council)
- Thorough consultation carried out with service providers and community

The wellbeing hub would aim to support the local community by;

- Creating a local mental health, physical health and volunteering hub

- Providing a space for statutory services and local community and voluntary groups to offer formal/informal sessions, drop in clinics, information sharing opportunities, educational meetings and help to prevent isolation

- Bringing some services closer to the patient's home, but not duplicating what GP surgery's already deliver

Due to open in spring/summer 2023

Over to You – Group work

How can we strengthen our health partnerships (INTs/Connects/H&WB Boards and others) to meet the needs of our communities and tackle health inequalities? (including how grass roots groups can share what they are doing and to avoid duplication).

1) **What is working well and WHY are they working well?**

Think about Structures/Partnerships/Networks/Forums which are supporting H&WB

2) What/Who is missing from our health partnerships & Networks?

3) What do we need (not just money) to make changes happen and strengthen the partnership working?

What's Next?

All feedback from the workshop will be used to improve service delivery going forward by sharing outcomes with INTs/Connects/H&WB Boards for future planning

Thank you!

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