



Breckland Health & Wellbeing Partnership

Strategy 2023-2025







Foreword from our Chair – Cllr Tristan Ashby, Executive Member for Health and Communities



I am delighted to introduce the joint Health and Wellbeing strategy for Breckland, which reflects the aims and priorities of the Breckland Health and Wellbeing Partnership.

Breckland is a place where people can thrive, with strong communities and excellent services working collaboratively to improve health outcomes for our residents and patients. We know, however that there are still complex health needs that need addressing and this strategy outlines our ambition to tackle key issues and remove barriers to improving the health and wellbeing of the people of Breckland.

Introduction

The Norfolk and Waveney integrated care system (ICS) launched in July 2022 bringing together partners from local authority, NHS, and wider partners to improve health and care outcomes. The ICS priorities include driving integration, addressing inequalities, prioritising prevention, and enabling resilient communities.

In addition to the newly formed ICS, health and wellbeing partnerships (HWP) were launched to work at a place level with a prevention led focus to improving health. Aligning priorities place boards and feeding up to the Norfolk and Waveney health and wellbeing board (HWB) and integrated care partnership (ICP). Breckland HWP is one of eight within the Norfolk and Waveney ICS and covers the same geographical footprint as the district council.

The Breckland health and wellbeing partnership brings together colleagues from district and county and council, health services, wider and local VCSE sector organisations and other partners involved in the improvement to the health and wellbeing of Breckland residents, to make a positive impact to people's lives. The partnership will enhance integrated approaches and collaborative behaviours at every level and promote an ethos of partnership and co-production, working with communities and organisations addressing health and wellbeing challenges that no single organisation can address alone.

The Covid-19 pandemic has had direct and indirect impacts on health across the UK. Prior to the pandemic, indicators in Breckland were poor around mental health, cardiovascular disease, and alcohol consumption. Therefore, the Breckland HWP have already begun to take action to help tackle inequalities created and/or exacerbated by the Covid-19 pandemic in these areas.





Our Vision

Our Vision is to transform the way in which people access the right opportunities to improve their health and wellbeing. Through collaborative working, building resilient communities and by taking an evidence-based approach to the delivery of our priorities.



The Breckland Population



62% of adults are overweight or obese

58.9 per 100,000 residents die from cardiovascular



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392.3 per
100,000 emergency
hospital admissions
for alcohol specific
conditions



15.1% people smoke



Multiple areas in high levels of deprivation and loneliness compared with Norfolk average



12.9 per 100,000 residents die by suicide.

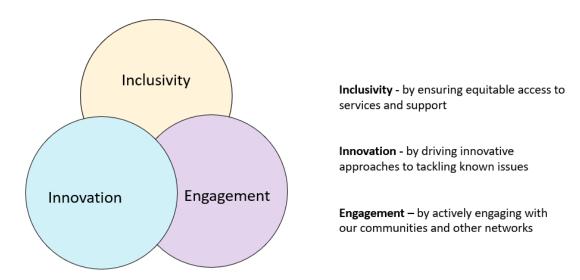


22.4% residents are lonely, higher than the Norfolk average





Priorities



How will we know we have achieved our priorities?

- ✓ Marked improvement in wellbeing, which will be evidenced in funded projects
- ✓ Reduced demand on public services, which will be evidenced through project evaluation
- ✓ All funding awards aligned to strategic priorities and offered on an evidence-based need.
- ✓ To see a significant improvement to workforce issues, including but not limited to quality hires, retention, and wider opportunities.
- ✓ Have an overarching data sharing agreement to enable the swift implementation of all projects delivered by or on behalf of the partnership.
- ✓ Provide appropriate access to the right opportunities in order to improve overall health and wellbeing.
- ✓ Breckland residents will be well informed of relevant self-help tools and resources, which will be evidenced through use of directory services and partnership feedback.

Challenges

- ➤ Cost of living Specifically within cost of living, Breckland is a largely rural district with lots of people using oil as their heating source which could increase risk of hardship with energy prices increasing globally
- Housing access to and availability of social housing. Due to elderly population, adaptions exceed current government funding
- Rural locality high prevalence of isolation due to poor transport links, leading to a feeling of loneliness
- > Areas of high deprivation particularly in Thetford, Dereham, Swaffham and Watton
- Low vaccine uptake
- Physical activity Attleborough has highest number of hip replacements e.g., high risk of falls





Action plan

Inclusivity

Innovation

Engagement

Tackling Health Inequalities in Breckland

Prevent Cardiovascular Disease
Improve Mental Health
Tackle issues arising from alcohol dependency and other alcohol related concerns

Funding & Assets

The partnership will ensure funded activity aligns to the priorities of the HWP. The partnership will identify funding opportunities and 'think outside the box' with how it utilises funding and assets to meet the collective aims of its beneficiaries.

Actions

Hardship

Use partner data to understand current need and predict future pressures. Identify existing provision and referral pathways - making recommendations to improve access and build capacity, where applicable. Plan a system-wide approach to managing current hardship.

Enablers

The partnership will identify and seek ways to overcome barriers to service delivery and manage service pressures & demands, including but not limited to workforce issues, IT Systems, data sharing agreements.

Vaccinations

The partnership will adhere to vaccination strategies by using its collective resources to promote vaccinations and review relevant data to identify uptake barriers, seeking out ways to overcome. Partnership will consider Winter pressures early and plan accordingly.

Engagement

Using the ICS Sub-group will People and support the aims Communities of the Active Now approach, programme by develop a plan to developing a maintain regular consistent contact with our approach to community embedding groups and physical activity organisations to into the health ensure they system, at a local always have a level. The group will define how to voice within the partnership. We utilise annual will develop local funding and activities to propose to the support the VCSE partnership to Place Leads. approve. Health Inclusion Group and PHM.

Physical Activity Housing

Develop a plan to reduce barriers to hospital discharge and respond to housing needs, such as adaptations to facilitate independent living. Design a system-approach to improve access to housing for people with health needs and improve the standards of rented homes to reduce health risks.