Patients and Communities Committee

Mon 25 March 2024, 15:00 - 17:00

Virtual

Agenda

15:00 - 15:00
0 min

Meeting Agenda

00. Patients and Communities Committee - March - FINAL.pdf (2 pages)

15:00 - 15:00
0 min

1. Chair's Welcome and Apologies for Absence

Information *Aliona Derrett*

15:00 - 15:00
0 min

2. Declarations of Interest

Information *Aliona Derrett*

To declare any interests specific to agenda items

02 Patients and Communities Committee register.pdf (3 pages)

15:00 - 15:00
0 min

3. Minutes from the Previous Meeting and Matters Arising

Decision *Aliona Derrett*

To approve the minutes from the previous meeting (21.1.24)

03 NW ICB PC Committee Minutes 22.01.24 DRAFT.pdf (14 pages)

15:00 - 15:00
0 min

4. Review Action Log

Review, update and approval *Aliona Derrett*

To note any outstanding actions from the previous meeting not yet completed

04. Patients and Communities Committee - Action Log MASTER 1.pdf (1 pages)

15:00 - 15:00
0 min

5. Spotlight on: Great Yarmouth and Waveney - Insights and Experiences

Information and discussion *Amrita Kulkarni and Shelley Ames*

05 Cover Sheet_GY Spotlight_25.3.24.pdf (3 pages)
05 i Spotlight on GY_PCC_25.3.24.pdf (8 pages)

15:00 - 15:00
0 min

6. Complaints Report

Information *Jon Punt*

For review and noting

06 March 2024 P & C Committee report v2.pdf (6 pages)

15:00 - 15:00
0 min

7. Population Health Management Strategy

Review and approval *Dr Sarah Gentry and Suzanne Meredith*

- 07 i Report cover sheet PHM.pdf (4 pages)
- 07 ii PHM Strategy Presentation.pdf (7 pages)
- 07 iii Population Health Management Strategy.pdf (29 pages)

15:00 - 15:00
0 min

8. Community Voices Update

Review and noting *Shelley Ames, Amrita Kulkarni, Nadia Jones*

- 08 CV update- P&CC 25.03.24.pdf (13 pages)

15:00 - 15:00
0 min

9. Place Board Updates

Review and noting *Mark Burgis and Carly West-Burnham*

- 09 Place slides - 25.03.24.pdf (9 pages)
- 09 West Norfolk Place Board Overview FINAL 140324.pdf (6 pages)

15:00 - 15:00
0 min

10. Healthwatch Updates

10.1. Healthwatch Suffolk - Asthma Survey

Review and noting *Luke Bacon*

- 10 i CYP Asthma Waveney Presentation - cover sheet.pdf (2 pages)
- 10 ii CYP Asthma Waveney Presentation.pdf (7 pages)

10.2. Healthwatch Norfolk

Review and noting *Alex Stewart*

- 10 iii Patients Commmunities Report - February 24 v1.pdf (18 pages)

15:00 - 15:00
0 min

11. Health Inequalities Framework

Review and approval *Tracy Williams and Nadia Jones*

- 11 HI Strategic Framework_Patients & Communities Committee.pdf (9 pages)
- 11 i N&W Health Inequalities Framework for Action_final draft V2.pdf (24 pages)

15:00 - 15:00
0 min

12. Population Health and Inequalities Board Update

Review and noting *Dr Frankie Swords*

- 12 i 2024.02.20_PHI Board Report Cover Sheet.pdf (2 pages)
- 12. ii 2024.02.20_PHI Board Assurance-Escalations- v4.pdf (2 pages)

15:00 - 15:00
0 min

13. Ageing Well Programme Board Update

Review and noting *Dr Frankie Swords*

- 13 Ageing Well Programme Cover Sheet.pdf (2 pages)
- 13 PCC Report - Ageing Well Programme - March 2024 (002).pdf (4 pages)

15:00 - 15:00
0 min

14. Any Other Business

Information and discussion *Aliona Derrett*

- People with Lived Experience Recruitment - Update (Rebecca Champion)

Meeting of the NHS Norfolk and Waveney ICB Patients & Communities Committee

Monday 25 March 2024, 1500-1700hrs

Meeting to be held via MS Teams

Item	Time	Agenda Item	Lead
1	15:00-15:15	**Chair's welcome and apologies for absence**	Chair
2		**Declarations of Interest** To declare any interests specific to agenda items ***For noting***	Chair
3		**Minutes from previous meeting and matters arising** To approve the minutes of the previous meeting (22.1.24) ***For approval***	Chair
4		**Action log** To note any outstanding actions from the previous meeting not yet completed ***For review, update, and approval***	Chair
5	15:15	**Spotlight on: GYW Place – Insights and Experiences** *For presentation and discussion*	Amrita Kulkarni & Shelley Ames
6	15:30	**Complaints Report** *For review and noting*	Jon Punt
7	15:40	**Population Health Management Strategy** *For review and approval*	Dr Sarah Gentry & Suzanne Meredith
8	15:50	**Community Voices Update** *For review and noting*	Shelley Ames, Amrita Kulkarni & Nadia Jones
9	16:00	**Place Board Updates** *For review and noting*	Mark Burgis & Carly West-Burnham
10	16:15 10mins 5mins	**Healthwatch Updates** • Healthwatch Suffolk – Asthma Survey • Healthwatch Norfolk *For review and noting*	Luke Bacon Alex Stewart
11	16:30	**Health Inequalities Framework** *For review and approval*	Tracy Williams & Nadia Jones
12	16:40	**Population Health and Inequalities Board Update** *For review and noting*	Dr Frankie Swords

Item	Time	Agenda Item	Lead
13	16:45	**Ageing Well Programme Board Update** *For review and noting*	Dr Frankie Swords
.14	16:50	**Any Other Business** • People with Lived Experience Recruitment - Update	Rebecca Champion
Date, time and venue of next meeting: Monday 20 May 2024, 1500-1700hrs via MS Teams			
Any queries or items for the next agenda please contact: rachael.parker9@nhs.net			

NHS Norfolk and Waveney Integrated Care Board (ICB)
Register of Interests

Declared interests of the Patients and Communities Committee

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Aliona Derrett	Non-Executive Member, Norfolk and Waveney ICB	Norfolk and Norwich University Hospital NHS FT				Indirect	My son-in-law, Richard Wharton, is a consultant surgeon at NNUHFT	2004	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Hear Norfolk	X			Direct	I am the Chief Executive Officer of Hear for Norfolk (Norfolk Deaf Association). The charity holds contracts with the N&W ICB	2010	Present	
		Derrett Consultancy Ltd	X			Direct	I am the Director of Derrett Consultancy Ltd	2018	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		MIND				Indirect	My husband, Robin Derrett, is the HR Director at Norfolk & Waveney MIND. MIND holds contracts with the N&W ICB	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		MoldovaDAR Ltd	X			Direct	I am Director of MoldovaDAR Ltd	2019	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		St Stephen's Gate Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Catherine Armor	Non-Executive Member, Norfolk and Waveney ICB	Educational Association			X	Direct	Trustee, Workers' Educational Association	Dec-23	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Norwich University of the Arts			X	Direct	Deputy Chair of Council, Norwich University of the Arts	2019	Present	
		Evolution Academy Trust			X	Direct	Trustee, Evolution Academy Trust	2022	Present	
		Cambridge University Press Pension Schemes		X		Direct	Trustee, Cambridge University Press Pension Schemes	2018	Present	
		East of England Ambulance Service NHS Trust				Indirect	Daughter-in-law is Technician for East of England Ambulance Service NHS Trust		Present	
		Brundall Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Paula Boyce	A representative from the Health and Wellbeing Partnerships	Great Yarmouth Borough Council	X			Direct	Employee of Great Yarmouth Borough Council	2023	Present	To be raised at all meetings to discuss prescribing or similar subject. Risk to be discussed on an individual basis. Individual to be prepared to leave the meeting if necessary.
		Emmaus, Norfolk and Waveney			X	Direct	Trustee and Board member of registered homeless charity Emmaus, Norfolk and Waveney	2023	Present	
Paul Benton	Director of Quality for care	Nothing to declare					N/A			N/A

Mark Burgis	Executive Director of Patients and Communities, Norfolk and Waveney ICB	Drayton Medical Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Lakenham Practice				Indirect	Wife is Nurse Prescriber who is currently undertaking occasional locum work at Lakenham Practice in Norwich	Aug-21	Present	Declare at any relevant meetings and remove myself from any significant discussions or decisions relating to the practice
Suzanne Meredith	Associate Director – Population health Management	Norfolk County Council	X			Direct	Employed by Norfolk County Council as Deputy Director of Public Health	2014	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		UKPHR		X		Direct	As part of Public Health professional requirements - Fellow of the Faculty of Public Health and professional registration on UKPHR	2014	Present	
		Hellesden Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Emma Ratzer	Partner Member - VCSE	Access Community Trust	X			Direct	I am the Chief Executive Officer of Access Community Trust, an organisation which holds contracts with NWICB	2009	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Community Access Trust
		VCSE Assembly			X	Direct	I am CEO of a voluntary sector organisation operating in NWCCG and Independent Chair of NWVCSE Assembly	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
Alex Stewart	Chief Executive, Healthwatch Norfolk	Member of Holt Medical Practice			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Dr Frankie Swords	Executive Medical Director, Norfolk and Waveney ICB	Norfolk and Norwich University Hospitals		X		Direct	Honorary Consultant Physician and Endocrinologist at Norfolk and Norwich University Hospitals NHS FT (1 day a week)	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest
		Multiple patient charities		X		Direct	Ad hoc Clinical Advisor for multiple patient charities - Addison Self Help Group - Pituitary Patient Support Group - Turner syndrome Society	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest
		British Medical Association		X		Direct	Member of the British Medical Association	1999	Present	Inform Chair and will not take part in any discussions or decisions relating to BMA
		Emerging Futures and St Martin's Housing Trust				Indirect	Husband is a mental health counsellor and undertakes work independently and with the private provider Better Help, and VCSE providers: Emerging Futures and St Martin's Housing Trust	Sep-22	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of counselling services by Emerging Futures, St Martin's Housing Trust or Better Help

		Long Stratton Medical Partnership			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Tracy Williams	Clinical Lead Health Inequalities and Inclusion Health, Specialty Adviser Norwich Place	North Norfolk Primary care	X				Employed 12 hours a week by North Norfolk Primary care, care taker of former Norwich Practices APMS contract, as a clinical Lead in the Inclusion Hub for vulnerable adults service .PCN Health Inequalities lead	Jul-20	Present	All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc
		Norfolk and Waveney Intergrated Care Board	X	X			Clinical lead for Health inequalities and inclusion health N&W ICB , Attend Quality and Safety Committee and ICP Partnership/H&WB Board, Norwich Place Clinical Adviser	Apr-23	Present	
		Queens Nursing Institute		X			Member of the Queens Nursing Institute	2012	Present	
		Royal college of Nursing		X			Member of the RCN	1987	Present	
		Faculty of Homeless and Health Inclusion		X			Member of the Faculty of Homeless and Health Inclusion awarded an Honorary fellowship March 2022	2014	Present	
		Norfolk and Norwich University Hospital			X		Sister employed registered nurse at NNUH		Present	
		Norfolk and Norwich University Hospital			X		Brother employed in an administration role at NNUH		Present	
Andy Yacoub	Chief Executive, Healthwatch Suffolk	Nothing to Declare	N/A				N/A	N/A		N/A
Jon Fox	Head of BI	Nothing to Declare	N/A				N/A	N/A		N/A

NHS Norfolk and Waveney Integrated Care Board

DRAFT Minutes of the Patients and Communities meeting

Held on Monday 22 January 2024

Meeting in Public

Committee members present:

- Aliona Derrett (AD), Non-Executive Director and Chair of the Patients and Communities Committee, NHS Norfolk and Waveney Integrated Care Board
- Suzanne Meredith (SM) Deputy Director of Public Health, Norfolk County Council and Associate Director of Population Health Management, NHS Norfolk and Waveney Integrated Care Board
- Paula Boyce (PB), Executive Director - People, Great Yarmouth Borough Council and representing the eight Norfolk and Waveney Health and Wellbeing Partnerships
- Tracy Williams (TW), Clinical Lead for Health Inequalities and Children, Young People and Maternity, NHS Norfolk and Waveney Integrated Care Board
- Cathy Armor (CA), Non-Executive Member and Deputy Chair of the Patients and Communities Committee, NHS Norfolk and Waveney Integrated Care Board
- Karin Bryant (KB), Associate Director of Local Commissioning, NHS Norfolk and Waveney Integrated Care Board
- Andy Yacoub (AY), Chief Executive Officer, Healthwatch Suffolk
- Dr Frankie Swords (FS), Executive Medical Director, NHS Norfolk and Waveney Integrated Care Board

Participants and observers in attendance:

- Caroline Williams (CW), Head of Engagement, Healthwatch Norfolk (attending for Alex Stewart and Judith Sharpe)
- Teresa Knowles (TW), Senior Nurse – Acutes, NHS Norfolk and Waveney Integrated Care Board for item 11
- Sheila Glenn (SG), Director of Planned Care and Cancer, NHS Norfolk and Waveney Integrated Care Board, for item 5.i
- William Snagge (WS), Senior Programme Manager, NHS Norfolk and Waveney Integrated Care Board, for item 7
- Sam Holmes (SH), Rethink Mental Health, for item 7
- Liz Joyce (LJ), Head of System Transformation, NHS Norfolk and Waveney Integrated Care Board, for item 6
- Dr Ardyn Ross (AR), Mental Health Clinical Lead, NHS Norfolk and Waveney Integrated Care Board, for item 5.ii

Attending to support the meeting:

- Rebecca Champion (RC), Senior Communications and Engagement Manager (Partnerships), NHS Norfolk and Waveney Integrated Care Board, and for item 13
- Rachael Parker (RP), Executive Assistant, NHS Norfolk and Waveney Integrated Care Board (Minutes)

1.	**Chairs welcome and apologies for absence**	
	Aliona Derrett (AD) welcomed everyone to the meeting. Apologies for absence had been received from Mark Burgis, Emma Ratzer and Alex Stewart.	
2.	**Declarations of Interest**	
	None declared.	
3.	**Agree Minutes from the Previous meeting and Matters Arising**	
	The minutes of the previous meeting were approved with the following amendment. It was noted that Karin Bryant's job title had been incorrectly recorded; Karin is Associate Director of Local Commissioning, not Associate Director of Commissioning as noted in the minutes. **Matters Arising** <u>Focus on Great Yarmouth insights and experiences:</u> It was noted that colleagues from the ICB and Healthwatch Norfolk had met, and connections made. In respect of Community Voices an introductory meeting had taken place with Shelley Ames, Caroline Williams and other colleagues and as a consequence work is now ongoing regarding how the qualitative datasets can be integrated. In terms of presenting the information to the Committee, AD suggested this item come to the March meeting, but if this were not achievable it could be deferred to May.	
4.	**Action Log**	
	The action log was reviewed, and the updates added to the log accordingly.	
5.i	**Spotlight on: Planned Care and Cancer Activity Update**	
	AD welcomed Sheila Glenn (SG) to the meeting to update on planned care and cancer. A paper and presentation had previously been circulated to the committee which were taken as read. SG explained that the Planned Care and Cancer team were very keen to ensure the committee had a good overview of everything they do, and whilst it would not be possible to provide in depth details at this meeting, SG was happy to provide more detail on any of the particular areas at future meetings. SG provided a very high level overview highlighting the work of the four sub teams within the Planned Care and Cancer team – cancer, elective access, long term condition national programmes, and system clinical programmes which are more akin to the future and that although this work has already started the teams are being aligned to continue that work after the restructure. Following SG presentation AD invited questions from the committee. Cathy Armor (CA) commented that it was good to see the improvements against the cancer targets but what are the main reasons why the targets are not currently being met. Dr Frankie Swords (FS) responded that there are primarily two reasons	

for this, for example women's cancers where the number of referrals has almost doubled in the last two years due to more widespread HRT use, and in skin where there is increasing awareness due to some high-profile public cases. The second reason is workforce and the reliance on a small number of people. For example, in one hospital there are four colorectal surgeons doing all the colorectal work and two of them were off sick for quite a prolonged period. There is nobody else who could do that work.

Tracy Williams (TW) commented on the comprehensive update and the large volume of work going on under the Directorate as a whole. TW asked, in relation to the some of the clinical programmes, how is primary care place engaged and utilised in the programmes. TW further asked how Core20 was being linked into the clinical programmes. In relation to place, SG responded that she meets regularly with local commissioning and primary care colleagues but acknowledged place could be better interlinked with the programme boards, who have asked if there could be some representation from place. However unfortunately place hasn't the capacity to do this. SG continued there are links into primary care depending on the niche or the programme that's being looked at, again it could be better but there's definitely a will there, so we use whatever mechanism we have to be able to have those conversations.

In relation to TW question regarding Core20, FS highlighted in the system clinical program boards, it is the five areas that have been nationally highlighted as most likely to underscore health inequalities that we have programme boards on. There is a specific one looking at chronic respiratory disease because we know that is one of the largest drivers of health inequalities in the country. We have a specific one looking at cardiovascular disease and CPD prevention and so on. So actually, that is how we've decided what to tackle by looking at the ones that make the biggest impact on health inequalities.

KB queried how one could onboard or offboard those clinical priorities, e.g., neurosciences which has been raised in various areas around neurology, rehab, etc. but it might come back to FS earlier point in terms of evidencing the scale of impact. FS responded that we do have that as part of the stroke team and the stroke work looks at one aspect of neuro rehab, they are not across the whole pathway.

SG commented there might be other things that come up and actually is that something the teams could take on – it is really an issue of capacity and priority. Priorities come from, and will be tied into, business planning and the priorities on an annual cycle. There will always be the odd thing that comes left field from Government, but overall, we want to be able to tie that in because ideally that should come from understanding our evidence, our understanding of what we need to do in relation to inequalities so trying to tie that back. Sometimes that will mean that as things come up, however worthy they may be, we have to say no because we've got to concentrate on absolutely nailing the things that we've said are our highest priority and will meet our needs.

SM also added the population health management database will also analyse that on a regular basis to look at where we know we've got opportunities in our system to make the biggest difference and the biggest impact. SM is sure that part of that information will be fed into the way work is prioritised going forward.

	SG agreed and noted her team is also working very closely with SM and their respective teams move back and forth in terms of understanding where they need to focus. AD sought reassurance that the website which is going to replace Knowledge Anglia is much more user friendly and will be easier to navigate and update. SG responded that she believed it was part of the procurement and was absolutely one of the key criteria and would be seen in action quite soon. Although SG hadn't seen it demonstrated in its totality the feedback she had heard up to now is that it should be easier to navigate but obviously it will have to be tested with patients. FS added the patient facing aspects will be hosted on the internet site whereas the provider / directory of services will be on the Knowledge NoW side, and individual directorates will have admin rights rather than having a single point of failure with one or two people who hold the key. AD commented, in relation to the first slide in SG presentation and cancer transformation, is SG and her team aware Macmillan Cancer is funding Community Action Norfolk for three years to do some preventative cancer work. AD suggested the cancer team might want to link with Community Action Norfolk to find out what that's about. It was noted that the cancer team were aware of this and supporting the partnership and it is being aligned with community voices. AD thanked SG for attending the meeting and for the work her and her team are doing in the background.	
5.ii	**Spotlight on: Community Mental Health Transformation**	
	AD welcomed Dr Ardyn Ross (AR), the ICB's Mental Health Clinical Lead, to the meeting to provide an update on Community Mental Health Transformation. A paper and presentation had previously been circulated to the committee which was taken as read. AR gave an overview of the mental health pathways including: • N&W Mental Health Strategy and the six commitments • National context for Adult MH Community transformation • Our local vision • Key principles • The New Community MH landscape and some of the offers available • Primary care MH and Advice and Guidance • Community Interface Service and Community therapy service • Personality Disorder / Complex Emotional Needs, Eating Disorders AD thanked AR for the presentations and invited questions from the committee. In relation to the equity of access approach and how that's being supported, TW asked is there any feedback on how people are supported to navigate the entry points TW also queried in relation to the community based roles which support primary care and the 17PCNs (and recognising the different population demographics amongst those), is there any population health management approach to what the roles are and how many there will be. AR responded in relation to TW first question around the entry points and agreed it could potentially	

be quite confusing for people trying to navigate those pathways, and there is certainly much more work to do around developing a directory of services and around people understanding how it works.

AR went on to explain about an important piece of work undertaken with some of the primary care PCNs linked to the navigation work, to raise awareness of the different roles. The care navigation teams have received training on who might be appropriate for which service. NHS Talking Therapies has also been linked in so practices can directly task them, and therapies can be organised more quickly.

In terms of ensuring inequalities work and the needs of individual populations, AR said the aim is to make the offer as bespoke as possible, but there is more work to do. Working closely with the experts by experience and community listeners, who are employed through organisations such as Access, and go into those communities and do the listening work and then bring that to a reference group which is populated by experts by experience, and that also feeds into other work too.

SM asked, how does prevention and wellbeing fit into the model, noting that public health have a role in supporting these elements too. AR responded it is something the experts by experience are very passionate about, meeting those needs that are aligned to mental health. Physical health and mental health are intertwined, and often people's mental health is rooted in financial and other social issues, so one important piece of work is linking our social prescribers and primary care mental health teams. Within the hubs there are other organisations such as Citizens Advice and other VCSE organisations going in which really support people with those issues. For those people most severely affected by their SMI, there are rehab teams populated by people who have a real understanding of how to access additional support in the community around housing and finances, for example.

AD commented that the community transformation work has been ongoing for some time now, so how close is it to becoming business as usual, bearing in mind that the information advice part is still to be fully implemented. AR responded that this is the last year of community transformation, a lot of work has been achieved and our primary care mental health teams are largely in place. Further work is required around the clinical relationships between the hubs and the sanctuaries and building and strengthening those pathways. The other crucial element is around the advice and guidance; the psychiatrists are not yet in place to do the important piece of work to keep people in primary care, so we don't need to step them up, as well as support for the mental health practitioners, risk sharing and medicines deprescribing. AR continued that it was never the intention for this to be the last piece of the transformation work, but it is reliant on some reengineering and completion of secondary care and CRHT and CMHT transformation work coming together with the community transformation work, but that is landing now.

Emma Willey (EW) added the reengineering work has been a key piece of work that hasn't progressed as planned. The intention was to work with NSFT to look at reviewing and modernising community mental health teams. For various reasons this hasn't been done but that is a priority for 2024/25 because whilst these fantastic new services are in place, the joining up is really important, but there is some duplication and batting back and forth which is completely unhelpful and proving disruptive. That is something that needs taking forward and requires more time to embed the new model as well, to ensure everyone is aware that everybody

	is working in a joined up and knowledgeable way and are all on the same page which takes time. In response to a comment FS had made in the meeting chat regarding deprescribing, AR agreed there is lots of work taking place in the deprescribing space. However, one of the issues, particularly for primary care, is the confidence around deprescribing people with mental health conditions, particularly those people who are complex. There's a real lack of confidence to do that without a psychiatrist supporting you. Although everybody is aware of the STOMP STAMP guidance it is really hard to actually enact it and our mental health clinical pharmacists don't quite fit into that role enough. We need our psychiatric colleagues to really take that piece of work forward. AD commented it does seem that quite a lot of progress has been made. There is still a bit to go, but the finishing line is getting closer and as long as we have an improvement for our community and the way they access the services, which is the test really. AD on behalf of the committee thanked AR and the teams in the background who have been working on this.	
6.	**Transformation Board Update**	
	AD welcomed Liz Joyce (LJ), Head of System Transformation for the N&W ICB to the meeting and invited her to update on the work of the Transformation Board. A paper had previously been circulated to the committee which was taken as read. LJ highlighted the report sets out and spans the activities of the Transformation Board feeder groups which cover a wide range of issues that the Transformation Board has been looking at since its last report to the committee last November. The report is also seeking the support of the Patients and Communities Committee with the proposed approach to the Joint Forward Plan refresh. LJ explained the Transformation Board has a number of ambitions and has tried to coordinate activity, demonstrate strategies and ensure workstreams align and join up to prevent duplication. It was noted this is likely to be the last report of the Transformation Board due to the creation of the Commissioning and Performance Committee. In relation to the Joint Forward Plan (JFP), LJ recognised there had been some really excellent progress in a number of the ambitions (population health management, prevention, health inequalities, and children and young people) however for the ambitions linked to primary care, urgent and emergency care, and elective recovery, progress had been more challenging due to the impact of industrial action as well as issues linked to workforce, and demand and capacity. LJ advised, there will be a light touch refresh to the JFP for next year and this is now underway. Other key areas of focus highlighted in the Transformation Report include • Clinical Strategy alignment • Community Services Review • Transition of the commissioning of specialised services from NHSE to the ICB	

	AD thanked LJ for the update and the clear and concise report. AD asked if committee members were happy to support the proposed approach to the JFP refresh. The committee approved the proposed approach. In relation to the Community Services Review moving to the Commissioning and Performance committee, AD sought reassurance that the committee will not just focus on money, performance or numbers, but the impact of the new community services will be evaluated to identify whether they are making a difference to the N&W population. AD asked LJ if there was a process or framework the committee will follow to measure this. FS responded that this was a little difficult to answer but felt the best way to answer it in future would be by looking at both the integrated performance report which currently goes to the performance committee (but will instead go to the Performance and Commissioning Committee), and the quality dashboard which should be signed off at the ICB Board on 23 January. The quality dashboard pulls together an enormous amount of metrics e.g. are cancers being detected earlier, are people surviving longer, is our experience of urgent and emergency care access better, are our waiting times better in mental health. All of those metrics relate to how it feels on the ground for the quality of service patients are receiving. AD commented that it is important the new committee does consider the impact and does not lose sight of this important aspect. KB added that in terms of the Community Services Review, she has flagged, and it has been recognised, there is no route of escalation and there are some queries on the governance so that will be picked up and addressed. In relation to the JFP and the clinical strategy, FS advised that a proposal is being put forward to align the publication dates of these two documents, to avoid any confusion.	
7.	**ICS Mental Health Coproduction Strategy**	
	AD welcomed William Snagge (WS), Senior Programme Manager in the ICB Strategic Mental Health commissioning team and Samantha Holmes (SH) from Rethink Mental Illness to the meeting to update on the ICS Mental Health Coproduction Strategy. A paper and presentation had previously been circulated to the committee which was taken as read. WS explained the purpose of attending today's committee was to i. give an update on the work undertaken thus far to develop and publish an all age mental health coproduction strategy, and ii. to introduce the draft strategy as it currently is and to obtain the committees endorsement of the strategy and the plans to develop a final strategy and the associated work to do that. WS advised this work will help to assure the ICB that it is delivering its function in a way that meets the needs of patients and communities, and engagement and feedback from local people and groups is obviously at the core of this work, as is addressing and reducing health inequalities. It also aligns with some NHSE guidance 'Working in partnership with people and communities' which explains how ICS' will respond to the ten principles when working with people in communities. WS added there was strong participation from families and carers and seldom heard communities in this work. Following WS and SH presentation, AD invited questions from the committee.	

	TW asked if the principles for this particular coproduction strategy can apply to other groups e.g. Core20Plus, linking synergies, sharing learning, and working together, rather than recreating something. WS responded that yes there are lots of synergies and would welcome the opportunity to have a conversation with TW around that to see what learning we can contribute. WS added that Shelley Ames and SH facilitated a session recently on the new framework with experts by experience already contributing to the framework and welcome the opportunity continue that development. AD added it will be good to integrated and have one toolkit rather than having versions of toolkits. Paula Boyce (PB) commented that although the work sounds good, as representative of all eight health and wellbeing partnerships this is the first time she has heard of the mental health coproduction strategy. As such, PB's request to WS and SH is can you ensure the governance that is already in place, e.g. the five place boards and the eight health and wellbeing partnerships of which Great Yarmouth alone has 35 partners around the table, are engaged in this. PB also sought clarification that this was a strategy to coproduce a mental health strategy it is not a mental health strategy. WS confirmed it is not a mental health strategy, it's a coproduction strategy, so it's a framework for ensuring that we coproduce mental health services and support effectively in the future on an ongoing basis. PB responded that she thought there will be a lot of the community-based partners that WS and PH need to speak to and hear from within those partnerships. It was noted that Healthwatch Suffolk have a lot of expertise at coproduction. WS agreed to contact Andy Yacoub for further input. AD thanked WS and PH for their update and asked that the committees' thanks and appreciation be passed on to members of the community who have contributed to the strategy getting to this point.	
8..	**Ageing Well Programme Board Update – Strategic Framework**	
	AD invited FS to update on the Ageing Well Programme Board and the Strategic Framework. Papers had previously been circulated to the committee which were taken as read. FS highlighted the ambition of the Norfolk and Waveney system was to help residents live longer, healthier, happier lives. It is particularly important to support our increasingly ageing population because of our demographic, to experience the best possible quality of life and maintain independence. Two workshops were held, the first in May 2023 which explored potential themes for the ageing well strategy and the second in December, where the themes and content of the draft Ageing Well Strategic Framework were tested and defined. A few final tweaks were made to the framework at the first Ageing Well Programme Board that was held on 11 January, and the framework had come to today's Patients and Communities Committee for sign off. FS explained the framework has nine different areas across three phases – preparing for later life, active aging, and frailer and more vulnerable older people, and the idea is that the framework can be used by individual providers and the system can use the framework to identify any gaps in services that need to be addressed.	

	AD thanked FS for the update and commented that the framework is very detailed and easy to follow, and AD found contextualising the matrix part very helpful. Furthermore, the workshops and health processes have been very well run and AD asked FS to congratulate her team and everyone in the background; AD is still receiving emails requesting information, so the communication is also working well. AD invited questions from the committee. Cathy Armor (CA) asked, if you're an older well person who has never needed to access any services, how do you get onto the prevention phase in the first place. FS responded that her team are working closely with public health because a lot of what CA is referring to is about public health and designing much broader services in the NHS. The second thing to highlight is there are other pinch points e.g. finding people who have high blood pressure but don't know they have high blood pressure. We want to help them take the medication even though they feel fine because we know that will reduce their chance of getting cardiovascular disease, stroke and dementia, so that is an active intervention. Similarly with Osteoporosis and women going through menopause who will have no idea what their osteoporosis risk is until they have a tumble, break a hip, and find themselves in need of care. So, there are opportunities to find, tackle and reduce those risk factors in advance but they're not necessarily already patients, so it's our public health and the broader determinants of our prevention agenda in health that aim to tackle these. SM commented how pleasing it is from a public health perspective that prevention is one of the elements of the ageing well framework. Public health is very involved with helping support and develop this, we all know we need this framework and it's really important that we do this. SM continued that in terms of prevention as a system, the health and wellbeing partnerships have a very active role to play in all the areas that FS has mentioned. Older people are an asset to our system and it's very exciting from a public health perspective, and we're very pleased to see this framework coming. FS responded that it was pleasing to have the support of public health, including the fact one of the four workstreams is being chaired and led by public health colleagues. KB asked what governance and oversight is in place to ensure that places for example are delivering the strategy. FS responded that the last Patients and Communities Committee agreed the terms of reference for the Ageing Well Programme board, and it has met for the first time. It's a bimonthly meeting but it's really important that the programme board doesn't own everything. There are a few priority areas which the board will be leading on systemwide but what is really important is for the individual places to use the strategy to identify what is needed locally, so it's absolutely for the localities to be leading on and working with their health and wellbeing and place boards. AD thanked FS for her responses and asked the committee if they were happy to approve the Ageing Well Strategic Framework. The committee approved the framework. Alex Stewart had provided the following feedback in relation to the strategic framework via email in advance of the meeting which was shared with FS and SG: *I have no problem in signing off the strategy. That said, I am disappointed that nowhere in the strategy is there any mention of evaluating how successful the*	

	strategy is, nor are there any timescales as to how information will be reported back to this committee and the public.	
9.	**Population Health and Health Inequalities Update**	
	AD invited FS to update on the work of the Population Health and Health Inequalities Board. A paper has previously been circulated which was taken as read. FS reminded the committee that the Population Health and Health Inequalities Board meets on a bi-monthly basis and provides assurance and escalation to the committee. FS highlighted the following points: • The ICS Population Health Management and Health Inequalities Strategies are on track for completion in March 2024 • The risk associated with the process for Equality Impact Assessments (EIAs). A very useful discussion has taken place with local authority and district council colleagues and a task and finish group has been established to develop a detailed plan on the implementation of a systemwide process for completing EIAs • Core20Plus – recommending that the armed forces community is recognised as an additional plus group for N&W • Community Health and Wellbeing Workers Pilot in Watton which has successfully supported individuals living in an area of high deprivation and involved door knocking on 200 of the most deprived households	
10..	**Links Between Quality and Commissioning**	
	AD invited Karin Bryant (KB) to inform the committee on the links between quality and commissioning. A paper and presentation had previously been circulated to the committee and were taken as read. KB began by explaining this item had come from a discussion at a previous committee and a request to know more about how commissioning and quality teams work together. KB was responding on behalf of the ICBs local commissioning team, which covers central Norfolk for both planned and unplanned care as well as community commissioning across the N&W footprint. KB highlighted the following: • KB is a member of the Quality and Safety Committee and the team have a number of risks on the Committee Risk Register. There is regular liaison in terms of ensuring the risks are meaningful and we are doing all we can to mitigate • The Local Commissioning team participated in the development of the quality strategy which KB felt had worked very well in terms of exchanging views. • There are a number of examples of joint working between local commissioning and quality teams, for example the catheter pathway work. The quality team is also invited to join local commissioning working groups or if there are particular provider contracting or performance issues.	

	• The local commissioning team is one of several commissioning teams; there will be commissioning happening in, for example, the children and young people, and mental health teams. • The local commissioning team may change with the new ICB structure, when there will be a single commissioning team. AD thanked KB and commented that she did not realise the commissioning teams are not part of one team but different specialities which makes it difficult to know where the commissioning sits. FS commented that current commissioning is done in multiple pockets but when the new structure goes live in April, there will be a central commissioning team which will address that exact issue. AD concluded by recognising the work of the local commissioning team and its efforts to link in with quality.	
11.	**Monitoring Mortality Rates Across the System and the Norfolk and Waveney Learning from Deaths (LFD) Forum**	
	AD welcomed Teresa Knowles (TK) to the meeting to provide some insight into the monitoring of mortality rates across the system and the Norfolk and Waveney Learning from Deaths (LFD) forum. A paper had previously been circulated to the committee which was taken has read. TK acknowledged the paper circulated was a direct lift from a paper FS had prepared and presented to the ICB Board the previous year. TK picked out some salient points from the paper to share with the committee. • The paper provides an overview of mortality monitoring across our system, the work of the Norfolk and Waveney Learning from Deaths Forum, and the rollout of the Medical Examiner Service. It includes details on how deaths are scrutinised, registered and the systems duty to learn from the deaths of our patients. It was noted that scrutiny is statutory for all NHS providers and currently 100% of deaths occurring in our acute hospitals are now scrutinised by a medical examiner and the medical examiner service is being rolled out to also include all community deaths. • In December 2023 some new Death certification reforms were released which changes practices around who can certificate a death and what that means to individuals. • There is a medical examiner officer based in each of our acute hospitals and the medical examiner service is being rolled out to include all deaths in the community as well, in preparation for this becoming a statutory requirement from April 2024. This means there will be independent scrutiny of a death by a medical examiner or an investigation by a coroner, and all deaths will be scrutinised in the system. There will then more opportunity to share and to learn from those as we move forward. • The Norfolk and Waveney Learning from Deaths Forum has been running since February 2023. It is chaired by Dr Frankie Swords who was the instigator of the forum, and it is co-chaired by Stuart Lines, the Director of Public Health. • There is a rolling programme where providers come to the forum to present their mortality metrics or to talk through any learning that they've identified from individual reviews of deaths, and then to share those with attendees.	

	• Thematic reviews are also undertaken including from local alerts, so they may, for example, conduct a review of the care of every patient who dies within an intensive care unit. Or where an alert has come through from the national system, because there's been a change in the overall number of deaths or within a specific disease or a population group, or any tragic high-profile cases. AD thanked TK for the paper and for presenting the information so clearly. AD asked for clarification in relation to the medical examiner service and the roll out to the community and does this mean they will be appointed by the community and mental health trusts. FS responded it is quite a specialist thing to do and you have to be a very experienced doctor - you have to have training and you work closely with the medical Examiner officer and so it has been determined nationally that it will be based out of the acute trusts, but our three medical examiner teams are currently reviewing about 80 community deaths a month. The NNUH is going to be scrutinising all NSFTs deaths and NNUH is already scrutinising all hospice deaths, Priscilla Bacon Lodge, for example. The James Paget is already scrutinising all deaths in certain care homes and certain GPs, similarly with the QEH. So every single death occurring across our community, whether it's in a community trust, a hospice, a mental health trust, and acute or at home or elsewhere, they will all have gone through either a medical examiner or the coroner from April 2024. SM asked whether the Medical Examiner service is just for adults because there is already quite a robust process in place for children. FS responded that children are not included, but the children's process comes to the Learning from Deaths forum as well. So we're not reinventing it, although it does apply to all deaths of people with LD&A, it doesn't replace the LeDeR rev. s of those deaths, but they will still have a medical examiner scrutiny. But yes, for children it is separate. TW commented that certainly as a clinician, learning from deaths is important in improving practice and informing how pathways could be different. TW continued that she is a member of the Drug and Alcohol Related Death Panel and is there a link between the drug and alcohol panel and learning from death panel. FS responded that there is a member of the Drug and Alcohol Related Death Panel on the Learning from Deaths Forum along with LeDeR and local maternity and neonatal representation. AD thanked TK for presenting today and thanked FS and TK for the excellent work around this.	
12..	**Healthwatch Suffolk Update**	
	AD invited Andy Yacoub (AY) to provide a highlight update to the committee. AY highlighted the following points: • Healthwatch Suffolk (HWS) have seen a positive change in access for people into GP practices. The surgeries have certainly had more patients 'through the door' and the feedback gained has been more positive. • A while ago, Phlebotomy was brought back into the surgeries in Waveney (previously delivered by ECCH). There continues to be valuable feedback about this, and the timing of appointments is not an issue (unlike many	

	comments reported in the rest of east Suffolk, where people wait many weeks, or have to go to hospital for them). • Concerns around 'wheelchair services' was raised. The issue was about an inappropriately sized replacement wheelchair being provided, and no consultation prior to such a change. Dangers of falling out of the wheelchair was one of the concerns. Thanks to Jennie Starling (N&W ICB) for working with the provider in order to resolve the situation. The service user is now being offered some different options for lightweight wheelchairs or powered models, depending on her preference. • The usual access to Dental and shortage of some medication at pharmacies has come up. The POD (Pharmacy on Demand) survey outcomes may help resolve some public concerns. • We were asked by two GP practices to assist in gaining new PPG members, one was pretty much from scratch. It seems that holding together a productive PPG is difficult, and we have been made aware of such issues across Suffolk, not just Waveney. It is worth noting, that practices do not seem to get guidance from the NHS on this. • Beccles practice are trialling 'AI robot' voice to text tech this month. This will give patients who are waiting in the call queue the option to have AI fill in the 'patches' form over the phone. HWS asked how they will gauge its success and they suggested that if people use it, they will know it is successful. HWS encouraged the practice have a way for patients to feedback. HWS have had no response from the practice. It's an interesting development, but we fear it could lead to further frustration. AD thanked AY for the update. It was noted that HWS will be providing an update regarding the outcome of the Asthma survey at the next meeting in March.	
13.	**Warm and Well Campaign Update**	
	AD invited Rebecca Champion (RC) to provide a brief update on the Warm and Well Campaign. RC explained that rather than providing a list of the work that the comms and engagement teams are working on, it would be more helpful to look at individual projects, particularly systemwide projects, to keep the committee informed about the work taking place. It was noted the Warm and Well Campaign is now led by Norfolk County Council (having taken over from the ICB last year) and the campaign has been running for a number of years. RC presented some slides which showed the activity across the provider webpages. The ICS webpage is focussed on finding the right health service and the county council webpage is much more around living costs, utility bills and hardship in particular the hardship scheme. RC explained that last year's campaign had been highly successful and as such the assets (materials and resources) had been updated and reused this year. The social media reach is particularly good and paid Facebook advertising is really effective at closely targeting the people we want to reach out to. RC went on to update about the healthcheck campaign which ran last year and aims to try and increase bookings in the areas of deprivation with low take up. There had already been a good uptake at the midpoint of the campaign. January will start to see more outdoor adverts e.g. on buses, and messaging will focus on	

	social isolation, mental health and post-Christmas hardships e.g. blue January. Leaflet door drops in targeted areas are also starting on 22 January. AD thanked RC for the update and added that feedback from one of the working groups of a health and wellbeing partnership was to receive information as hard copy rather than digitally, so it is good to have the two options.	
14.	Any Other Business	
	FS asked whether the committee should consider having a risk register. AD responded that she will be asking RP to organise a meeting of the committee, to reflect on the committee meetings and any elements that are missing, which will include a risk register. **Action: A meeting of the committee to be organised to reflect on the committee and discuss plans for the next financial year**	**RP**
Date, time, and venue of next meeting: Monday 25 March 2024, 1500-1700hrs via MS Teams		

Minutes agreed as accurate record of meeting:

Signed: …… Date: ……...
Chair

Code
RED Overdue
AMBER Update due for next Committee
GREEN Update given
BLUE Action Closed
PURPLE Action has a longer timescale

Improving lives together
Norfolk and Waveney Integrated Care System

Norfolk & Waveney ICB Patients and Communities Committee
Action Log

No	Meeting date added	Description	Owner	Action Required	Action Undertaken / Progress	Due date	Status
11	24.7.23	Children & Young People update to come to a future meeting	R Hulme	Update to include service user / patient feedback and examples of progress made, impact and outcomes and the difference the improvements are making to residents	15.1.24: Awaiting confirmation whether R Hulme can update at May's meeting 18.3.24: R Hulme unable to attend in May, awaiting confirmation whether another member of the CYP team can provide an update instead	***20.5.24 tbc***	
12	25.9.23	HWS Asthma Survey	A Yacoub	HWS to update at November's meeting on the outcome of the asthma survey	27.11.23: Asthma survey findings and key learning - agenda item for March meeting	25.3.24 ~~27.11.23~~	
16	25.9.23	Integration with VSCE	M Burgis	M Burgis to pass on AD thoughts from the meeting to D Williams around clairfying issues and improving engagement with the VCSE sector	27.11.23: MB has feedback to D Williams and the wider team and this is being acted on. VCSE Assembly update to be an agenda item for January's meeting 18.3.24: Update deferred to a future meeting	22.1.24 ~~27.11.23~~	
19 (actions 4 & 10 merged 27.11.23)	27.11.23 action 4 raised 30.1.23 action 10 raised 24.7.23	Lived experience representative	PH / RC	*(Action #4)* Committee members to provide feedback to PH. Reflect at March meeting as to where we are and what adaptations have been made to the current plan to take this forward *(Action #10)* MB and PH to ensure lived experience representation for the PH&I Board is linked into the Patients and Communities Committee lived experience representation work currently underway	The pack has been finalised and shared widely for comment with partner organisations, stakeholders and forums. Comments will then be factored into the final pack. Roles expected to be advertised late March 2023. 22.5.23: Working through some HMRC issues relating to payment method and policy, but hopeful that a policy already in use in some London trusts and HMRC approved, can be used in Norfolk and Waveney. 24.7.23: Ongoing. Continuing to work with HMRC and ICB Finance colleagues to ensure suitable policy is in place prior to recruitment commencing 25.9.23: Draft recruitment packs have been circulated to the committee. Still awaiting confirmation from HMRC regarding a suitable policy 27.11.23: HMRC has requested to have sight of the paperwork the ICB will use to pay lived experience representatives *27.11.23 Actions 4 and 10 merged as both linked to Lived Experience Representatives* 15.1.24: ICB Finance team still awaiting a response / update from HMRC	25.3.24 ~~22.1.24~~ ~~27.11.23~~ ~~25.9.23~~ ~~22.5.23~~ ~~23.3.23~~	
20	22.1.24	Focus on Great Yarmouth - Insights and Experiences	SA	Item to come to the March meeting (but if this is not achievable it could be deferred to May)	18.3.24: Agenda item for March meeting	25.3.24	
21	22.1.24	Patients and Communities Committee Planning Session	RP	Planning session to be organised to reflect on the committee's first year and plan for the next financial year		25.3.24	

Norfolk and Waveney
Integrated Care Board

Agenda item: 5

Subject:	**Spotlight on Great Yarmouth Insights**
Presented by:	**Shelley Ames, Senior Integration & Partnerships Manager, NWICB** **Alex Stewart, Chief Executive, Healthwatch**
Prepared by:	**Shelley Ames, Senior Integration & Partnerships Manager, NWICB** **Alex Stewart, Chief Executive, Healthwatch**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**25.03.24**

Purpose of paper:

To provide an update on actions undertaken to explore collaboration opportunities between Healthwatch Norfolk and the ICS Community Voices programme.

Report

In response to actions taken at previous Patient & Communities Committee meetings opportunities have been explored between Healthwatch Norfolk and the Community Voices programme, which is delivered via a multi-agency approach led by the Integrated Care Board.

Community Voices supports access to services by training trusted communicators, in VCSE and local government organisations, to understand signs and symptoms, services that are available and risk factors relating to conditions or behaviours. As part of this approach to improve health literacy in communities we ask our trusted communicators to report back their insights, which are held in an insight bank.

Community Voices is not a universal programme – it seeks to engage seldom heard voices through organisations that have developed relationships with particular groups. It provides insights into communities not traditionally engaged via other mechanisms, including those that frequently do not access health and care services. As such Community Voices does not report the insights of large numbers of the population, rather focusing resources on those with greatest need.

These insights highlight key themes and trends, as demonstrated by the accompanying presentation slides. Given the remit of Healthwatch Norfolk (and Suffolk) there will be other insights collated through their engagement mechanisms that can help to create a ‘richer picture’ of communities of interest.

This presentation, created by partners at Great Yarmouth Borough Council, highlights the data collated by Community Voices in recent months in Great Yarmouth. It reflects both positive and negative sentiments shared by communities that experience health inequalities.

It is recognised that by combining our qualitative insights together we can gain a better understanding of our communities – of the barriers they face, what may enable them to make healthier choices or access services, and how we can make changes in the way we design and deliver services. There are many other agencies that collect qualitative insights, and these are not routinely shared.

We are working with the ICB Data Hub team to scope how we might start to bring together qualitative insights for our system into one place, exploring opportunities such as Natural Language Processing (NLP) to automate where we can. The development of a qualitative ‘Insight Bank’ that partners can access is one action we plan to take over the coming months and will enable a richer picture from the qualitative data insights we are already collecting in our system.

We are also committed to strengthening partnership working between our Healthwatch organisations and the Community Voices programme, and as part of the Health Inequalities Framework implementation will seek to embed consideration for qualitative insights to better learn from our communities into all of our processes.
.

Recommendation to the Committee:

To note progress made and support next steps.

Key Risks	
Clinical and Quality:	Health inequalities are avoidable, unfair and systematic differences in health between different groups of people, which impact on longer term health outcomes and a person's ability to access healthcare. This work is fundamental to the delivery of our ambitions in relation to Prevention and addressing Health Inequalities. There is a risk we do not achieve the impact we seek if we do not develop the infrastructure, the culture and approaches advocated as best practice.
Finance and Performance:	None identified
Impact Assessment (environmental and equalities):	N/A
Reputation:	Reputational risk associated with lack of response to insights generated.
Legal:	Compliance with legal duties pertaining to health inequalities
Information Governance:	None identified
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	1. The NHS provides a comprehensive service, available to all 3. The NHS aspires to the highest standards of excellence and professionalism 4. The patient will be at the heart of everything the NHS does 5. The NHS works across organisational boundaries 6. The NHS is committed to providing best value for taxpayers' money 7. The NHS is accountable to the public, communities, and patients that it serves
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	

Governance

Process/Committee approval with date(s) (as appropriate)	

Improving lives **together**

Norfolk and Waveney Integrated Care System

Spotlight on Great Yarmouth Insights

Shelley Ames, Senior Integration & Partnerships Manager, NWICB

Alex Stewart, Chief Executive, Healthwatch Norfolk

Introduction

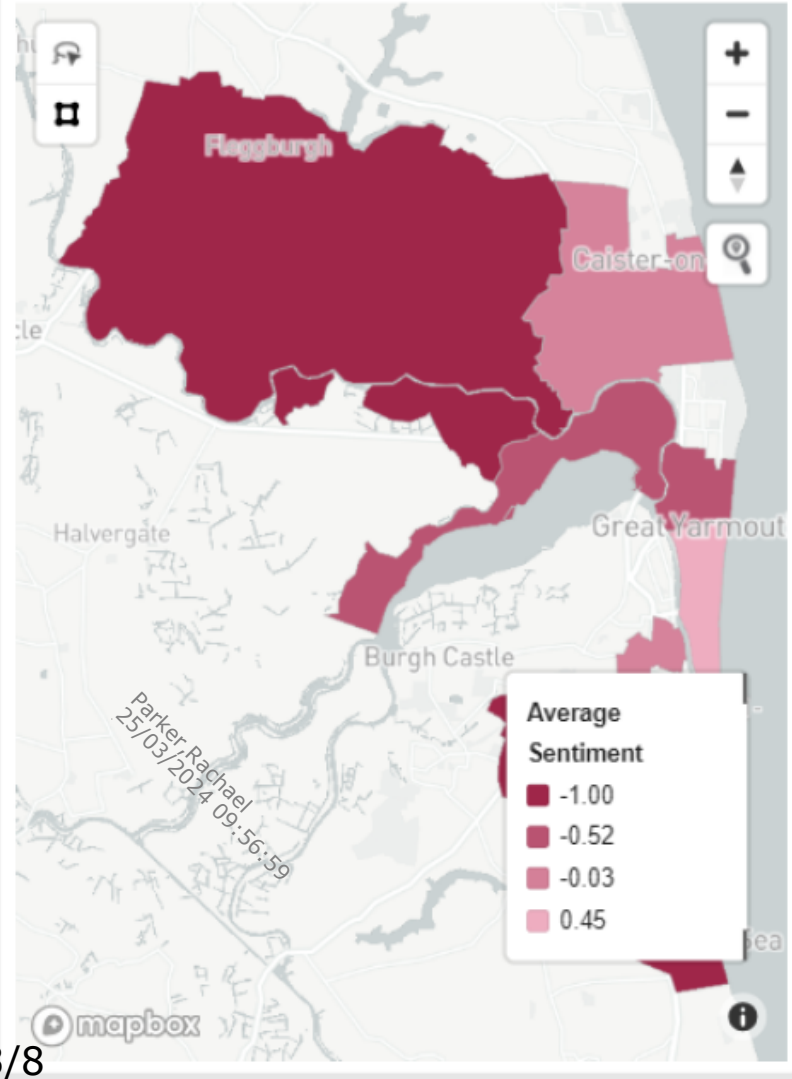
- Ongoing conversations relating to Community Voices and a strategic partnership with our Healthwatch organisations
- Delivery models very different – as is primary purpose of the engagement
- All approaches generate **qualitative insights** relating to groups that experience health inequalities
- Opportunity to combine our insights to understand key themes and trends
- More detailed interrogation sometimes required - opportunities for further engagement and/or research
- Combining insights currently a manual process requiring significant resource – this is our first step

Trust in health services

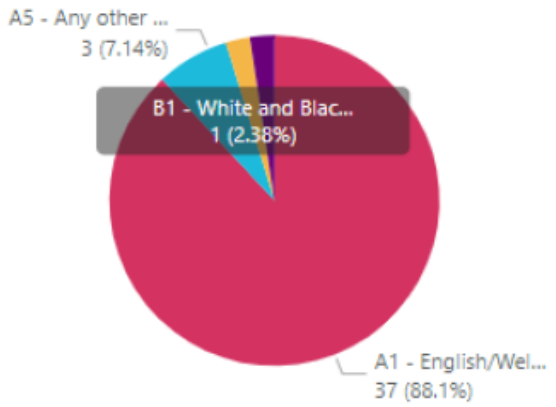
44 Community Voices conversations related to the chosen content in Great Yarmouth.
People aged **16 - 24yrs** spoke the **most positively** about the chosen content, while people aged **65 - 74yrs** spoke the **most negatively**.

Community Voices
Using your feedback to improve care

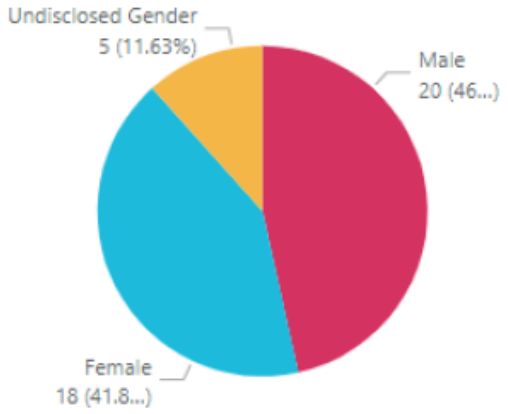
Average Sentiment by Area



Conversations by Ethnicity



Conversations by Gender



- There is a reasonably high level of trust in health services in conversations held in Great Yarmouth compared to other geographic areas.
- Trust is often contingent on the perceived competence and attentiveness of healthcare providers, as well as the consistency of care received.
- However, there are also concerns about the stretched resources of the healthcare system, especially in the context of long waiting lists and limited access to services, which contributes to a lack of trust among some residents.
- Breakdowns in communication between health services are major causes for a lack of trust, with patients not being sure their diagnoses have been transferred, and express frustration with not being heard, difficulties in obtaining timely information when communicating with health services themselves.

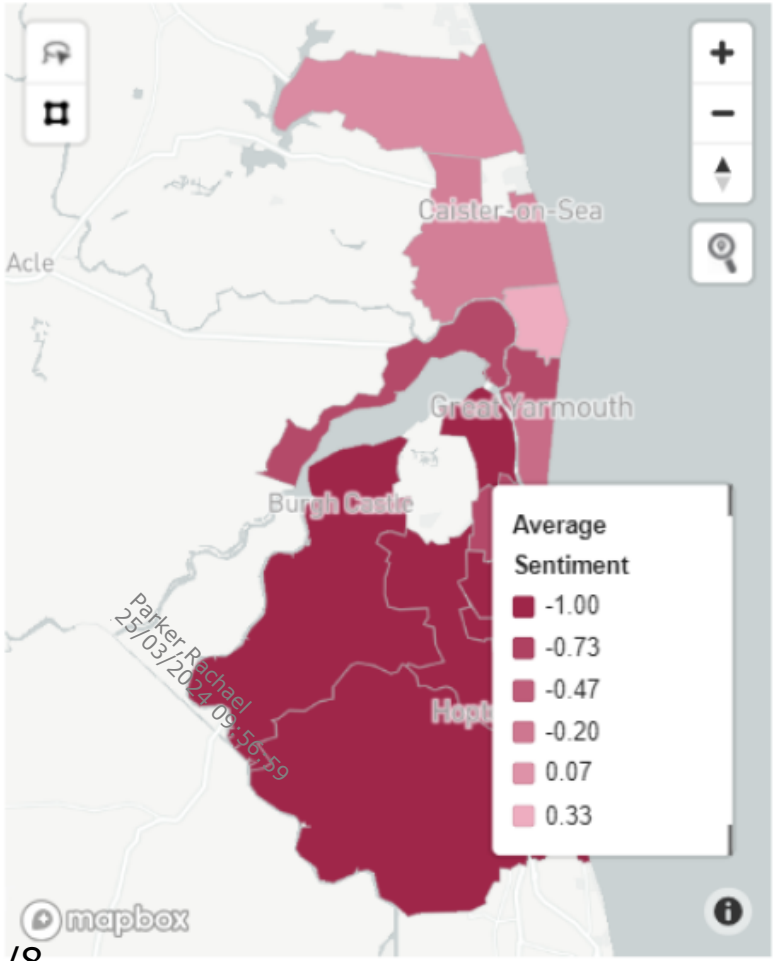
"she no longer had any faith in the health service because it is not there to use anymore"
Conversation Quote

Accessibility of health services

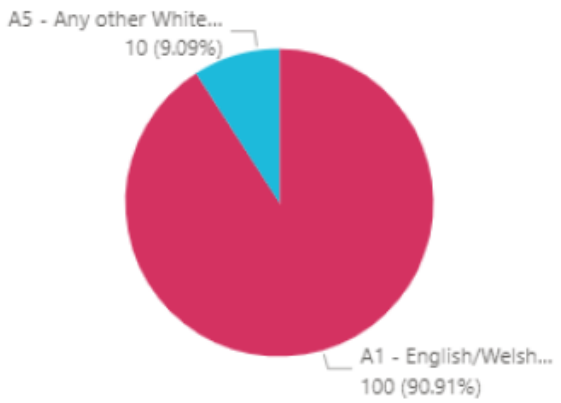
122 Community Voices conversations related to the chosen content. People aged **16 - 24yrs** spoke the **most positively** about the chosen content, while people aged **25 - 34yrs** spoke the **most negatively**. People from a **E2 - Any other ethnic group** background spoke **most positively** about the chosen content, and people from a **A3 - Gypsy or Irish Traveller** background spoke the **most negatively**. Within the topic, **Accessibility of GP surgery** was the most common topic raised. **Accessibility of COVID-19 Vaccinations** was spoken about **most positively**, and **Availability of walk-in centres** was spoken about the **most negatively**.

Community Voices
Using your feedback to improve care

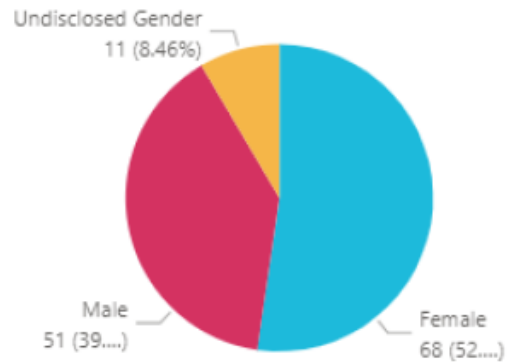
Average Sentiment by Area



Conversations by Ethnicity



Conversations by Gender



- Language barriers are the most commonly reported barrier to accessing health services in Great Yarmouth, either due to speaking English as a second language, or due to a lack of understanding of medical terminology.
- Financial constraints are also highlighted as barriers to accessing health services, including the cost of private treatments, phone bills for accessing services, and inability to afford prescription delivery services.
- The accessibility of specialist care, particularly mental health care is a common issue raised by respondents in Great Yarmouth, who can see General Practitioners as barriers rather than enablers of access to hospital treatment.

"the healthcare is a bit harder to say is perfect at the moment .To get an appointment with a family doctor take ages.To get appointment with duty doctors they all have different opinions.You must have a serious health issue to get a good check up"

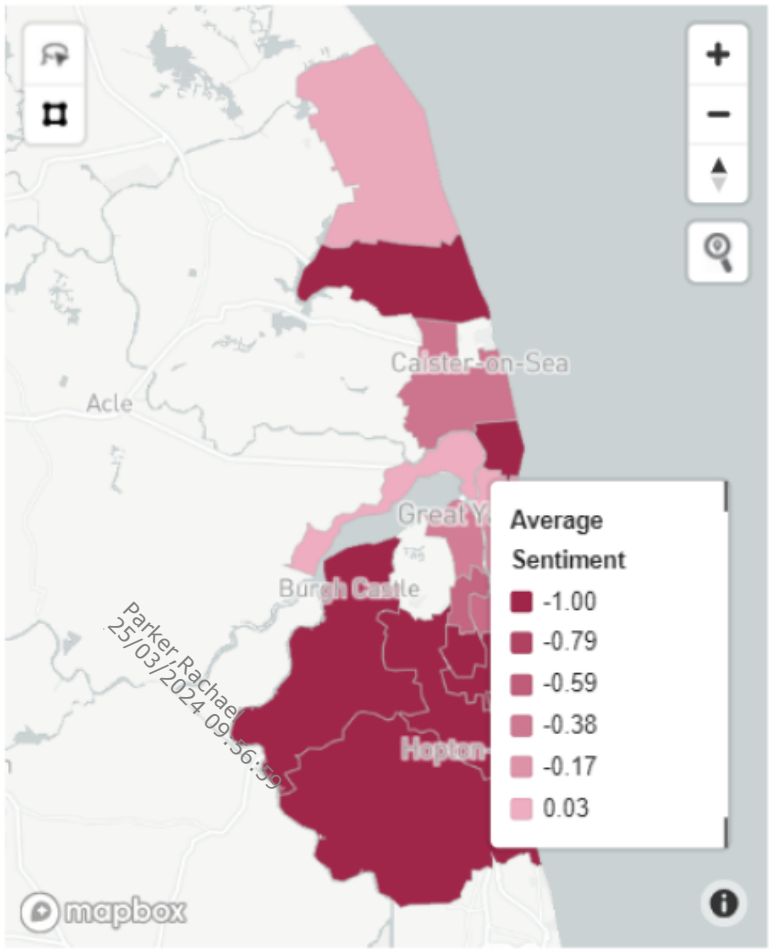
Conversation Quote

General practice & doctors

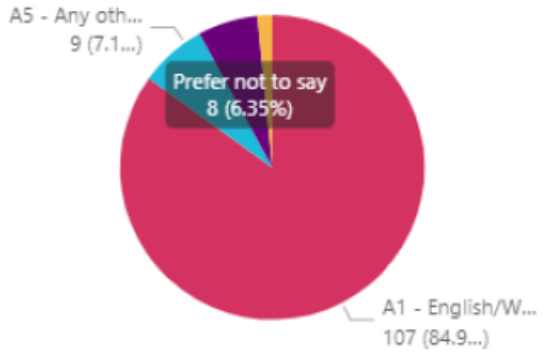
118 Community Voices conversations related to the chosen content. People aged **65 - 74yrs** spoke the **most positively** about the chosen content, while people aged **16 - 24yrs** spoke the **most negatively**. People from a **B2 - White and Black African** background spoke **most positively** about the chosen content, and people from a **B1 - White and Black Caribbean** background spoke the **most negatively**. Within the topic, **General Practitioners** was the most common topic raised. **General Practitioners** was spoken about **most positively**, and **Contacting GP reception by phone** was spoken about the **most negatively**.

Community Voices
Using your feedback to improve care

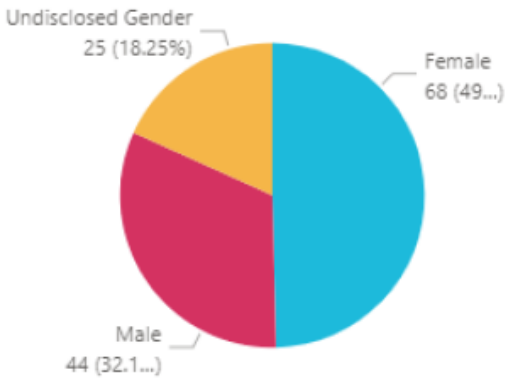
Average Sentiment by Area



Conversations by Ethnicity



Conversations by Gender



- There are mixed responses to online booking systems for GP appointments, with those who speak positively suggesting that limitations remain, such as only being able to access the website during opening hours.
- Frustration with waiting times has reduced since conversations began and pandemic pressures have eased, but frustration with a perceived transition away from face-to-face appointments remains among some respondents.
- The attitude of reception staff is mentioned as a barrier, particularly when accessing surgeries over the phone.
- There is a perceived lack of continuity in care when doctors change from appointment to appointment, and there is a perception that respondents can feel they are being rushed through appointments.

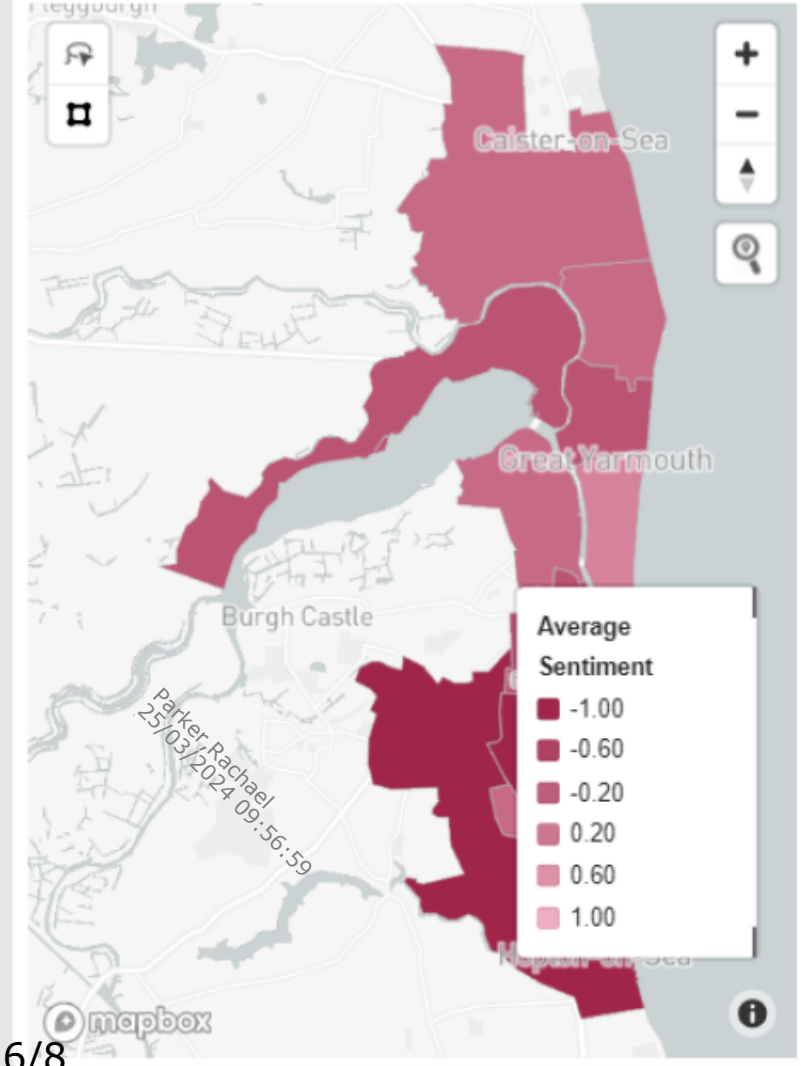
"The receptionists can be rude and not very understanding"
Conversation Quote

Healthy lifestyles

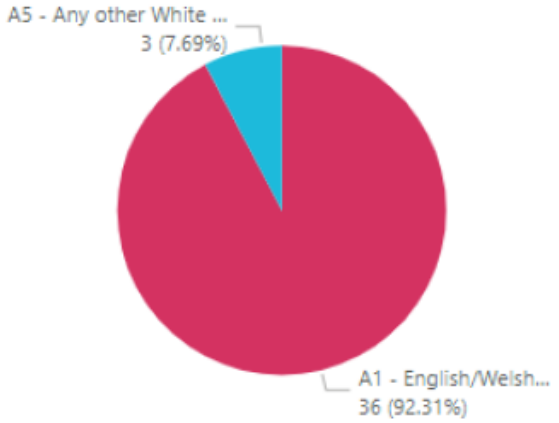
42 Community Voices conversations related to the chosen content. People aged **75+ yrs** spoke the **most positively** about the chosen content, while people aged **65 - 74yrs** spoke the **most negatively**. Within the topic, **Exercise** was the most common topic raised. **Exercise** was spoken about **most positively**, and **Access to exercise facilities** was spoken about the **most negatively**.

Community Voices
Using your feedback to improve care

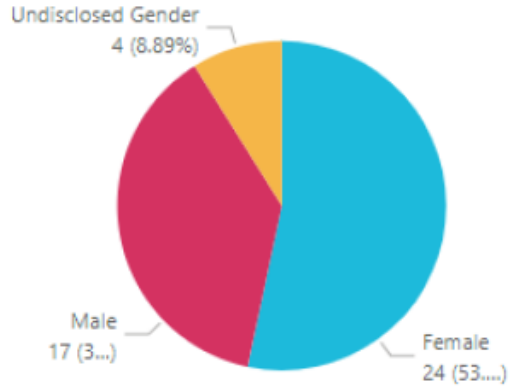
Average Sentiment by Area



Conversations by Ethnicity



Conversations by Gender



- Healthy lifestyles are a particularly common topic for people who are concerned with ageing
- Financial constraints are seen as a significant barrier to maintaining a healthy lifestyle for many respondents. Some mention difficulties affording nutritious food, and the difficulties they face maintaining a a healthy lifestyle while using a food bank, or costs preventing them from accessing exercise facilities.
- Several respondents discussed their struggles with smoking cessation, indicating a desire to quit for health reasons but facing challenges such as addiction, stress, and dissatisfaction with available cessation support services.
- Some residents express a desire for a holistic approach to health, including physical, mental, and financial wellbeing to support their overall health and lifestyle management. Some see community groups as a version of this holistic approach in action.

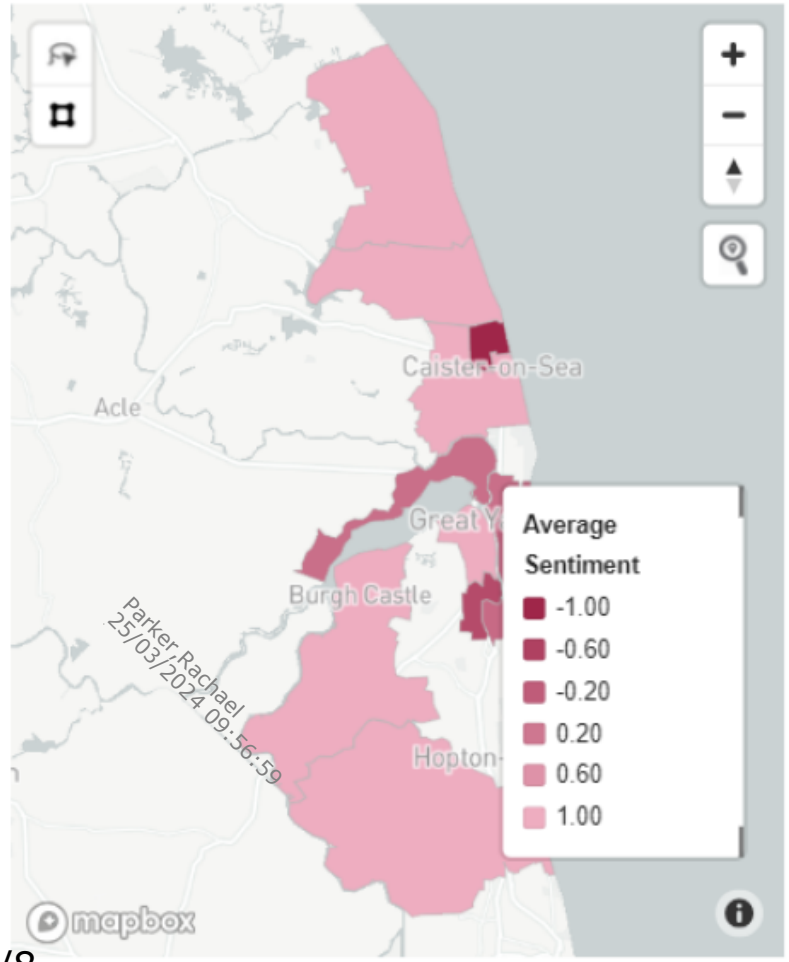
"there should be more accessible and affordable exercise"
Conversation Quote

Standard of medical treatment

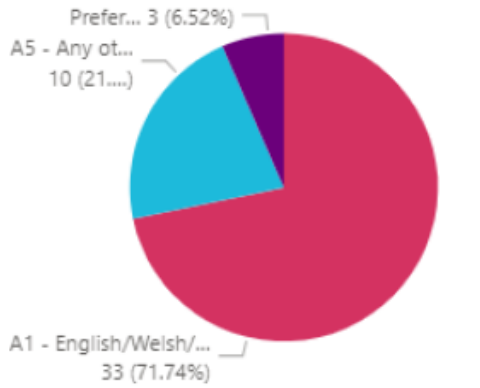
44 Community Voices conversations related to the chosen content. People aged **16 - 24yrs** spoke the **most positively** about the chosen content, while people aged **27 - 34yrs** spoke the **most negatively**. People from a **Prefer not to say** background spoke **most positively** about the chosen content, and people from a **A4 - Roma** background spoke the **most negatively**. Within the topic, **Health Service Staff attitude** was the most common topic raised. **Inpatient experience** was spoken about **most positively**, and **Paediatric Support** was spoken about the **most negatively**.

Community Voices
Using your feedback to improve care

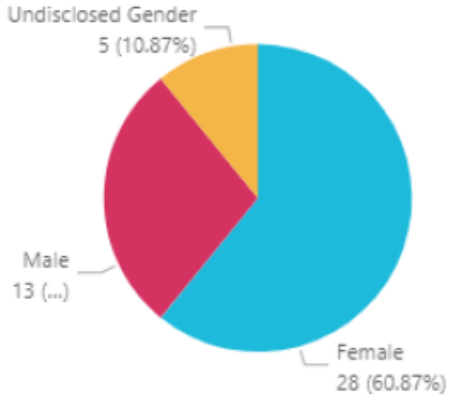
Average Sentiment by Area



Conversations by Ethnicity



Conversations by Gender



- Feedback on the standard of medical treatment varies widely in Great Yarmouth, with negative responses often reflecting a feeling of being dismissed or not listened to, or a lack of follow-up care
- When assessing their satisfaction with medical treatment, much value is placed by respondents on the attitude of health service staff, particularly reception staff, with positive responses reflecting on compassion and clear communication of medical professionals.
- The perceived efficiency of experiences is mentioned, but does not appear as frequently in conversations as good communication and compassion.
- Where respondents mention receiving treatment for serious health conditions such as heart failure or cancer, excellent care is often emphasised.

"The NHS is very good and I have received excellent service over the years and recently."
Conversation Quote

Summary & next steps

Summary

- By combining our insights we gain a richer understanding
- Opportunity to look at geographies as well as thematic areas of focus
- Community Voices identifies themes, some warrant further interrogation which HWN may be able to provide
- We are providing the insights – responsibility lies with the system to respond
- Health Inequalities Framework implementation will identify opportunities to embed in process – governance review, commissioning processes, EHIA's etc
- Data Hub – opportunity to pool qualitative insights, with Community Voices building the platform

Next steps

- Sharing insights to support action i.e. primary care strategy, practices encouraged to consider rolling out Health Inequalities Training
- Continued collaboration between HWN/HWS and Community Voices
- Continued development of Data Hub to 'house' qualitative' insights and make them available to the system
- Implementation of HI Framework – embedding qualitative insights into decision making processes
- Governance review – how do we best 'plug' our insights in to the system

Norfolk and Waveney
Integrated Care Board

Agenda item: 6

Subject:	**Complaints and Enquiries activity – summary of Q1 to Q3 2023-24**
Presented by:	**Jon Punt, Complaints and Enquiries Manager**
Prepared by:	**Jon Punt, Complaints and Enquiries Manager**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**25 March 2024**

Purpose of paper:

This paper provides further detail on the formal complaints and informal concerns/queries that the ICB has received during 2023/24, up until 31 December 2023 (quarters 1 to 3)

Executive Summary:

The ICB has seen a steady increase in contacts in 2023/24, this paper seeks to detail the reasons behind this, while offering insight into the themes and trends behind the contacts received and the learning taken from some specific cases.

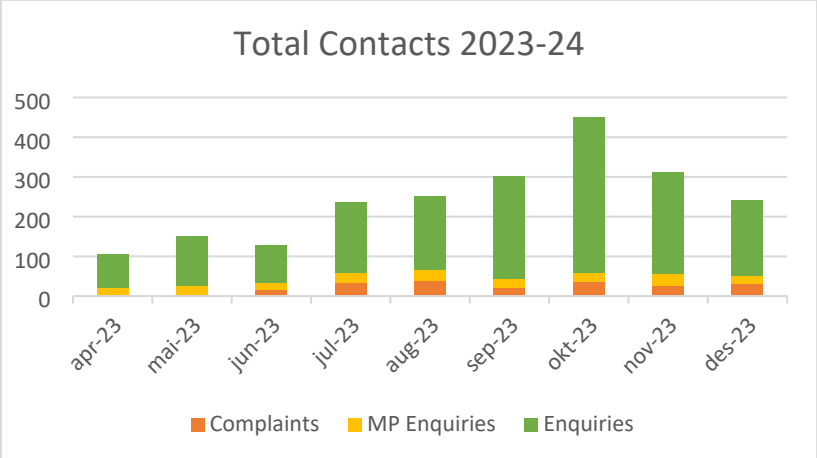
2023/24 volumes

The ICB has seen an exponential rise in the volume of contacts received during the year, compared to 2022/23.

This is primarily due to the full delegation of handling complaints and concerns regarding primary care from NHS England to ICBs.

This occurred in shadow form on 1 April 2023 and then fully on 1 July 2023. This dramatically increased the number of contacts from 1 July 2023 and was more than the initial indicative numbers NHS England advised the ICB could expect.

The total volume of contacts received monthly is displayed in the graph below.



- 204 formal complaints have been received across the reporting period, compared to 44 over the same period in the previous year, an increase of 364 percent. 159 of these complaints were relating to primary care services.

- 207 MP enquiries were received, compared to 187 during Q1 to Q3 2022-23, an increase of 11 percent.

- Informal enquiries have increased only slightly during the reporting period (1763 in 2023-24 from 1753 in 2022-23), however if looking specifically at the period post delegation of primary care complaints/concerns the percentile increase is much sharper. This was due to the fact Q1 in 2022-23 was very busy with queries regarding the vaccination programme.

- When looking at just Q2 and Q3 of 2023-24, 1459 enquiries were received compared to 1017 for the same period in 2022-23, an increase of 43 percent.

Performance against KPIs

Acknowledgements - of the 204 formal complaints received, 199 (98 percent) were acknowledged within the target timescale of three working days.

Response times - of the 154 complaints which have been closed so far, 98 have been responded to within the target timescale the ICB sets of 30 working days.

At the time of writing, 27 were sent after the 30 working days, while the remaining 29 cases were closed either due to consent not being received, insufficient detail available to proceed with the complaint, or an alternative means of resolution was found.

Therefore, of the applicable cases responded to, 78 percent were within the target timescale.

That being said, the team have an open caseload of 46 complaints, 13 of which have already gone beyond the 30 working day target timescale and are not included in the figures above.

In addition to this work, the team inherited a caseload of 47 formal complaints which transferred over from NHS England's regional complaints team, who previously managed primary care complaints. Most of these cases were responded to quickly and closed within six weeks of the ICB receiving them.

However, two cases are still active and were reliant on receiving information from clinical reviewers before they can be concluded and responded to. The Complaints and Enquiries team are actively chasing the required information so these cases can be finalised.

There are no specific target timescales for the ICB to handle informal enquiries or queries from Members of Parliament. However, the team look to resolve these as swiftly as possible and at the time of writing 1709 of the 1763 enquiries had been responded to.

In addition, of the 207 MP queries received, 197 have been responded to with the remaining being live matters.

Trends and themes

Access to dentistry - Access to NHS dentistry was the largest area of formal complaint and received the highest number of contacts across the reporting period. This consisted of 65 formal complaints, 270 informal enquiries and 42 MP enquiries.

Many people were raising their experience in trying to obtain NHS treatment without success. These contacts included difficulties in getting up-to-date information about practices taking on new NHS patients, with patients having to spend a lot of time contacting individual providers. Patients also described issues in obtaining urgent or emergency treatment.

Access to GP Practices – A large proportion of contacts received about primary care related to people raising issues about the way in which they access their GP practice. This was made up of 15 formal complaints, 40 enquiries 20 MP queries.

As detailed previous in reports to the committee, typically the areas of dissatisfaction are around appointments not being immediately available, or the time patients are waiting to get through to their practice.

Continuing Healthcare (CHC) Formal Complaints - While only 14 formal complaints have been received regarding NHS CHC, it is worth noting the majority of these (ten) have been received in Q3, with five received in December 2023 alone. This might point to an increasing trend in complaints, and has been referencing issues such as:

- A lack of communication with patients and their families
- Processes not being followed

- Staff attitude
- Appeals and eligibility

Elective treatment delays – across all three acute hospitals in Norfolk and Waveney 36 informal concerns and 22 MP queries have been received about delays in patients being seen for elective treatment.

The Complaints and Enquiries team has attempted to de-escalate these concerns wherever possible, signposting to resources available locally around what patients can do while they wait.

Learning from complaints

Pharmacy branch closures – A number of branch closures of pharmacies has seen increased wait times for patients in receiving their medication.

It has also placed additional pressures on staff. Where appropriate, the ICB will be working with local teams and providers to ensure affected patients are aware of alternative ways they can obtain their prescriptions, possibly through home delivery services or online pharmacies.

CHC complaints – complainants have been citing long delays in getting retrospective assessments completed for consideration of CHC.

It had been acknowledged that the CHC team experienced a number of operational delays and pressures however at that time, the ICB were recruiting a team to deliver completion of the CHC retrospective work, which has taken longer than expected.

The lack of communication about the status of the assessments has been identified as impact on families. Had regular updates been provided, or a willingness to be candid about the situation, could have avoided the additional stresses and anxieties felt by the family. Consideration has been given to how any future delays can be more pro-actively communicated, and how the patients waiting the longest can be prioritised when new staff are full embedded.

Children and Young People's Continuing Care – because of a change in legislation, it was identified that carers were no longer able to support on holidays for young people, which were outside of their usual travel distances.

As the contract for care is between the ICB and the agency, rather than the agency and the family, this has led to the need to develop an agreed approach, so all families are aware of what support is available. There are many challenges relating to asking an agency to provide care away from home and it is the responsibility of the ICB to consider these alongside the beneficial effects of the holiday for the young person and their family. The ICB's Children and Young People's Team are taking this forward.

Primary care missed opportunities - The ICB has received complaints concerning late referrals for potential cancers and the need to undertake further investigations.

This has identified learning whereby clinicians could not only improve their record keeping, but also in what more they can do to discuss risks and benefits of investigations with their patients.

Dental patients affected by cancer treatment – following feedback from local MPs around difficulties in access, the ICB is now developing a specific pathway for patients who have been left with their teeth weakened after cancer treatment.

Waits for Neurodevelopmental Service for Children and Young People – Long waits to be assessed for a potential autism or ADHD diagnosis has been a regular theme, which has seen the ICB's Children's and Young people's Team develop better literature and signposting advice for families. This is with a view to not only helping them seek support while waiting, but offering potential alternative providers under the NHS' Right to Choose.

Future development work – so what next?

The Complaints and Enquiries Team will become the Patient Experience team as part of the ICB recent restructure.

Moving forward as the service increases a focus on a broader patient experience, better triangulation of information will be sought with colleagues in providers and the ICB. Initial conversations around patient experience networks across the system are ongoing.

Recommendation to the Committee:

To note the contents of the report

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	N/A
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	

Norfolk and Waveney
Integrated Care Board

Agenda item: 7

Subject:	**Population Health Management Strategy**
Presented by:	**Sarah Gentry, Public Health Registrar** **Suzanne Meredith, Associate Director Population Health Management**
Prepared by:	**Sarah Gentry, Public Health Registrar** **Suzanne Meredith, Associate Director Population Health Management**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**25/03/2024**

Purpose of paper:

To present a final draft of the Population Health Management (PHM) Strategy for feedback and sign off by the Norfolk and Waveney Integrated Care Board Patients and Communities Committee, with the aim of publishing the strategy on April 1st 2024.

Executive Summary:

The Norfolk and Waveney Joint Forward Plan contains an objective under Ambition 1 to develop a Population Health Management Strategy by the end of March 2024. A draft strategy has been developed (attached at Appendix A).

The PHM strategy sets out plans for how Norfolk and Waveney Integrated Care System will proactively use joined up data to support improvements in health and wellbeing.

The draft PHM strategy was developed through a consultation and feedback process, conducted as part of a series of engagement events and presentations at key professional fora. A significant review of the existing literature and relevant local and national strategies was also undertaken.

The PHM Strategy aligns closely with the Health Inequalities Strategic Framework for Action.

The strategy development was overseen by the PHM Oversight group (PHMOG) and the content has been endorsed by the Population Health and Inequalities Board.

Report

1. Background

Ambition 1 in the Norfolk and Waveney Joint Forward Plan sets out an objective to develop a Population Health Management Strategy:

"to proactively use joined up data and to put in place targeted support to deliver improvements in health and wellbeing. The strategy will include our plans for how we will be using data, how we will be developing our ICS-wide intelligence function and a single analytical platform to carry out relevant analysis to support our local decision making and planning and how we will evaluate our programme.

This proactive approach will be focussed on prevention, reducing inequalities and improving the quality of care. It will also be driven by our knowledge of local communities, and by partners working together to identify new things that can really help to improve health."

2. The PHM strategy development process

The draft PHM strategy (Appendix A) has been developed as follows:

- The PHMOG oversaw the development of the strategy
- A small editorial team was established, including clinical advisors
- A review of existing good practice from other areas and relevant national and local strategies
- Iterations around a series of drafts – including a working draft vision, aims/objectives, benefits, working principles, initial system priorities (see Appendix A)
- Three engagement events were held (September 2023 - January 2024), which tested the working content and invited feedback on priority setting and how the strategy should be implemented. These events were well attended and included a range of different representatives including BI, IG, Place and partnerships, Public Health, Quality, Clinicians, primary care and VCSE representatives and other providers.
- Close alignment was assured with close working with the team leading the development of the Health Inequalities Strategic framework for action
- A series of case studies were developed with system partners for inclusion in the strategy
- The strategy was presented for feedback to the Clinical and Care Professional assembly, the multi-professional forum and the Public Health senior management team.
- The strategy final draft content was endorsed by the Population Health and Inequalities Board in February 2024.

3. Next steps

- The aim is to publish the strategy on April 1st as per the timeline in the JFP, once it is signed off by the Patient and Communities Committee.

- The PHMOG will continue to oversee development of plans for implementation and dissemination, together with a framework for monitoring impact.

Recommendation to the Committee:

a) Note the content of the draft PHM strategy (Appendix A) and provide any final feedback
b) Sign-off the draft PHM strategy for publication on April 1st 2024

Key Risks	
Clinical and Quality:	PHM is a systematic way of working to understand the health and care needs of our population and put in place new models of care to deliver improvements in health and well-being. It is fundamental to the delivery of our ambitions in relation to Prevention and addressing Health Inequalities. There is a risk we do not achieve the impact we seek if we do not develop the infrastructure, the culture and approaches advocated as best practice.
Finance and Performance:	PHM has the potential to support improvements in performance and demand through delivery of evidence-based, proactive, targeted interventions. There may be a financial risk in terms of establishing the infrastructure needed to deliver a PHM programme at scale.
Impact Assessment (environmental and equalities):	PHM is a key approach to addressing Health Inequalities.
Reputation:	The development of the PHM strategy is a JFP objective and there is a high expectation that this will be delivered in line with the JFP timescales.
Legal:	N/A
Information Governance:	Conforming to all IG requirements is fundamental to our PHM strategy.
Resource Required:	To deliver a system-wide PHM programme to meet our ICS ambitions, input is required from a wide range of different teams across the system, to review the health needs of the population and plan new models of service delivery. There is a risk that there will not be the capacity, particularly in clinical teams, to deliver the interventions.
Reference document(s):	N/A
NHS Constitution:	1. The NHS provides a comprehensive service, available to all 3. The NHS aspires to the highest standards of excellence and professionalism

	4. The patient will be at the heart of everything the NHS does 5. The NHS works across organisational boundaries 6. The NHS is committed to providing best value for taxpayers' money 7. The NHS is accountable to the public, communities, and patients that it serves
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	BAF 06

Governance

Process/Committee approval with date(s) (as appropriate)	

Appendix A- Draft PHM Strategy

Improving lives **together**

Norfolk and Waveney Integrated Care System

Patients and Communities Committee – 25.3.24
Item 7: Population Health Management Strategy

Population Health Management Strategy

Patients and Communities Committee

25th March 2024

How and why this strategy was developed

Joint Forward Plan eight Ambitions and underpinning objectives

Ambition	Ambition Objective
1	**PHM, Reducing Inequalities & Supporting Prevention**
1a	Development and delivery of two strategies: A Population Health Management Strategy, and a Norfolk and Waveney Health Inequalities Strategy to deliver the "Core20PLUS5" approach

Workshop 1

- How can we, as an ICS, work together to deliver our PHM priorities?

Workshop 2

- SOAR analysis considering the Strengths, Opportunities, Aspirations and Results of our PHM approach.

Workshop 3

- How will you apply the PHM Strategy in your role, and who do you think you need to link with to make this happen?

Parker Rachael 25/03/2024 09:56:59

Population Health Management

Know

- Gathering insight and data about health and the wider aspects that impact a person's health such as housing and employment.
- Identifying where best to focus collective resources for greatest impact and targeted prevention.
- Monitoring impact, driving continuous improvement and measuring success.

Connect

- Connecting all of us working to improve health outcomes across health, social care, public services and the voluntary sector.
- Ensuring people receive the right service at the right time, by the right people.

Prevent

- Changing the focus of healthcare from reactive care to proactive, preventative care.
- Helping us reduce health inequalities and develop long-term health solutions.
- Supporting people to live their healthiest lives, based on what matters to them and making every contact count.

Proactive, targeted healthcare for your community

Visit the Population Health Academy to find out more about how it can help you.

Vision

Deliver proactive, targeted care and support to help people and communities live healthier lives

Smoking & smoking in pregnancy

- 9,640 fewer smokers if Norfolk &Waveney (N&W) met England average prevalence.
- National ambition to be 'smokefree' (prevalence <5%) by 2030.
- 245 fewer mothers smoking at the end of pregnancy per year if N&W met England average rates.
- ICS ambition to reduce smoking in pregnancy from 12% to 9% by 2026 and then 6% by 2028.

Serious mental illness

- 660 more people with SMI with a comprehensive care plan in place if N&W met England average rates, reducing risk of self-harm.
- People with SMI also in the most deprived 20% of the population have 6,090 more unplanned acute hospital admissions compared to the ICB average.

Cardiovascular disease, diabetes & respiratory

- 330 more people with AF would have their stroke risk better managed if N&W met England average rates.
- Lowering blood pressure, detecting and managing AF, and better management of COPD and asthma, reduces likelihood of emergency admissions for CVD and respiratory conditions.
- ICS ambition to improve identification and treatment of hypertension by 5% in the 6 months after the CVD PREVENT reporting tools have gone live. Identify and offer high risk patients low intensity statins.

Early cancer diagnosis

- 31 more people with earlier diagnosis per year if N&W met England average rates.
- 20% of the life expectancy gap between most and least deprived communities is due to cancer, and those in the most deprived areas are less likely to be referred as an urgent referral for suspected cancer.
- Screening uptake is lower in more deprived communities.

Children & young people

- CORE20PLUS5 for Children & Young People key clinical areas of health inequalities: asthma, diabetes, epilepsy, oral health, mental health.
- Addressing excess weight in reception children to alter worsening trend.
- More need compared to England average in children's social and emotional health and school absences.
- Vaccination & immunisation.

Core system approach

Wider system approach

What we will do next

Infrastructure: the basic building blocks that must be in place

- Completion of PHM software procurement exercise
- Collaboration with BI team to refine data and analysis requirements and to develop the "Data Hub"
- Develop a plan for training and workforce development and associated resources to support a PHM approach
- Information Governance: supporting the development of our ICB Section 251 Application for Risk Stratification and Population Health Management
- Continue to review and update our progress against the NHS England Maturity Matrix

Intelligence: opportunities to improve care quality, efficiency & equity

- Refinement of our initial PHM system priorities
- Development of a PHM team workplan based on our system priorities and focused on areas PHM can have the greatest impact
- Work with partners and share data to support broadening a PHM approach

Interventions: proactive interventions to prevent illness, improve health and reduce health inequalities

- Development of a programme of evaluation based on the best available data and insights to measure progress
- Develop to a PHM dashboard to start to monitor our progress against our priorities
- Develop a communications and engagement plan, including sharing learning

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

Norfolk and Waveney Integrated Care System

Population Health Management Strategy (2024-2029)

Contents

Introduction

The health and care needs of people in Norfolk and Waveney are changing. People are living longer, and our population is ageing faster than other areas. More people are living with two or more long term health conditions. There are also health inequalities across different parts of Norfolk and Waveney, and some specific groups of people.

Our health and care system needs to adapt to respond to these challenges.

Population Health Management (PHM) is a way of working, delivering care in a proactive rather than reactive way. Using local knowledge and linked-up data, we can accurately target support, care, and services to those who need it or will benefit from it the most. In this way we can focus on preventing ill-health and addressing health inequalities and make the biggest impact on improving health outcomes.

Norfolk and Waveney Integrated Care System already has a successful track record of using PHM approaches with the Protect NoW Programme, linking data and information, and working in partnership to deliver targeted, proactive, and integrated care. We want to build on this success.

This strategy sets out our vision for PHM in Norfolk and Waveney for the next 5 years, our working principles and data-driven priorities for action and how we will deliver them, to improve health and reduce health inequalities for our residents.

Glossary

Health inequalities: "unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them". (1)

Intervention: "a health intervention is an act performed for, with or on behalf of a person or population whose purpose is to assess, improve, maintain, promote or modify health, functioning or health conditions". (2)

Maturity Matrix: the NHS England Population Health Management Maturity Matrix allows systems to assess their progress on the journey of development for building PHM capability. (3)

Place: place-based partnerships bring together the NHS, local councils and voluntary organisations, residents, people who access services, carers, and families. These partnerships lead design and delivery of integrated services in their local area. In Norfolk and Waveney five Place Boards bring together colleagues from health and social care to integrate services with a focus on effective operational delivery and improving people's care. (4)

Population health: "An approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional, or national population, while reducing health inequalities. It includes action to reduce the occurrence of ill health, action to deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies". (5)

Population health management: a way of working, using joined up local data and information to better understand the health and care needs of our local people and proactively put in place new and improved models of care to deliver improvements in health and well-being and reduce health inequalities.

Prevention: "A shared and demonstrable commitment to a preventative approach, which focuses on promoting good health and wellbeing for all citizens". (7)

Primary Care Networks (PCNs): GP practices are working together with community, mental health, social care, pharmacy, hospital, and voluntary services in groups known as PCNs. They bring together health partners to enable more personalised and coordinated health and social care services for people closer to home. (8)

Public health: The science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society. (9)

Unwarranted variation: "differences that cannot be explained by illness, medical need, or the dictates of evidence-based medicine". (11)

Wider determinants of health: "Wider determinants are a diverse range of social, economic, and environmental factors which impact on people's health. They're also known as social determinants". (12)

The Vision

Deliver proactive, targeted care and support to help people and communities live healthier lives.

Population Health Management is an enabler

Population Health Management (PHM) is an approach that can be used by everyone across the Integrated Care System (ICS) striving to improve health for all(13). It supports and enables the delivery of proactive, personalised, and preventative healthcare for every community and actively helps to reduce health inequalities (Figure 1).

Figure 1 - PHM is an enabler

It can be summarised by the terms Know, Connect, Prevent (Figure 1).

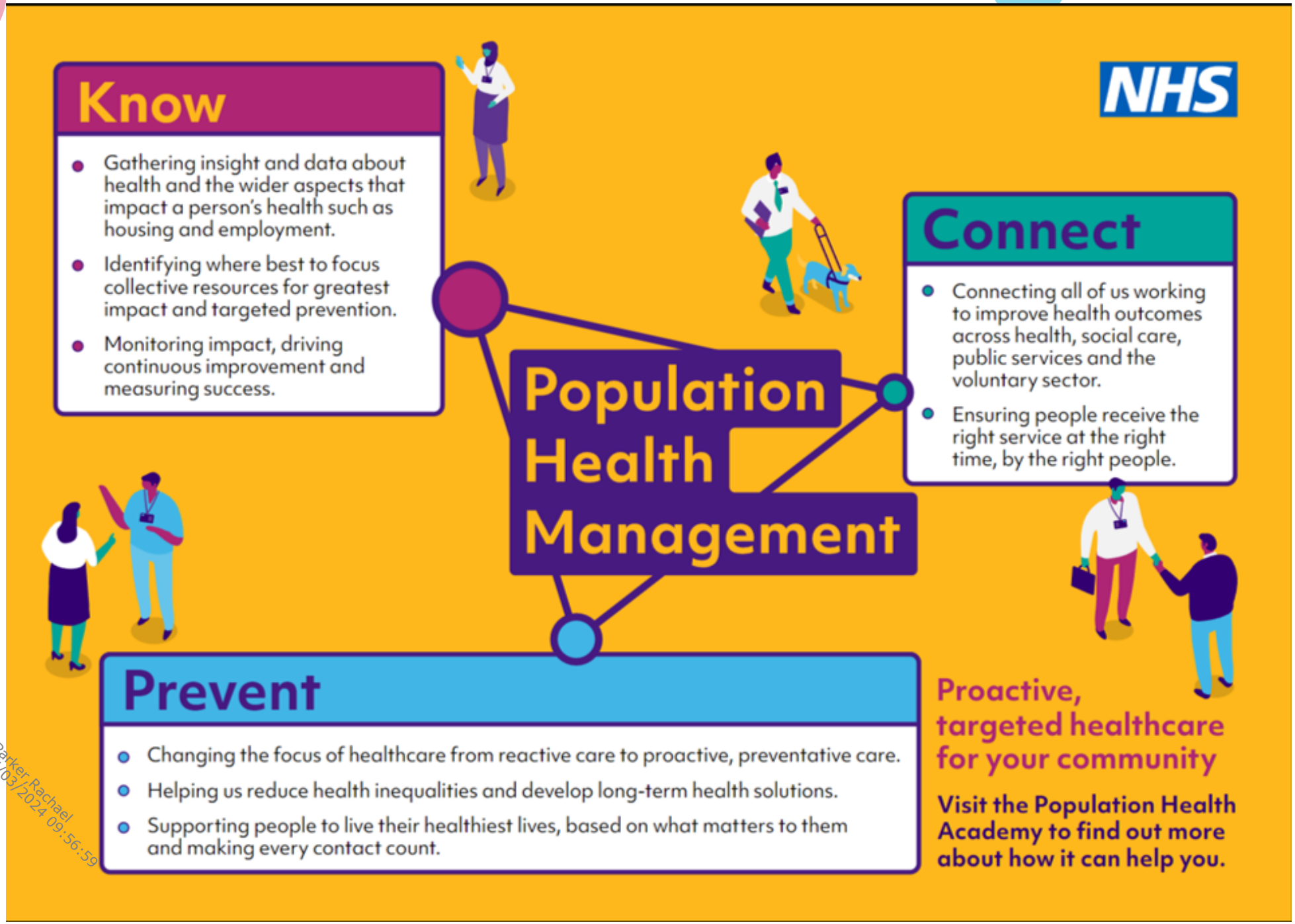


Figure 2 - Know, Connect, Prevent framework (13)

PHM will support the system to achieve its priorities

PHM supports the overarching ICS mission to help the people of Norfolk and Waveney to live longer, healthier, and happier lives, and is an enabler for all the other ICS strategies.

Figure 3 - PHM can support the delivery of ICS strategies

Existing strategies available here:
https://improvinglivesnw.org.uk/~documents/route%3A/download/691/

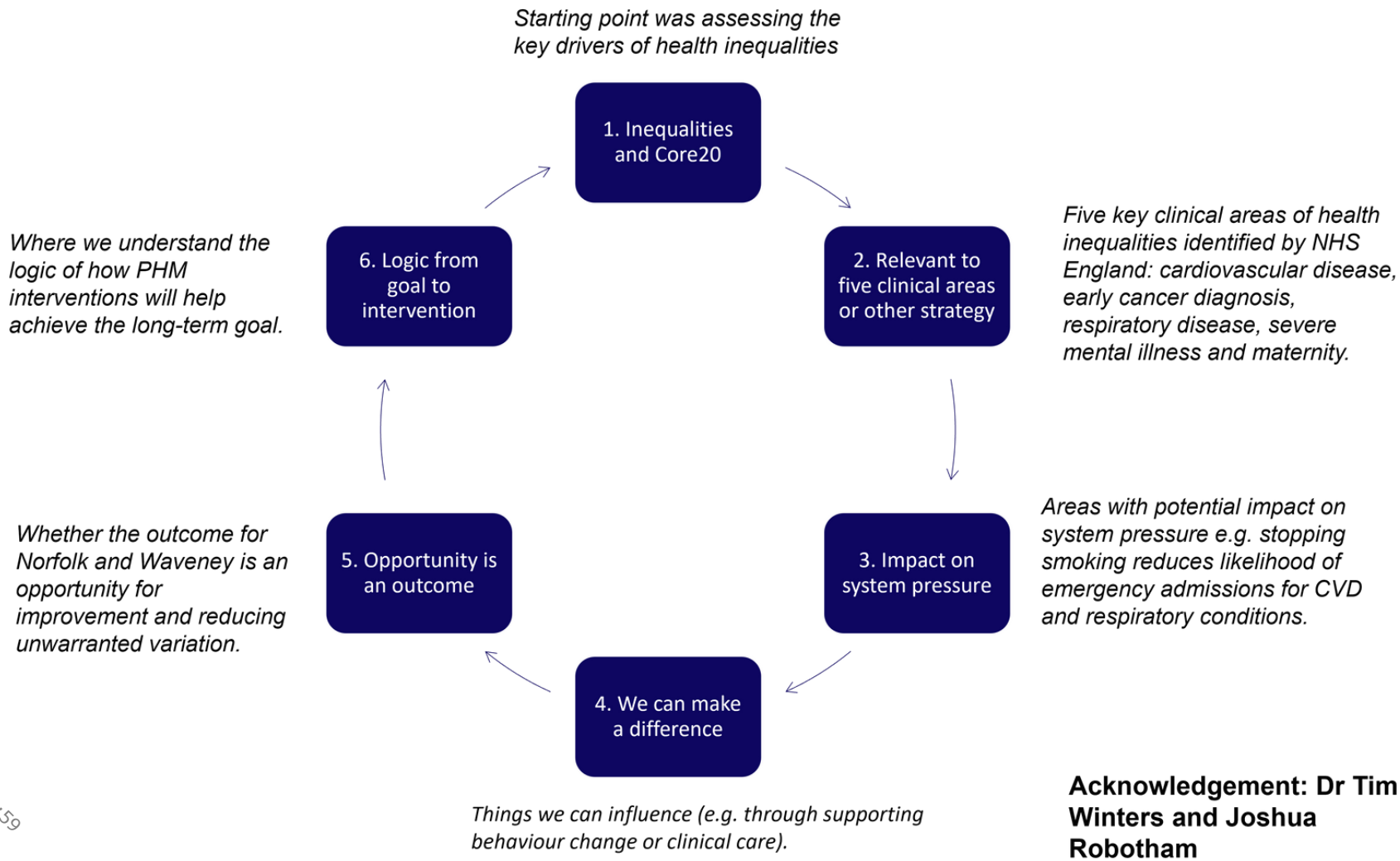
Our Population Health Management working principles

We held three engagement workshops on development of this strategy, our principles and how we can work together to implement PHM. We have engaged on the strategy at a wide range of ICS and Integrated Care Board (ICB) forums. We also undertook a significant review of the existing literature and relevant local and national strategies. The outputs of these workshops and this review helped us develop the following working principles:

- **Move from reactive to proactive care:**
  - Focus on prevention, using a targeted approach and managing long-term conditions.
- **Data-driven:**
  - Using linked-data from many sources to identify reversible risk and opportunities to implement evidence-based interventions to reduce unwarranted variation.
- **Focus on health inequalities:**
  - In access, quality, and outcomes, encompassing the wider determinants of health.
- **At scale and scalable:**
  - Transitioning successful pilot projects into business as usual, for evaluation, monitoring, encouraging innovation and sharing good practice widely.
- **People-focused:**
  - Involve people, communities and Voluntary, Community & Social Enterprise (VCSE) stakeholders in partnership.

Our initial priorities

To put those working principles into action, we used the following framework to identify our initial system level priorities, presented Figure 4.

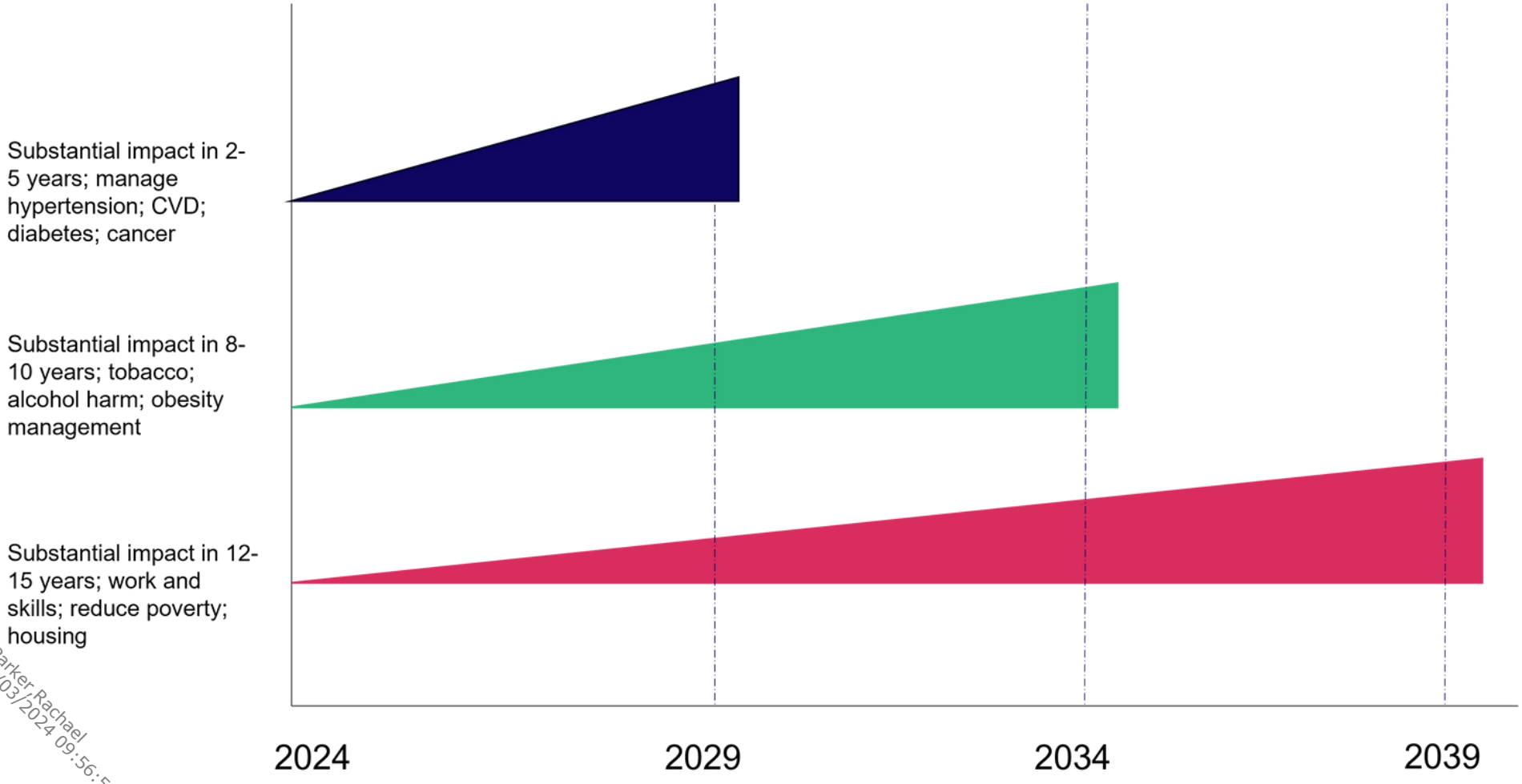


Acknowledgement: Dr Tim Winters and Joshua Robotham

Figure 4 - Framework for identifying initial PHM priorities

Based on this framework five data-driven PHM priority areas have been identified (Figure 6).

We have considered both areas where we can have a rapid impact (illustrated in dark blue below) to drive improvements and build momentum for PHM, and work on areas with longer-term benefits (illustrated in pink below), such as the wider determinants of health, where over a longer period we can have a bigger impact (Figure 5).



Adapted from Public Health England. Reducing health inequalities: system, scale and sustainability. 2017. PHE: London. Available from: Reducing health inequalities: system, scale and sustainability (publishing.service.gov.uk)

Figure 5 - Impact in the short, medium, and long term

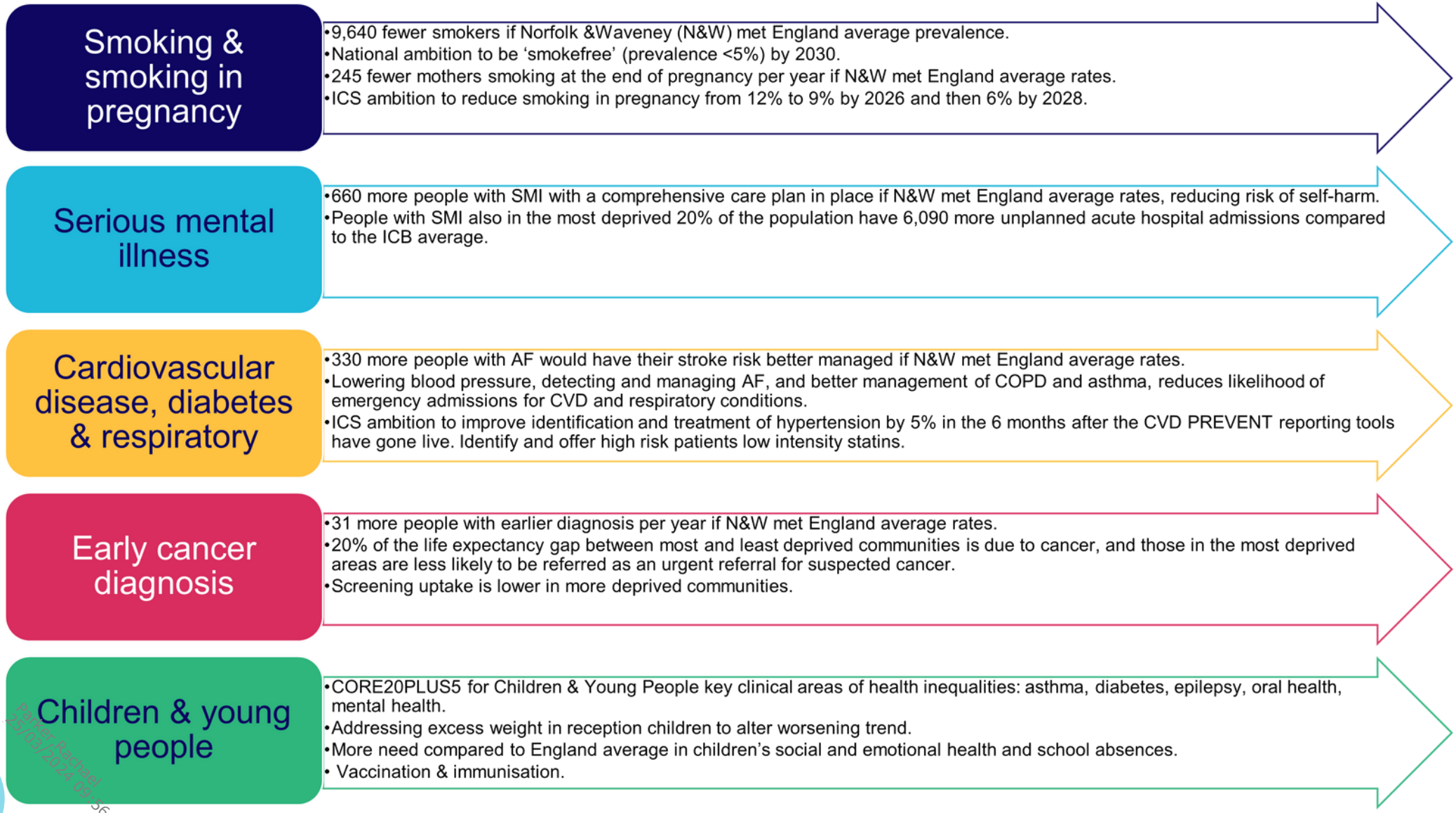


Figure 6 - Initial PHM priorities (acknowledgement Dr Tim Winters and Joshua Robotham)

Delivery - working together at different levels

There is no 'one size fits all' model of PHM, as different local populations will have different needs. How a PHM approach can work is illustrated in the PHM improvement cycle, developed by NHS England (Figure 7).

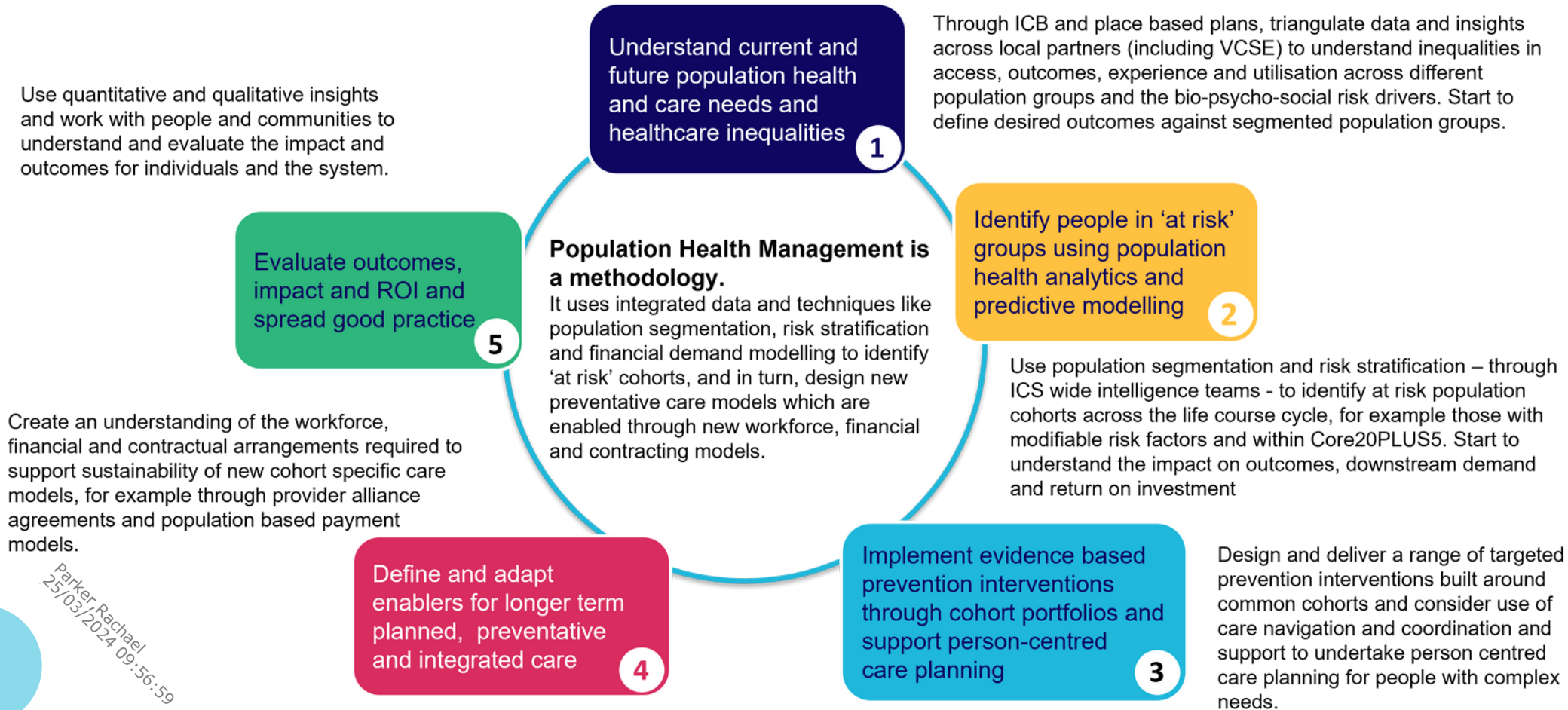


Figure 7 - PHM Improvement Cycle (3)

Building on this, our proposed approach to delivery involves working at different levels – the "core" and "wider" system, as outlined in Figure 8.

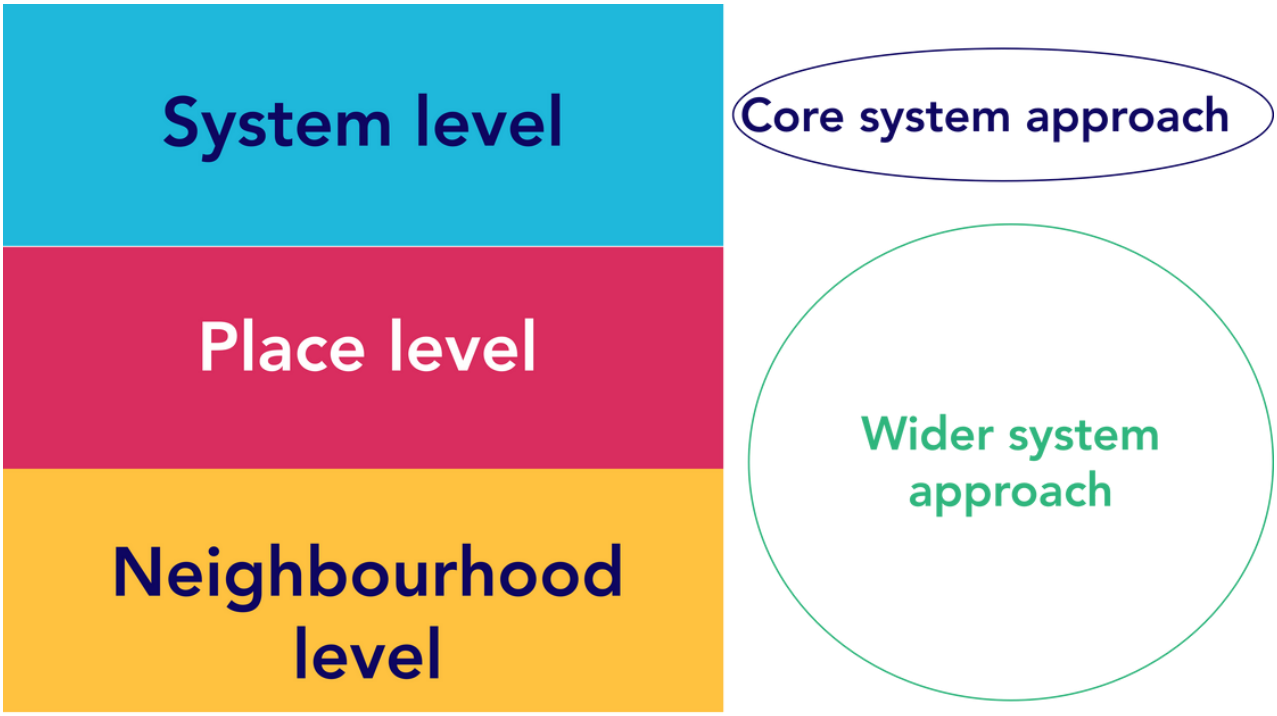


Figure 8 - Core and wider system approaches to delivery

Core system approach

The core system approach will involve:

- Development of system wide programmes based on identified system priorities, using strategic analysis.
- Prioritisation of interventions to make the biggest impact.
- Close working between Programme Leads and the ICB PHM team.
- Utilising Protect NoW Virtual Support Team (call handler team).
- Embedding evaluation and monitoring of the programme.
- System level support from Business Intelligence (BI), Patient and Engagement and Information Governance (IG) teams.
- The Clinical Steering Group, the PHM Oversight Group and reporting to the Population Health and Inequalities Board.

Case study: "ABC" (Atrial Fibrillation, Blood Pressure, Cholesterol) Cardiovascular Disease Programme

A core system PHM approach is being taken in Norfolk and Waveney to improve outcomes for people with Cardiovascular Disease (CVD). CVD has been identified as a priority opportunity for improvement, and key areas of focus identified are Atrial fibrillation, Blood pressure and Cholesterol (ABC). The "ABC" project involves a universal offer to GP practices of access to CVD Prevent indicators which link directly with practice data, that they can use to identify their at-risk patients. There will also be a tiered offer involving our Protect NoW Virtual Support Team (call handler team) to contact high risk patients living in areas of deprivation and direct them to appropriate support, including signposting to clinical care and lifestyle support, to improve CVD outcomes and reduce health inequalities.

Acknowledgement: Joe Crowe

Case study: Digital Weight Management Programme

The evidence-based NHS England Digital Weight Management Programme (DWMP) supports adults living with obesity and a diagnosis of diabetes, hypertension, or both to manage their weight and improve their health. Improving uptake of this national preventative programme was identified as a key opportunity to proactively improve health for this group of people in Norfolk and Waveney.

Eligible patients were identified using primary care data and contacted by letter, text message and/or motivational interviewing phone calls by the Protect NoW Virtual Support Team. Eligible patients were also able to sign up via a website landing page. At the time of writing over 32,000 eligible patients had been contacted and over 4,000 agreed to a referral, which was then made by their GP practice. Patients not able to access a digital programme were signposted to Local Authority Tier 2 services. Norfolk and Waveney went from 22% of system target uptake to 164% and at the time of writing was the number one referring system in the country. As of December 2023, 93% of referrals met eligibility criteria and the proportion of patients from the most deprived areas of Norfolk and Waveney taking up referrals was high relative to their representation in the general population. Patients accessing the programme receive tiered support to manage their weight and improve their health.

The project was led by the ICB Planned Care and Cancer Team working with the PHM team and wider partners including GP practices, NHS England and Local Authority Tier 2 Weight Management Services.

Acknowledgement: Jo Maule, February 2024

Wider system approach

The wider system offer will involve:

- Supporting PHM as a way of working for everyone.
- Giving teams the support they need to deliver their own local projects, based on the needs of their local populations.
- Workforce development and training, including upskilling place teams and PCN leads.
- Support for data access and interpretation.
- Advice for identification of evidence-based interventions.
- Advice on evaluation.
- Sharing of ideas and best practice.

Case study: Great Yarmouth & Waveney Warm Homes Programme

The Warm Homes project in Great Yarmouth and Waveney enables a targeted PHM approach to identify clinically and socially vulnerable residents that may be eligible for welfare and financial support including the Household Support Fund (HSF). Its aim is to positively impact on exacerbations of chronic respiratory ill-health caused by living in cold homes and fuel poverty.

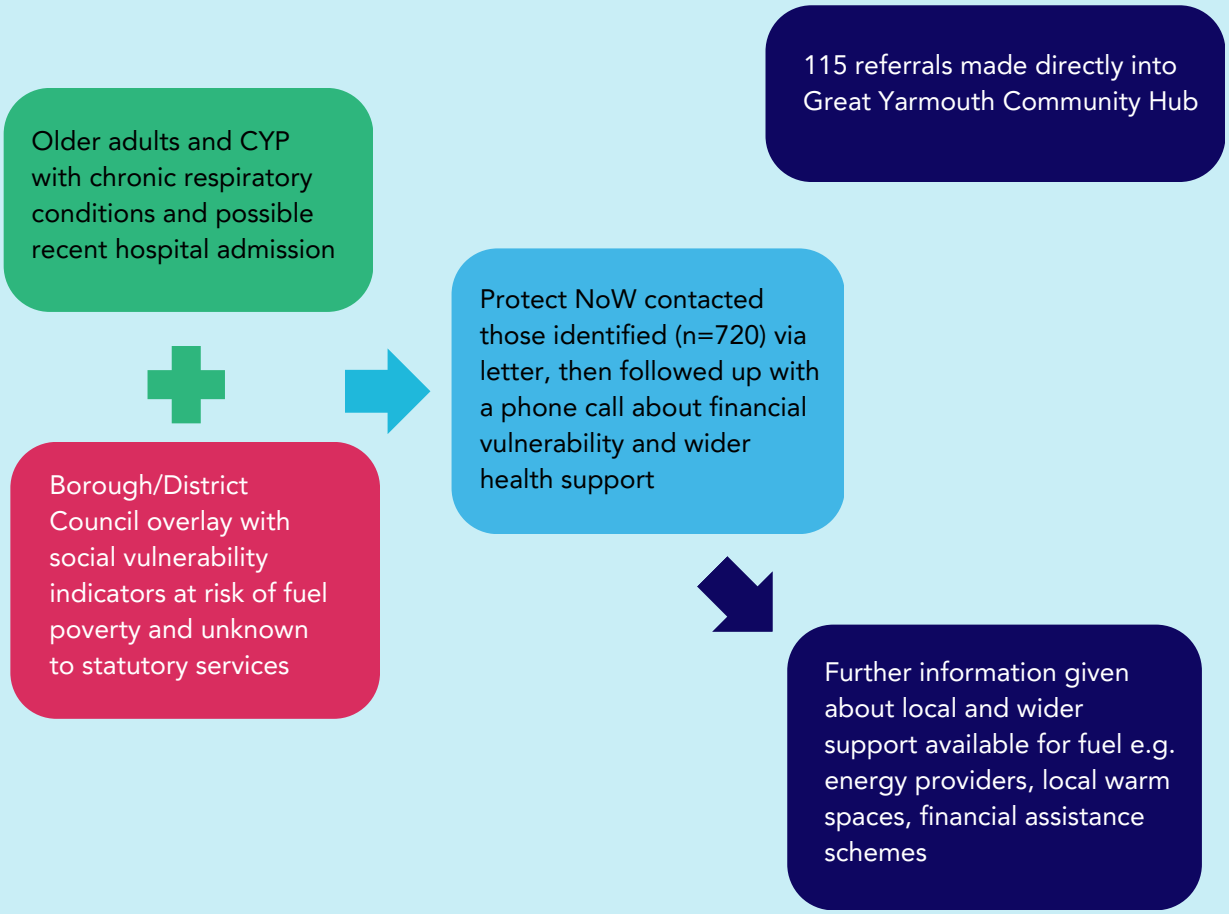
The project demonstrates the benefits of linking health and local authority (Great Yarmouth Borough Council and East Suffolk Council) data sets to identify specific vulnerable households to receive non-clinical support to improve their health. Working in partnership, NHS & Local Authority partners first trialled this approach in winter 2022/23. In winter 2023/24 the project was rolled out again and aimed to find a much bigger eligible cohort.

All households contacted had an individual with a chronic respiratory condition, aged 60+ or a child aged under 10 living in the most deprived areas of the locality (Index of Multiple Deprivation 1 & 2) and some individuals had experienced a recent hospital admission. The Protect NoW team proactively sent out letters and followed up with telephone calls. They signposted to key links on wider welfare and health support and made appropriate referrals to the respective Local Authority.

Case study continues overleaf

Case study: Great Yarmouth & Waveney Warm Homes Programme (continued)

As of February 2023, Great Yarmouth contacts have been carried out, see initial output details below. Waveney contacts will be contacted in due course with an expected cohort in the region of 300-400 people. Partners plan to undertake a collaborative review of the impact and learning from the project to ensure how we operate continues to be refined and benefits well understood, as well as scalability and sustainability considered.



Acknowledgements: Sophie Crowe and Rachel Hunt

Protect NoW Virtual Support Team (VST)

Protect NoW is the Norfolk and Waveney Integrated Care System's initiative to deliver proactive population health and care which is focussed on tackling health inequalities. The Protect NoW programme of work uses data-led, PHM approaches and comprises a growing number of distinct projects, each focused on optimising mental and/or physical health and reducing unwarranted variation (Figure 9).

Protect NoW is a dynamic collaboration between NHS organisations, Local Authorities, VCSE and independent partners working across Norfolk and Waveney.

The Protect NoW Virtual Support Team (VST) is the delivery arm for many of the programmes. The team is made up of a supervisor and five call agents, from diverse professional backgrounds and with a wide range of different skills and experience. They each have strong communication skills and are passionate about improving the lives of people in Norfolk and Waveney. The team engages with people to offer targeted support and interventions to prevent ill-health and improve health outcomes. They undertake training aligned to each project and have a strong track record of delivering PHM interventions.

COVID Vaccination Uptake

Aim: Increase vaccine uptake and gain insight into hesitancy.

Scope: To reach out to all patients considered at risk, immunosuppressed and housebound and book them in for the vaccination within various sites across N&W. (Partnership with NHSE, NCC, QEH, NNUH, JPAGET, GP Practices, PSL)

Flu Vaccination

Aim: Increase flu vaccination uptake and support to book

Scope: 3,000 most at-risk patients not vaccinated against flu in the preceding 12 months.
(Partnership with PSL & GP Practices)

Reducing avoidable admissions

Priority Patient Review
Aim: Reduce hospital admissions through primary care risk alerts relating to six biomedical markers – review, action and follow up.

Scope: 33 Practices across N&W, 12 month Pilot project.
(Partnership with PSL & GP Practices)

Diabetes prevention

Aim: Increase referrals into National Diabetes Prevention Programme to prevent / reverse type 2 diabetes and address clinical variation.

Scope: 43,000 people in N&W with pre-diabetes / HBA1c of 42 – 47 in the last 24 months. Initial cohort circa 15,000 of in areas of highest deprivation.
(Partnership with PSL, Reed Health, GP Practices)

Improving Access Psychological Therapies (IAPT)

Aim: Increase referrals to Wellbeing Service and address clinical variation.

Scope: 8,000 Patients prescribed medication for depression / anxiety but not accessing IAPT. Focus on Practices with the biggest 'gap to ambition'.
(Partnership with Wellbeing, NSFT & PSL)

Health checks

Aim: Encourage patients who are overdue their health check, to take up the offer.

Scope: Aged 40 – 74, significantly overdue their health check. Focus on Practices with the biggest 'gap to ambition'.
(Partnership with NCC)

Figure 9 - Some key Protect NoW Projects. Acknowledgement Catarina Hamlet - part 1, continues overleaf

Pain management

Aim: Triage and prioritise waiting patients by acuity.

Scope: Patients waiting more than 20 weeks for a first outpatient appointment in West Norfolk. (Partnership with QEH)

Cervical screening

Aim: Increase cervical screening in eligible women with no recorded cervical screening or none in last 3-5 years and gain insight into reasons for missed appointments / encourage to re-book.

Scope: 25,000 + over two years across N&W – most at risk (2,500) through smoking and lifestyle identified. (Partnership with PSL, GP Practices)

Long Covid clinic design

Aim: Gain insight from those with lived experience of Long Covid to inform design of service specification for commissioning Long Covid clinics from community provider
.
Scope: 13,500 people across N&W 12+ weeks after confirmed Covid 19 infection.
(Partnership with PSL, GP Practices)

Cataracts waiting list

Aim: To reduce back log and inequalities in the cataract's surgery waiting list at the NNUH (70+weeks).

Scope: Offer patients the surgery in commissioned providers by the CCG (legacy). (Partnership with NNUH)

Housebound vaccination

Aim: Support GP Practices Covid vaccination rollout to housebound patients.

Scope: GP Practices provided a list of patients identified in their system as Housebound, the VST contacted these patients to confirm their status and if they wanted to get the vaccine. (Partnership with GP Practices)

Cold homes

Aim: Identify vulnerable residents living with chronic respiratory conditions, who may also be eligible for financial support from the Household Support Fund, but unaware of their eligibility.

Scope: VST to call these patients and refer them to their registered Borough Council, for financial aid if needed. (Partnership with GYBC/PSL and ESBC)

Figure 9 - Some key Protect NoW Projects. Acknowledgement Catarina Hamlet - part 2

Case study: Lowestoft Healthy Hearts

The Lowestoft Healthy Hearts programme aims to improve hypertension outcomes, using a range of interventions focused around healthy lifestyle support.

Lowestoft PCN was identified as an area with opportunities for improvements in hypertension outcomes. The focus of this project is support for lifestyle change to improve this. Trusted Communicators will help identify suitable support for at-risk patients, such as gym access or home blood pressure monitoring, offering wrap-around lifestyle support.

Acknowledgement: Joe Crowe

The capabilities which form the foundation of PHM

We have used NHS England's "Four I's", which are the four key capabilities that form the foundation of PHM, to establish where we are, where we need to be and how to get there (Figure 10).

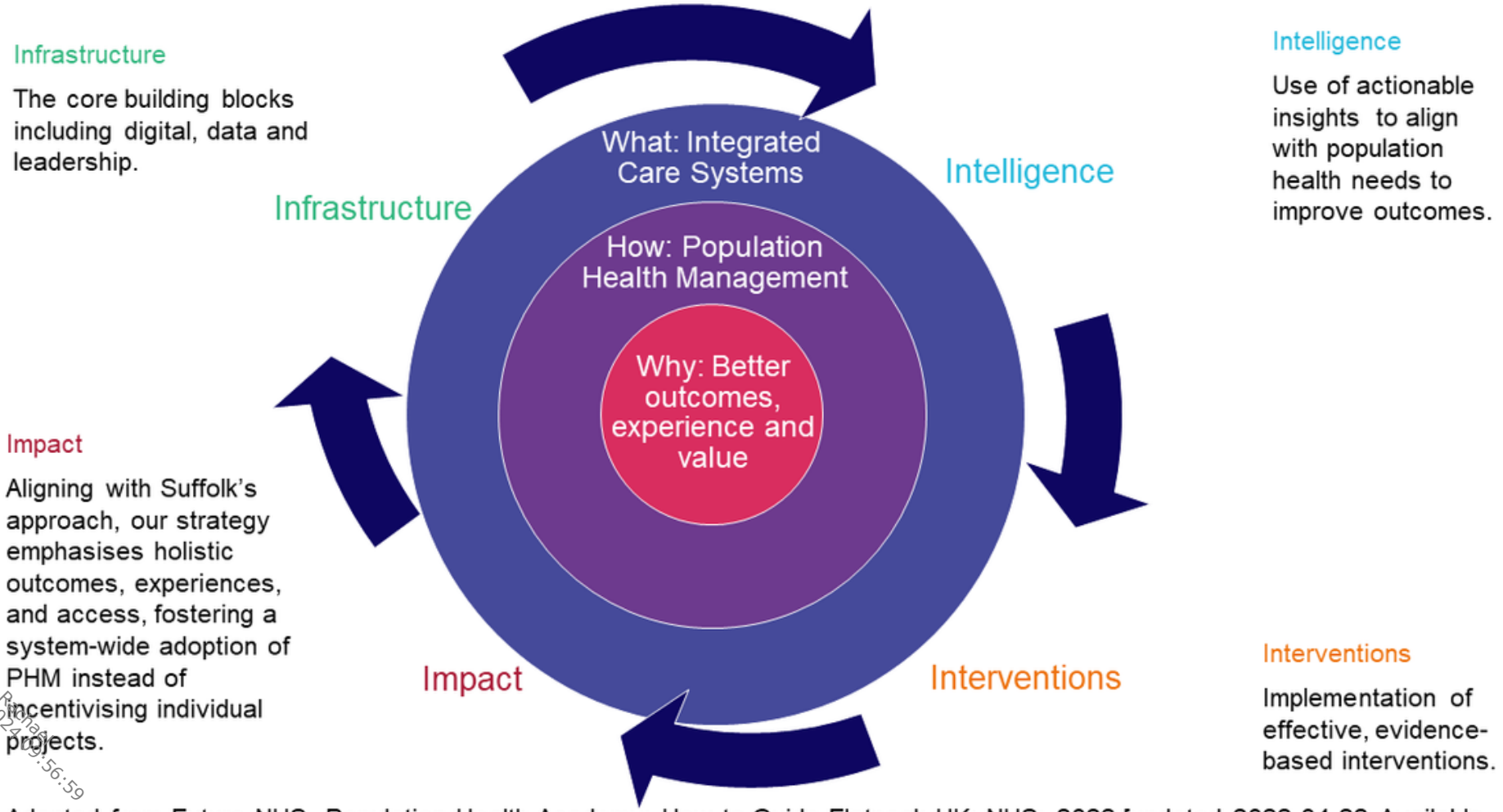


Figure 10 - PHM Capabilities

Where we are → Where we are going

We conducted a SOAR (Strengths, Opportunities, Aspirations, Results) analysis for each of the PHM capabilities (Infrastructure, Intelligence, Interventions, and Impact) in collaboration with stakeholders at our engagement events. The results for 'Impact' are integrated across the "Where we are going" column.

	Where we are	Where we are going
Infrastructure: the basic building blocks that must be in place	• Developing a shared understanding and vision for PHM • Developed governance structures and understanding of roles, including PHM Clinical Steering Group and PHM Oversight Group • Alignment with ICS strategies, including Health Inequalities • Promoting integration through ICS formation • "Data Hub" creation • Majority sign-up on a system level data sharing agreement • Information Governance processes in place for PHM programmes • "Community Voices" initiative providing qualitative insights • Some local and national PHM training and resources available • Baseline Maturity Matrix completed	• Move from reactive to proactive, preventative, integrated care • Working together to focus on system priorities • Support the delivery of core and system wide approaches • Further development of the "Data Hub" • Centralised data repository providing stakeholder interoperability • Person-level data aggregation and linkage across partners • 100% sign up on system level data sharing agreement • Relevant training available to those across the ICS • Continually monitor and improve upon the Maturity Matrix for PHM • Platforms to share learning and good practice across systems
Intelligence: opportunities to improve care quality, efficiency & equity	• Established & experienced PHM Team • Leadership from Clinical Advisors • PHM Projects Governance Pack developed • Initial PHM priorities identified • Utilisation of existing resources and skills within the ICS • Strong links with Public Health Team • Sharing evaluation of our PHM programmes with decision makers • Some PHM expertise available within the system	• Data-driven approach (quantitative & qualitative) • Identifying unmet need & reducing unwarranted variation • Identification of data gaps and improved data quality • Further development of a population health intelligence capabilities and locally developed strategic analysis tools • Cross-system PHM support • Reduce demand caused by failure to do something right first time • Workforce with relevant skills across the system • Stakeholders can access & interpret data to understand their population's needs • Surveillance & oversight of PHM to understand what is happening across the system and minimise overlap and duplication

Figure 11 - Where we are and where we want to go - continues overleaf

	Where we are	Where we are going
Interventions: proactive interventions to prevent illness, improve health and reduce health inequalities	• Lessons learned from experiences and evaluation of N&W PHM programmes and place-led work • Track record of delivering PHM programmes in Norfolk and Waveney • Established and experienced Protect NoW call handler team • Evaluation template included within Governance Pack • Plans to create a communications and engagement strategy, including consulting our residents where appropriate • Interventions which encompass the wider determinants of health	• Improvements in population health outcomes • Reduced health inequalities (access, experience, and outcome) • Better outcomes for cohorts with protected characteristics • Move towards integrated, personalised, proactive care • Patient empowerment • Use data to target limited resource and return on investment • Improved system capacity • Working at different levels of the system & across boundaries including with the voluntary sector • Embedded evaluation to build and share what works • Effective programmes become business as usual • Build momentum for PHM by sharing best practice • Support adoption and spread of innovation

Figure 11 - Where we are and where we want to go - continued

What we will do next

We will develop an Action Plan for the delivery of this strategy between April and September 2024 as part of our commitment in the Norfolk and Waveney Joint Forward Plan. This will be led by the PHM Oversight Group and overseen by the Population Health and Inequalities Board. It will include SMART objectives, milestones and trajectories developed in collaboration with key stakeholders including Programme Leads, Business Intelligence and Information Governance colleagues. This Action Plan, subject to resources, will include:

Infrastructure: the basic building blocks that must be in place

- Completion of PHM software procurement exercise
- Collaboration with BI team to refine data and analysis requirements and to develop the "Data Hub"
- Develop a plan for training and workforce development and associated resources to support a PHM approach
- Information Governance: supporting the development of our ICB Section 251 Application for Risk Stratification and Population Health Management
- Continue to review and update our progress against the NHS England Maturity Matrix

Intelligence: opportunities to improve care quality, efficiency & equity

- Refinement of our initial PHM system priorities
- Development of a PHM team workplan based on our system priorities and focused on areas PHM can have the greatest impact
- Work with partners and share data to support broadening a PHM approach

Interventions: proactive interventions to prevent illness, improve health and reduce health inequalities

- Development of a programme of evaluation based on the best available data and insights to measure progress
- Develop to a PHM dashboard to start to monitor our progress against our priorities
- Develop a communications and engagement plan, including sharing learning

Lenses of PHM – How our stakeholders hope to apply this strategy

PHM is for everyone. These are some examples from our third engagement workshop of how stakeholders plan to apply the PHM strategy. Everyone is encouraged to advocate for a PHM approach and support implementation of this strategy across the ICS.

I will look at how I can use a PHM approach to reduce health inequalities.

I will look for opportunities to use a PHM approach to proactively care for my patients.

I will support the management of data in line with legislation.

Work with partners using a PHM approach to target system priorities so we can reduce unwarranted variation and have the biggest impact possible.

I will work with colleagues to further develop the Data Hub, so it can be used to support a PHM approach across the system.

I will support and encourage colleagues to use PHM approach in their work, using concrete examples where possible.

I will support sharing data for linkage from my organisation and delivery of interventions in PHM programmes.

Support embedding evaluation in PHM programmes, so we can scale up what works and stop what doesn't; support adoption and spread of innovation.

Summary

This strategy sets out our vision for PHM in Norfolk and Waveney for the next 5 years - to deliver proactive, targeted care and support to help people and communities live healthier lives. Using PHM approaches, everyone across the system can work together to prevent ill-health, reduce health inequalities and make the biggest impact on improving health outcomes. We will move from reactive to proactive care, be data-driven, focus on health inequalities, work at scale and be people-focussed. We have used a framework, taking health inequalities as a starting point, and considered areas we could make the biggest difference. These initial PHM system priorities are smoking and smoking in pregnancy; serious mental illness; cardiovascular disease, respiratory and diabetes; early cancer diagnosis; and children and young people. We will be building the infrastructure, intelligence and interventions to support the delivery of PHM across Norfolk and Waveney. An action plan to support this strategy will be developed with milestones and objectives.

References

1. England N. NHS England » What are healthcare inequalities? UK: NHS England,; 2023 [Available from: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/]
2. World Health Organization. International Classification of Health Interventions 2017 [Available from: http://www.who.int/classifications/ichi/en/]
3. Future NHS. Population Health Academy: How to Guide Flatpack UK: NHS; 2022 [updated 2022-04-22. Available from: https://future.nhs.uk/connect.ti/populationhealth/view?objectID=131791269]
4. Norfolk and Waveney Integrated Care System. Place boards - Norfolk & Waveney Integrated Care System (ICS: @nandwics; 2024 [Available from: https://improvinglivesnw.org.uk/our-work/working-better-together/our-places/]
5. Buck D, Baylis A, Dougall D, Robertson R. A Vision for Population Health. London: King's Fund; 2018.
6. Norfolk and Waveney Integrated Care System. Joint Forward Plan 2023-2028. Norfolk, UK: Norfolk and Waveney Integrated Care System,; 2023.
7. Local Government Association. Prevention: @LGAcomms; 2023 [Available from: https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/integration-and-better-care-fund/better-care-fund/integration-resource-library/prevention]
8. System NaWIC. Primary Care Networks - Norfolk & Waveney Integrated Care System (ICS: @nandwics; 2023 [Available from: https://improvinglivesnw.org.uk/our-work/working-better-together/primary-care-networks/]
9. Faculty of Public Health. What is Public Health? - FPH - Faculty of Public Health 2023 [Available from: https://www.fph.org.uk/what-is-public-health/]
10. NHS England. NHS England » Population health management 2023 [Available from: https://www.england.nhs.uk/long-read/population-health-management/]
11. NHS Providers. Reducing 'unwarranted variation' and the GIRFT programme: NHS Providers; 2024 [Available from: https://nhsproviders.org/news-blogs/blogs/reducing-unwarranted-variation-and-the-girft-programme]
12. (OHID) OfHIaD. Wider Determinants of Health - OHID 2024 [Available from: https://fingertips.phe.org.uk/profile/wider-determinants]
13. FutureNHS. HM messaging framework 2023 [updated 2023-11-21. Available from: https://future.nhs.uk/populationhealth/view?objectID=1072563]

Community Voices

Using your feedback to improve care

Improving lives together

Norfolk and Waveney Integrated Care System

Patients and Communities Committee – 25.3.24
Item 8: Community Voices Update

Norfolk & Waveney Community Voices

Shelley Ames, Senior Integration & Partnership Manager (GYW)
Amrita Kulkarni, Senior Programme Manager Community Voices
Nadia Jones, Public Health Principal- Prevention

Our vision

Norfolk and Waveney Community Voices aims to ensure that people who experience disadvantage because of where they live or who they are can be empowered to understand and act on their health, have a place to share their views, and can help shape how health services are designed and delivered.

What we do

Hold conversations with communities that have significant health inequalities about their experiences and what matters to them.

Listen

Why we do it

To ensure that seldom heard voices are heard by health services.

Record insights from the conversations that help build a picture about health and wellbeing within a place or community.

Capture

To better understand community and individual health priorities, concerns and assets.

Provide high quality advice, guidance and information that promotes health and wellbeing.

Respond

To share insight and learning across the Integrated Care System, and give communities a role in shaping service design and delivery.

Help community based organisations develop strong networks, relationships and trust, which helps people to help themselves and prevent ill health.

Enable

To empower trusted communicators and communities to use existing assets and identify local action that will increase health and wellbeing.

How we do it

- By facilitating the right training and providing an infrastructure which works well – with networks, access to good quality resources and time to reflect on good practice.
- By building good quality insight data that can be shared appropriately across partner agencies
- By evaluating the effectiveness of what we do, why we do it and how we do it.
- In partnership with good governance and support from all the sectors involved.
- By recognising that good health is influenced by a range of factors.

The model

Core Community Voices Programme

Having conversations with communities that experience health inequality about their experiences in relation to health, and what matters to them

Sharing insights through the insight bank

Supporting access to support services

Making Every Contact Count

Workforce development

Engagement Insight

Community Voices Projects

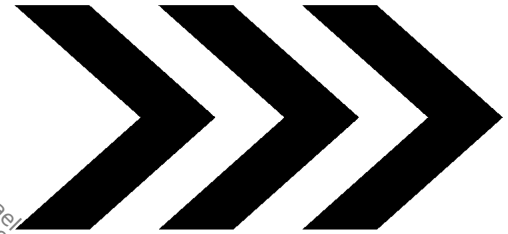
Having conversations about specific topics/subjects

Recording insights about specific topics into the insight bank

Supporting access to specific services

Projects

CV Pilot 1	CV Pilot 2	CV Pilot 3	CV Pilot 4	CV Pilot 5	CV Pilot 6	CV Pilot 7	CV Pilot 8	CV Pilot 9	CV Pilot 10
Access to COVID vaccination	Access to research	Access to bowel cancer screening	Refugee and asylum seekers support	Health improv (smoking)	Core 20 Connectors CYP	Research network (REN2)	Health Inequalities strategy/ framework	RIPPLE	Lowestoft CVD
System-wide	GYW	System (plus focus)	System (plus focus)	System (plus focus)	GY & Norwich	System	GY, North, West	GY, North, West	Waveney



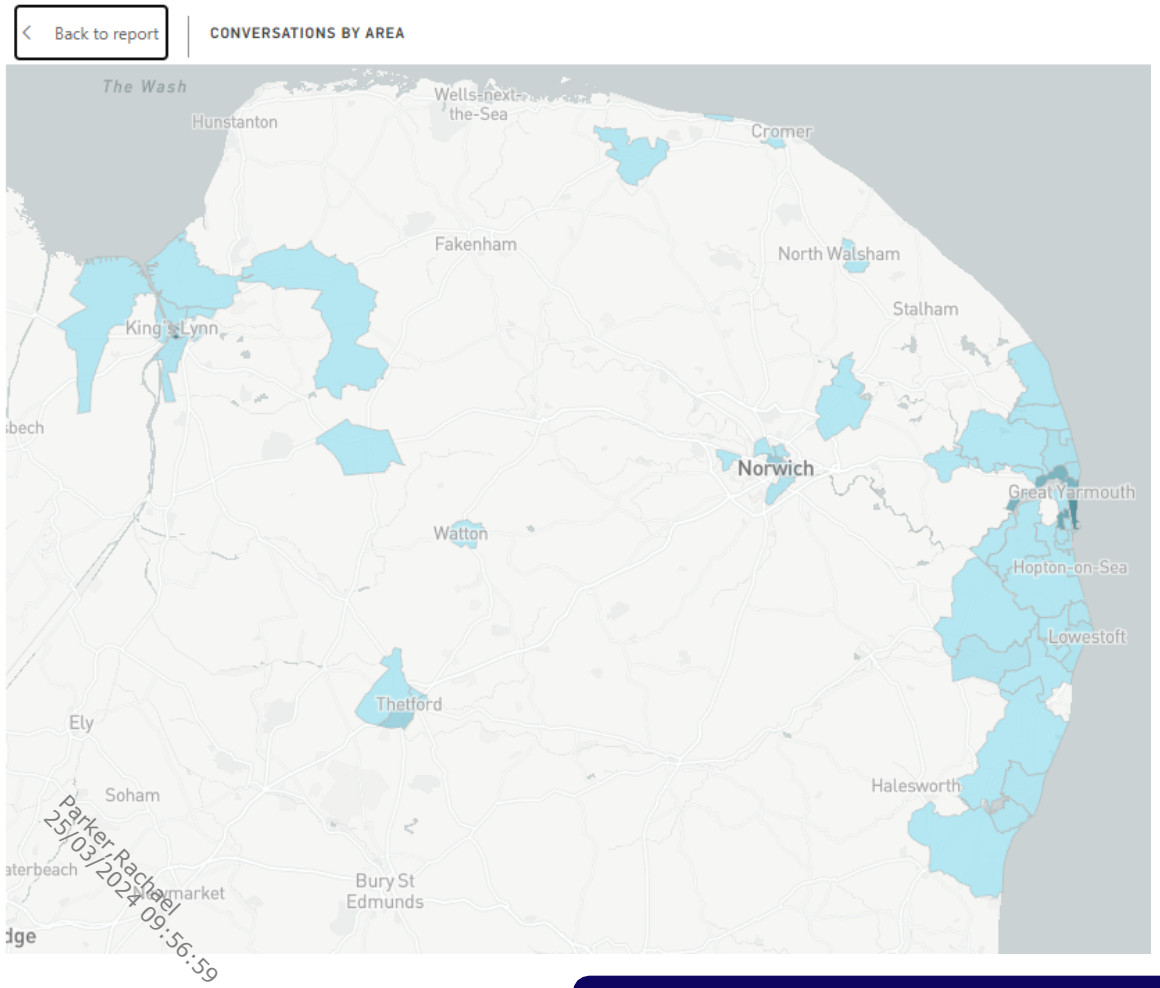
Parker Rachael 25/03/2024 09:56:59

CV 11	CV 12
Women's Health	Targeted Lung Health Checks

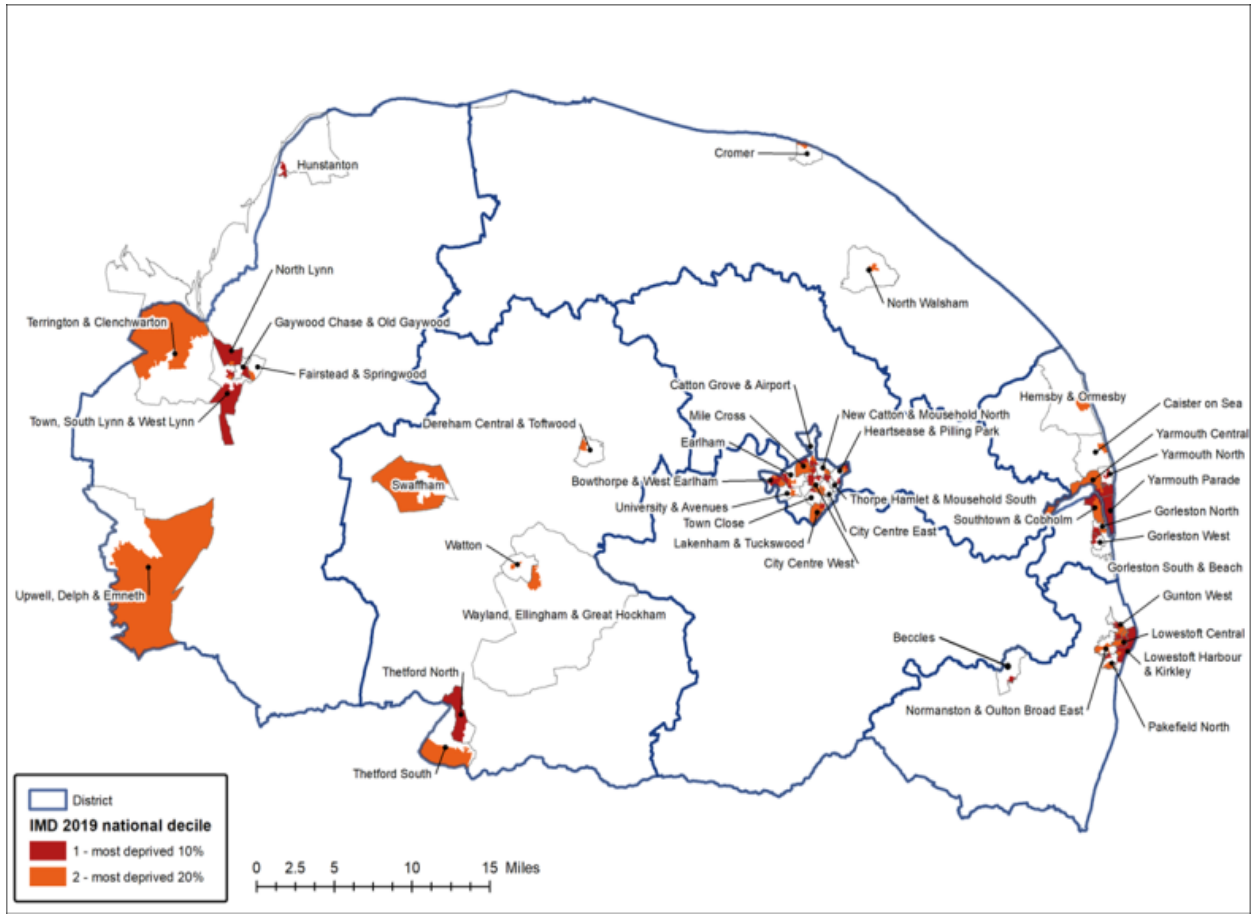
Key

- Area/Remit
- Completed
- Underway
- Potential

Who are we reaching?



Core20 populations



2150+ Community Voices conversations recorded

What are we hearing-Trends and Themes

Accessibility of health services

492 Community Voices conversations related to the chosen content.
respondents spoke the **most positively** about the chosen content than any other gender.
People aged **25 - 34yrs** spoke the **most positively** about the chosen content, while people aged **35 - 44yrs** spoke the **most negatively**.
People from a **B1 - White and Black Caribbean** background spoke **most positively** about the chosen content, and people from a **A2 - Irish** background spoke the **most negatively**.
Within the topic, **Accessibility of GP surgery** was the most common topic raised. **Accessibility of COVID-19 Vaccinations** was spoken about **most positively**, and **Availability of walk-in centres** was spoken about the **most negatively**.

"Sometimes in the past when my English was not as good the surgery would write to explain things but this took ages"
Conversation Quote

General practice & doctors

385 Community Voices conversations related to the chosen content.
respondents spoke the **most positively** about the chosen content than any other gender.
People aged **75+ yrs** spoke the **most positively** about the chosen content, while people aged **66 - 74yrs** spoke the **most negatively**.
People from a **B2 - White and Black African** background spoke **most positively** about the chosen content, and people from a **Prefer not to say** background spoke the **most negatively**.
Within the topic, **General Practitioners** was the most common topic raised. **General Practitioners** was spoken about **most positively**, and **Contacting GP reception by phone** was spoken about the **most negatively**.

Dentistry

167 Community Voices conversations related to the chosen content.
Male respondents spoke the **most positively** about the chosen content than any other gender.
People aged **66 - 74yrs** spoke the **most positively** about the chosen content, while people aged **Prefer not to say** spoke the **most negatively**.
People from a **B4 - Any other Mixed/multiple ethnic background** background spoke **most positively** about the chosen content, and people from a **A4 - Roma** background spoke the **most negatively**.
Within the topic, **Accessibility of Dentistry** was the most common topic raised. **Dentistry** was spoken about **most positively**, and **Accessibility of Dentistry** was spoken about the **most negatively**.

"The GP's are good but it is hard to get to see them"
Conversation Quote

Cost of living and money

177 Community Voices conversations related to the chosen content.
respondents spoke the **most positively** about the chosen content than any other gender.
People aged **36 - 44yrs** spoke the **most positively** about the chosen content, while people aged **Prefer not to say** spoke the **most negatively**.
People from a **B4 - Any other Mixed/multiple ethnic background** background spoke **most positively** about the chosen content, and people from a background spoke the **most negatively**.
Within the topic, **Cost of Living** was the most common topic raised. **Government Support** was spoken about **most positively**, and **Cost of Living** was spoken about the **most negatively**.

Delivery outputs*

Outcomes

Information about local community groups given 50	Advised to contact GP 29	Support given to access benefits 20	Assisted to attend GP 19	Blue badge application completed 3
Vaccination information given 16	Child benefit application completed 2	Support given to attend local social events 8	Court summons prevented for council tax arrears 1	Drug and alcohol support referral completed 2
Housing application completed 6	Interpreter booked for health visit 4	PIP application completed 8	Support given to access dentist 5	Assisted to register with a GP 12
Support given to register on the NHS Low Income Scheme 3	Support given to become digitally included 3	Medical information translated 3	Contact made with GP 10	NAS application completed 7

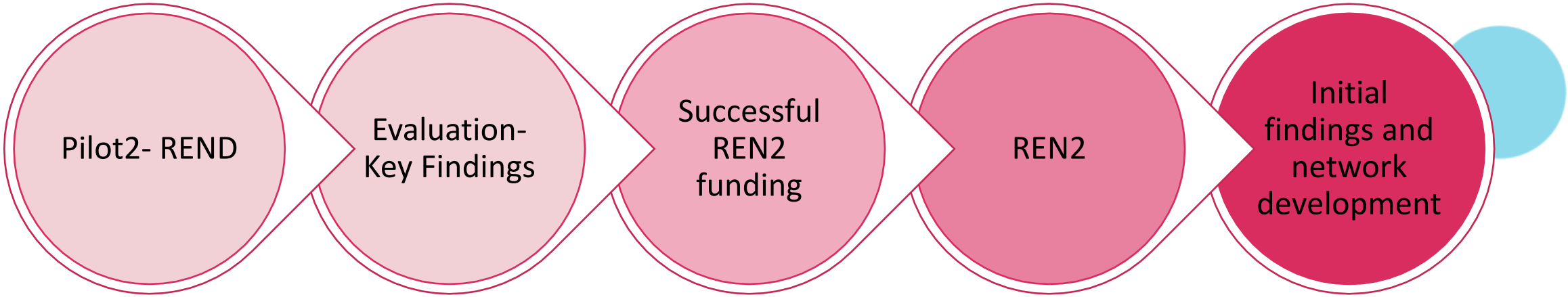
Provide high quality advice, guidance and information that promotes health and wellbeing.

Respond

To share insight and learning across the Integrated Care System, and give communities a role in shaping service design and delivery.

Data from pilots

CV Pilot 2 and 7 (REND and REN2)



200 research conversations in 2months across GY&W

- Enabled new and productive research collaborations
- Generated local research knowledge, our understanding of activity in our diverse coastal communities
- Mechanisms from which to further embed and grow research engagement

17 organisations (across WN, NN, Norwich, Breckland and Waveney)

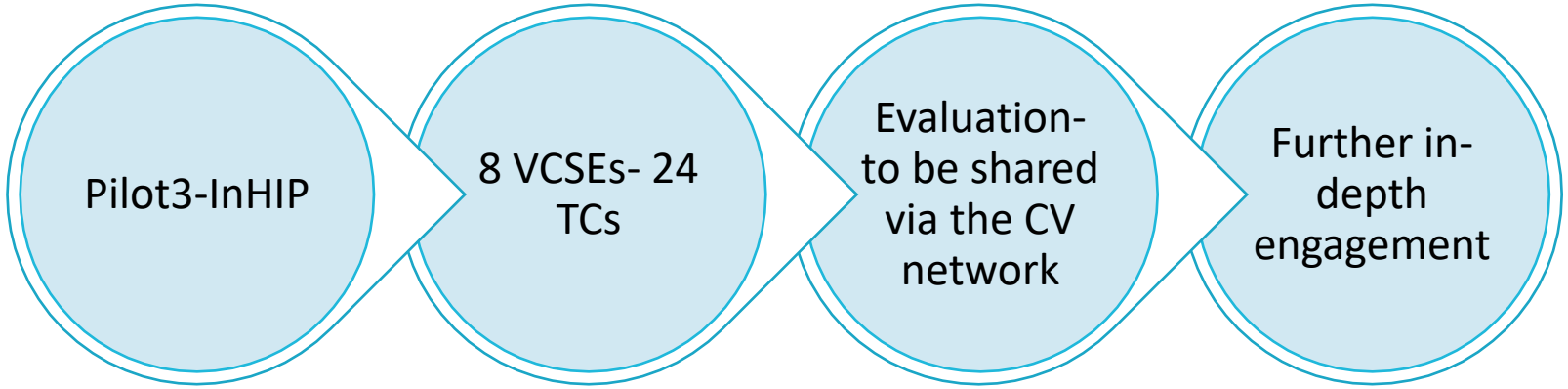
Creating spaces to:

- Learn together
- Share what works
- Build our evidence base

Research topics relevant to communities- mental health, cancer, heart disease and obesity.

Known barriers- transport, time requirements, lack of knowledge around what research is occurring

CV Pilot 3 (Bowel Cancer Screening)



Focus on increasing awareness of Cancer and Screening, focus on Bowel Cancer

Awareness of Bowel Cancer Signs, Symptoms and Screening:

- Overall good awareness of bowel cancer signs, symptoms and screening tests
- Generally positive feedback on the FIT test, willingness to repeat it
- willingness to seek medical advice for concerning symptoms.

Barriers to Seeking Medical Advice or Screening:
language issues, mental health or diagnosis anxiety, caring responsibilities, and lack of a fixed abode.

Insights influencing further in-depth engagement re bowel cancer- possible roll out of Community Voices approach

(CV pilot 5) Healthy Behaviours- Case study

Pilot5- Healthy Behaviours

Evaluation- Key Findings

Insights influencing new Community & Specialist Stop Smoking Services

Insights and next steps shared with CV network

Case study published

Methodology: data and underpinned behaviour change model

Demographics of the sample

Smoking cessation across Norfolk

128 conversations about barriers & enablers

52 conversations on what stuck out to stopping smoking
53 conversations about champions

58.4% 41.5%

Age group
16-24 years old: 2.5%
25-34 years old: 22.8%
35-44 years old: 23.7%
45-54 years old: 27.9%
55-64 years old: 17.8%
65-74 years old: 5%

Smoking cessation Norwich data

98 conversations around health services

50% 40%

Age group
18-30 years old: 14
31-60 years old: 51
61> years old: 31

(CV pilot 5) How CV Insight is being used

- Insights confirmed much of which is known around barriers and enablers to smoking behaviour change (grouped according to COM-B behaviour change model), but we now have qualitative Norfolk evidence to support the research.
- Confirmed the value of a new Community Stop Smoking Service as part of a redesigned LA offer, which will undertake targeted activities at place (e.g. anchor institutions, workplaces, social housing)
- Confirmed the value of Specialist Stop Smoking Service (Reed Wellbeing) employing an adviser to work with targeted priority population groups (e.g. GRT, Polish community, homeless)
- Insights will be given to both the new Community & Specialist Stop Smoking Services providers to take into account in all service delivery.
- Conversations represented an opportunity to make an intervention around smoking (in particular New Routes Integration)
    - Working through the Ready to Change 3-step journey (Quiz; Learn; Action)
    - Looking at online resources
    - Downloading Stop Smoking App
- This has opened up a new avenue for us to explore as part of the Community Enablement pillar of the PH Behaviour Change Strategy

CV Pilot 8- Health Inequalities

	Living and Working	Lifestyle	H&C Services
What would make Norfolk and Waveney a better place to live and work in? 	Secure, local jobs with fair wages. Clean, safe and connected neighbourhoods. Caring and inclusive communities with good facilities. Strong economy and lower cost of living. Affordable and well-maintained housing.		Access to dental services. Mental health support and services Access to a GP. Better maternity services. Support for people with caring responsibilities.
What do people do to keep healthy and well, physically and mentally? 	Socialise with friends and family. Volunteer their time and skills. Attend local community groups.	Do physical exercise. Eat healthily. Get enough sleep. Stop smoking. Be aware of their mental health and reduce stress. Seek health support (NHS/other). Stay connected to people. Get sufficient rest	Be aware of their mental health and seek support. Get sufficient rest to carry on with caring role.
What stops people keeping healthy and well? 	Limited money. Cost or availability of transport, especially in rural areas. Long working hours. Language barriers. Feeling lonely or isolated.	Smoking. Stress. Long working hours.	Lack of appropriate, affordable, accessible services. Poor mental health limiting ability to seek support. Lack of GP care.
What matters most to people when it comes to support for their health? 	Lack of appropriate, affordable, accessible (preventative and remedial) services. Wider determinants of health (income, employment and housing). Having support to deal with social isolation.	Being able to exercise.	Accessibility of GP. Accessibility of mental health services. Accessibility of dental care. Support in the individual's preferred language. NHS waiting times. Reducing long waiting times for services.

Core20Plus groups engaged via 6 VCSEs

153 conversations recorded (over a short engagement period)

The evidence from Community Voices insights gathered represents three 'pillars'
- Living and working conditions
- Lifestyle and
- health and care services to inform the

Opportunities/Developments?

Joint Forward Plan

Core20Plus Framework

Health Inequalities Framework

- ❑Shift from reactive to proactive approach of delivering projects
- ❑Further developing health literacy in our core20plus5 communities via trusted communicator model
- ❑Create a fuller picture of who our communities are and what they are telling us about their health and care experiences
- ❑Shifting our ICS and ICB culture to prevention
- ❑Demonstrating value for money- focusing on people/community groups who need more hence reducing costs

Improving lives together
Norfolk and Waveney Integrated Care System

Patients and Communities Committee – 25.3.24
Item 9: Place Board Updates

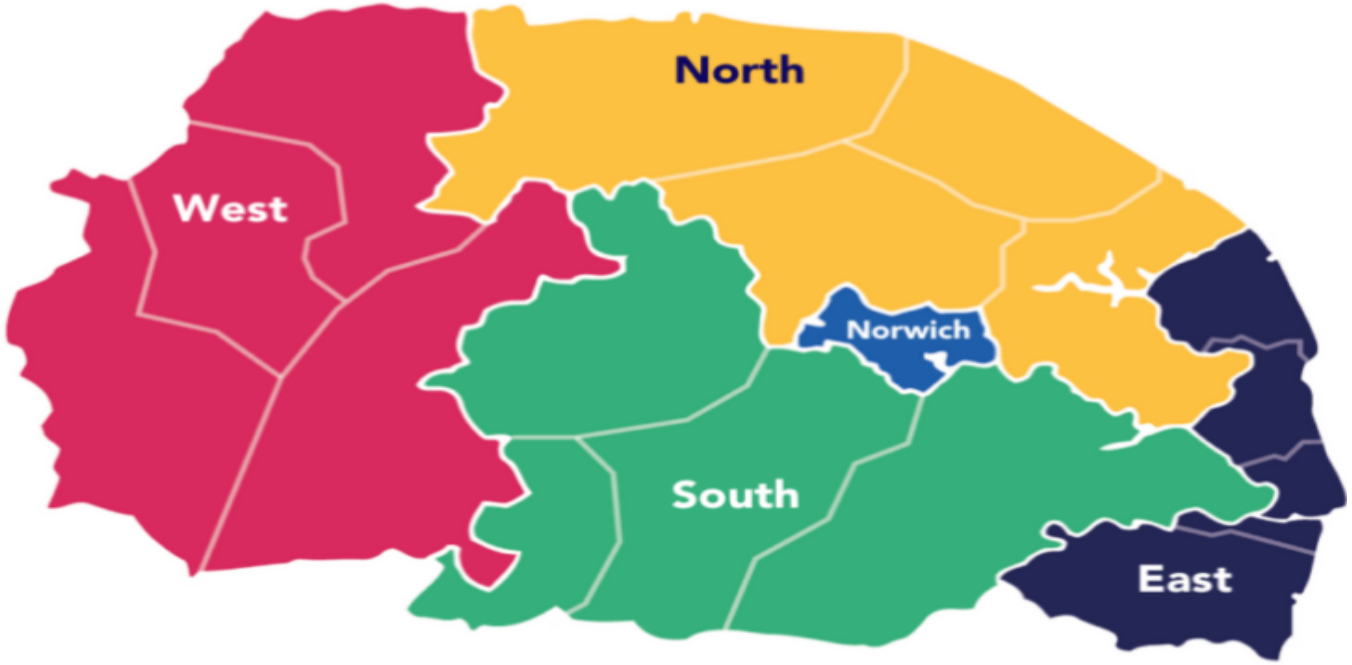
Defining place and its opportunities

25 March 2024

Mark Burgis
Executive Director of Patients and Communities

Place Geography

- Place-based partnerships bring together the NHS, local councils and voluntary organisations, residents, people who access services, carers and families. These partnerships will lead design and delivery of integrated services in their local area.
- In Norfolk and Waveney, five Place Boards bring together colleagues from health and social care to integrate services with a focus on effective operational delivery and improving people's care. They work closely with our seven Health and wellbeing partnerships based around district council footprints.



What is the purpose of the Place Boards?

- To identify local health and care priorities and deliverables, using data and intelligence, that focus on addressing the health and wellbeing needs of the Place population together with local Health and Wellbeing Partnerships.
- To consistently use a system-wide perspective when considering how to integrate health and care services, including VCSE and independent sector agencies.
- To provide oversight and assurance to the ICB; developing a shared Place Plan made up of the ICS strategic objectives/ICS strategy and local need.
- To ensure effective operational delivery within existing local resources to improve people's care at Place.
- To support delivery of national and system priorities and commitments.

Work needed to make place flourish

1. Define the remit and responsibilities of Place – inline with principle of subsidiarity.

For example: develop our operating model at 'place'

2. Realign ICB expertise and capacity to Place, underpinned by a compelling ICS strategic narrative of Place & our ICS approach.

For example: PHM strategy, finance & BI resource & drive a culture change.

3. Introduce mechanisms for agile & effective Place governance/decision making & delegation.

For example: Sign off place accountability and governance framework

4. Recognise Place Partnerships as enablers to NHSE 'left-shift' transformation ambitions

activity eg Dermatology/fracture clinic etc

5. Build on the impartiality of Place with an effective Place operating model (eg similar to an 'alliance agreement').

NB - Place benefits at risk if place function is aligned to one provider.

6. ICB to complete a talent-based approach to identify 'Place' capability & skills & extensive workload delivery managed by place teams.

For example: workforce review of Place skill & workforce gaps

"We want to progress our Place collaboration to enable people-centred care through services that are joined up, consistent and make sense to those who use them".
N&W ICP Strategy commitment

Linking our ICS & JFP ambition's – What could be done where?

N&W Joint forward Plan Priorities	Strategic Planning (Assessing Need, Priority Setting and Resource Allocation)	Securing Services (Specifying outcomes, Designing services, Shaping the structure of supply (e.g. procurement)	Delivering Services (Planning capacity & managing demand and service development and improvement)	Monitoring and Evaluation (Managing performance against agreed outcomes and seeking users' views)	Assurance (Assuring quality and safety and governance)
1. Population Health Management, Reducing Inequalities and Supporting Prevention	ICS	Place	Place	Place	ICS
2. Primary Care Resilience and Transformation	ICS	Place	Place	Place	ICS
3. Improving services for Babies, Children and Young People and developing our Local Maternity and Neonatal System (LMNS)	ICS	Place (Jointly for East, Central, West)	Place	Place (Jointly for East, Central, West)	ICS
4. Transforming Mental Health services	ICS	Place (Jointly for East, Central, West) inc through MH collabs	Place inc. through MH collaboratives	Place inc. through MH collaboratives	ICS
5. Transforming care in later life	ICS	ICS	Place	ICS	ICS
6. Improving Urgent and Emergency Care	ICS	ICS	Place	ICS	ICS
7. Elective Recovery and Improvement	ICS	ICS	Place	ICS	ICS
8. Improving Productivity and Efficiency	ICS	Place	Place	ICS	ICS

Key place achievements to date 1/1

- **West Norfolk** The Board's has adopted an oversight and programme management approach, which included the **2023/24 Winter Plan**: supported by c.£1m investment to enable the delivery of an Acute Respiratory Infection Hub, Non-Emergency Patient Transport improvements and additional capacity to support hospital discharge to community services for recovery and rehabilitation.
- **South Norfolk** One notable example has been our work with Breckland District Council, Watton Medical Practice and the ICB to address health inequalities and engagement in Watton, CORE20 area, through the deployment of Community Health and Wellbeing Workers (CHWWs). The service has generated more than 366 referrals for health interventions and 474 referrals for welfare in the first 9 months. Demonstrating the hidden need in that area. In a survey, 95% of the respondents reported that the CHWWs were extremely interested in their needs and 90% strongly agreed that the CHWWs understood their needs. The practice and the council have also found the service a great way to support residents and increase positive engagement.

Key place achievements to date 1/2

- **Gt Yarmouth & Waveney – Health Connect** is an example of the partnership work in GY&W Place, providing targeted support to help residents to recover faster and avoid hospital admission. The service offers practical and emotional support in residents own homes, as well as connecting them to wider health, social and community wellbeing services. Launched in December 2022, Health Connect has supported upwards of 700 residents, extended its reach month by month, and as of summer 2023 operated with a full complement of Health Connector staff. Reasons for referrals to the service vary greatly and can result in one off, simple phone-based support or a longer period of home visiting and check in calls. The Health Connectors' role is to listen, assess the situation, understand what matters to the person, then provide both direct support and co-ordinate other more specialist interventions. From spring 2024 Health Connect is collaborating with Public Health Suffolk, to provide targeted assistance to Waveney residents who have been discharged from secondary care for respiratory conditions. This partnership will also contribute to a larger initiative aimed at raising awareness of the broader determinants of health particularly for more vulnerable residents, who are at increased risk of respiratory illness.

Key place achievements to date 1/3

- **Norwich –** Local foundations continue to be developed with a wide range of community health and care providers, district councils and voluntary sector colleagues to provide more joined up care and address the needs of our populations. CHESS provides complex health and enhanced social support to those on the social care holding list or those that need further support following a crisis. The team work closely with healthcare professionals.
- In response to the Fuller Stocktake Report we are working at GP Practice footprint and convening multi-disciplinary teams from a range of health, care and voluntary sectors to explore better ways of working for the local population based around their needs.
- **North Norfolk** Sharing Best Practice **-** A piece of work has been identified around how we 'share best practice' and access to a 'shared evaluation toolkit' across the system to support the work of the Place Boards and Health and Wellbeing Partnerships. Whilst in the early stages, support and leadership is being sought with the ICB Evidence and Evaluation Team, as well as system partners

Opportunities

Place ideally positioned to act as an enabler

- Tackling Health inequalities at a place and neighbourhood level
- Supporting the development of integrated neighbourhood teams
- Population Health management
- Collaborating with moving services from the acute to the community (closer to home)
- Building sustainable relationships and resilience amongst providers
- Tackling preventative measures to enable healthy populations
- Engagement to hear the voice of local residents
- Using health and care assets Eg workforce and Estates more efficiently

NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 9

Subject:	**West Norfolk Place Board**
Presented by:	**Carly West-Burnham, Chair of the West Norfolk Place Board**
Prepared by:	**Rob Jakeman, Head of Integration and Partnerships (West Norfolk) N&W ICB**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**25 March 2024**

Purpose of paper:

To update the Patient and Communities Committee regarding activities being led by the West Norfolk Place Board and to seek input about further developments at Place in West Norfolk.

Executive Summary:

This report provides a summary of the following:

- Background regarding the establishment and role of the West Norfolk Place Board
- West Norfolk Place Board Priorities
- Key activities over the course of 2023/24
- Future developments and opportunities

Slides will be presented at the meeting to highlight key points for the Committee's consideration.

Background

West Norfolk Place Board is one of five Place Boards operating across Norfolk & Waveney. Established in August 2022, the Place Boards share the same terms of reference with the following aim:

'Bringing together colleagues from health and care to integrate services with a focus on operational delivery and improving people's care. Part of the governance structure of the ICS – accountable to the ICB and aligned to the local Health and Wellbeing Partnerships in their Place'

From the outset, the West Norfolk Place Board has sought to ensure that its membership is drawn from leaders across the diverse range of organisations involved in health and care delivery in West Norfolk. The Board was initially chaired by an Executive lead from Norfolk Community Health and Care (NCHC), and until recently the Vice Chair role was provided by the representative from Norfolk & Suffolk Foundation Trust. The current Chair and Vice

Chair are representatives from the Queen Elizabeth Hospital (QEH) and Borough Council of King's Lynn and West Norfolk, respectively.

The Board also comprises members from Local Authorities, General Practice and the Voluntary, Community and Social Enterprise sector. In addition, the Board maintains close working relationships with the Health and Wellbeing Partnerships that operate within the footprint of West Norfolk Place (King's Lynn and West Norfolk and Breckland), with representatives from both attending the Place Board (and vice versa). Administrative support is provided by the Norfolk & Waveney Integrated Care Board (ICB).

Whilst the Board's remit is advisory, it has an oversight and assurance role in relation to activities within its work programme (see below) and seeks to influence change through partnership working and developing a shared sense of commitment across West Norfolk.

Place Board Priorities

The West Norfolk Place Board recognised the importance of not developing its priorities in isolation; that they must be aligned with Integrated Care System goals and objectives (including the Joint Forward Plan) and dovetail with the ambitions of the King's Lynn and West Norfolk and Breckland Health and Wellbeing Partnerships to maximise impact. This is reflected in the information provided in the slides that will be presented at the meeting.

The Place Board also works with the Health and Wellbeing Partnerships to produce a Quarterly West Place Newsletter to help raise awareness about developments amongst colleagues working across West Norfolk, and to encourage their input.

The Place Board identified the following priorities to specifically focus on during 2023/24:

Priority 1: Urgent and Emergency Care
- a) Winter Resilience
- b) Integrated Virtual Ward, Discharge and Community Support

Priority 2: System Integration
- a) Community Transformation Fund – promoting independence and prevention across health, social care and housing sectors
- b) Population Health Management – smarter use of data to improve care

Key Activities during 2023/24

Priority 1: Urgent and Emergency Care:

The Board monitors Urgent and Emergency Care Programme developments as a standing item on its agenda. This has included:

- **2023/24 Winter Plan**: supported by c.£1m investment to enable the delivery of an Acute Respiratory Infection Hub, Non-Emergency Patient Transport improvements and additional capacity to support hospital discharge to community services for recovery and rehabilitation.

- **Integrated Virtual Ward:**. A key priority for the Place Board has been to support development of the West Integrated Virtual Ward for "Step-up" and "Step-down" patients to ensure that the limited resources available (staff and equipment) are used in the most effective way for the West system, avoiding duplication, improving efficiencies, and addressing the unique challenges and opportunities of the West.

- **Integrated Urgent and Emergency Care Hub:** The Board has endorsed a new approach to simplifying the triage of urgent care needs, through a multi-disciplinary approach involving professionals across acute, community and voluntary sectors. A single multi-disciplinary West Place Integrated Urgent and Emergency Care (UEC) Hub has been established, providing co-ordination across several existing stand-alone hub functions with the aim of facilitating a streamlined patient referral process and support future West Norfolk Urgent and Emergency Care models of care.

Priority 2: System Integration:

The ICB's West Norfolk Place team was allocated a non-recurrent allocation of c.£600K in 2023/24 to support community transformation initiatives that contribute to 'ageing well'. The team has worked with the West Place Board to develop proposals for the use of this resource and to perform a programme management role in relation to implementation of the initiatives:

- **Out of Hours Palliative Care Response**: A lack of capacity had been identified in out of hours community services to respond to palliative care needs, which had resulted in unnecessary conveyances to QEH. This project worked with Norfolk Hospice Tapping House to provide a telephone service for patients, available 7 days a week from 7pm to 7 am, with nursing support available to be deployed where required. In the first 2 quarters of 2023/24, the service received 160 referrals, which has helped reduce system pressures and patient feedback has been very positive.

- **Leg Ulcer Support:** General Practice and NCHC had identified that more capacity was required to support patients in the early part of the leg ulcer pathway in primary care and reduce pressure on specialist provision. This project invested in leg ulcer nurses to provide advice and guidance for primary care staff across the West Norfolk Primary Care Networks in the management of leg ulcers. This has resulted in improved integrated working between NHCH and Primary Care, numerous support and education sessions to staff and direct support to patients (28 reported in the last quarter) with improved patient outcomes and feedback.

- **Care Home Support:** The Place Board endorsed training packages, arranged by Norfolk County Council, on a 'train the trainer' basis for falls prevention, with 11 homes trained in the last reporting period. In addition, following feedback from Care Homes, a mobile dentistry unit has been commissioned which has been providing check ups to residents, including those with complex needs associated with dementia. 10 Care Homes were booked in for support in January and February. Palliative care training and support to Care Homes has also been provided by a dedicated role hosted by Norfolk Hospice Tapping House.

- **Falls Response:** Following a presentation from a patient advocate about their concerns regarding falls response within West Norfolk, a task and finish group was established involving representation from NCHC, EEAST and NCC with the patient advocate kept informed and attending one of the meetings. This has resulted in improvements including optimisation of the Swift service model, with plans in place to address other factors such as lifting equipment availability.

- **Falls Prevention:** This was identified by Place Board Members as a key focus of the year which provided the impetus for a project that is currently in delivery. The project aims to contact individuals at heightened risk of susceptibility to injurious falls and offering them housing support and access to exercise support (on a one-to-one basis or

in groups). This has been delivered by teams from the Borough Council of King's Lynn and West Norfolk, Breckland District Council and the Active NoW service, and included partners such as NCHC and QEH in terms of referrals. Referral routes from numerous sources; such as libraries, housing associations, ambulance service, Social Prescribers are being encouraged and qualitative feedback from service users is being captured to enable an evaluation of the benefits to be undertaken.

Future Developments and Opportunities

The Place Board has discussions about its priorities and potential work programme for 2023/24 and has finalised these at its meeting on the 12th March. The agreed priorities are:

- Priority 1: Urgent and Emergency Care
  This remains a key priority for the Place Board, as there are significant developments underway that the Board can continue to contribute to.

- Priority 2: Tackling Health Inequalities
  This has always been central to the Board's activities, but members would like to make this more explicitly a priority over the next year. This will include contribution to the delivery of the newly developed Health Inequalities Strategic Framework for Action and to the associated clinical conditions identified within the Core20Plus5 frameworks[1]

  The Place Board will also have an important role in leading West Norfolk's role within the Marmot Place Programme (see below), which will involve joint working with the Health and Wellbeing Partnerships in tackling health inequalities.

- Priority 3: West Norfolk Place Development
  Place Board members have identified that there are several enablers that can be developed to further improve the capability and capacity of West Norfolk. These include enhancing Integrated Neighbourhood Team working, enhancing community involvement (for example, through wider application of the Community Voices programme), enabling increased data sharing across partners to facilitate more integrated care and better use of public estates for service delivery. This particularly applies to the New Hospital Programme, which is a crucial opportunity for West Norfolk to take advantage of in the near future.

<u>West Norfolk's inclusion in the Marmot Place Programme</u>

A 'Marmot Place' is a place which has a significant commitment to tackle health inequalities through action on the social determinants of health, the social and economic conditions which shape our health, and has strong and effective plans and policies to achieve these reductions in health inequalities.

The Institute of Health Equity[2], established by Professor Sir Michael Marmot, has supported over 40 Local Authorities to become 'Marmot Places', through a process of analysis, reporting and implementing recommendations, that typically runs over a 2-year period.

West Norfolk has recently secured a place on the Marmot Place Programme, with a provisional starting date of May 2024. This is anticipated to be a catalyst for positive change in West Norfolk, and for the wider system as learning from the Programme will be widely shared, as it will enable:

[1] These derive from NHS England and comprise frameworks for adults and children and young people
[2] Institute of Health Equity information accessible here

- Access to expert advice and guidance, using learning across multiple areas over the last 10 years
- Provision of an independently produced position statement and evidence-based recommendations to enable change
- Mentoring and facilitation in developing partnerships that are better equipped to face the complex challenges associated with tackling health inequalities
- Supporting a culture shift that means that health inequalities is part of everybody's business
- Being associated with Michael Marmot's Institute provides a sense of gravitas and brings senior engagement to lead change
- Learning from an ever-growing network of Marmot Places that provide peer support
- Support from the Institute beyond the 2 years of the focussed Programme: once part of the Marmot Programme, a Place remains within its support framework indefinitely

The Place Board and Health and Wellbeing Partnerships will be at the forefront in leading these changes for West Norfolk.

Opportunities

The West Norfolk Place Board has made significant progress in its development since August 2022 and has a clear direction for the year ahead. The inclusion within the Marmot Place Programme also offers a considerable opportunity for West Norfolk, and the wider Norfolk & Waveney system, to utilise. There is also a strong sense of commitment and enthusiasm from partners.

This provides a good basis for further development, as it is important to acknowledge that currently the Place Boards operate on an advisory basis, with no formal delegated powers, and relatively marginal resources to deploy (limited to the Community Transformation Programme). Given that this report has demonstrated a track record of delivery, within the resources at its disposal, there is an opportunity to consider whether there is appetite to widen the ambitions of the Place Board(s), and provide the resources, delegations and accountability arrangements to facilitate this.

Recommendation to the Committee:

The Committee is asked to note the report and consider any opportunities for joint working with the West Norfolk Place Board.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	N/A
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	None
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	N/A

Norfolk and Waveney
Integrated Care Board

Agenda item: 10 i

Subject:	**Children and Young People's Asthma Care and Support**
Presented by:	**Luke Bacon, Research and Business Development Officer, Healthwatch Suffolk**
Prepared by:	**Luke Bacon, Research and Business Development Officer, Healthwatch Suffolk**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**25 March 2024**

Purpose of paper:

To share with the committee the results and key recommendations of the asthma survey undertaken by Healthwatch Suffolk.

Executive Summary:

Families across Suffolk (and north east Essex) have helped to show where changes could be made to improve asthma care for children and young people. This research was funded by the ICBs in Suffolk and north east Essex and Norfolk and Waveney to support better planning of asthma care, now and in the future. The project was co-produced and developed by Healthwatch Suffolk and Healthwatch Essex together (with an extension of the project into Waveney). For more information, please visit: https://healthwatchsuffolk.co.uk/cypasthma/

Recommendation to the Committee:

To review and note the recommendations within the presentation.

Key Risks	
Clinical and Quality:	
Finance and Performance:	
Impact Assessment (environmental and equalities):	
Reputation:	

Legal:	
Information Governance:	
Resource Required:	
Reference document(s):	
NHS Constitution:	
Conflicts of Interest:	
Reference to relevant risk on the Board Assurance Framework	

Governance

Process/Committee approval with date(s) (as appropriate)	

healthwatch Suffolk

Children and young people's asthma support in Waveney

Published January 2024

Key Recommendations

Promote the use of **asthma plans**

Provide **accessible information about asthma** to families and schools.

Ensure appointments are accessible, **follow up** from hospital admission and a **yearly asthma review**

Method

Co-produced survey for SNEE adapted for Waveney. Between September and November 23, this gathered:

130 responses in SNEE including 5 children aged 11-15, 14 young people aged 16+ and 111 parents.

And 25 responses in Waveney, including 23 parents and three children and young people aged 16 or above.

Asthma Plans

The National Bundle of Care for Children and Young People with Asthma states all CYP with asthma should have a personalised asthma plan, however:

A third in Waveney and SNEE did not have an asthma plan, or were unsure.

Only 69% in Waveney and 60% in SNEE said they understood their asthma plan.

Info and awareness

Parents told us there were gaps in the support for asthma from their children's school.

19% of parents in Waveney and 16% of parents in SNEE said that they didn't know or were unsure what to do if their child was having an asthma attack.

Suggestions for how to improve this included general training, paper and online resources, discussion of triggers and regular reviews.

Access to care

Two in five respondents in Norfolk and Waveney, and over a third in SNEE said they had been unable to access an asthma appointment because they were offered during school or college times.

44% of children, parents and guardians in Norfolk and Waveney, and 48% of respondents in SNEE felt children and young people's asthma was not monitored regularly enough.

Only 54% parents, guardians and young people who had been admitted to hospital in Norfolk and Waveney had a follow up review with their GP.

For more information, visit:

https://healthwatchsuffolk.co.uk/cypasthma/

healthwatch Suffolk

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format, please contact us on 0800 448 8234 or by email to info@healthwatchsuffolk.co.uk.

Date	25 March 2024
Item	10 ii
Report by (name and title)	Patients and Communities Committee
Subject	Healthwatch Norfolk Quarterly Update

Reason for Report

The purpose of this report is to provide Committee Members with information on Healthwatch Norfolk recent engagement and communication undertaken by Healthwatch and provide some feedback in relation to services being provided.

Recommendations

1. The Committee is asked to note the report.

Intelligence and Engagement report

Introduction

In the last quarter of 2023 , Healthwatch published 727 individual reviews, relating to 100 different services delivered in Norfolk. The average rating of these reviews was 4.0 (out of five). Over half of the reviews we received were through our feedback centre (53% 385). As well as this 44% were collected by our engagement team (321), 2% (18) of our reviews were received through the post, and less than 1% (3) reviews came through our helpdesk.

We received some demographic data from 40% (288) of our reviews in this period; age, gender, and ethnicity are displayed in table 1 below.

Table 1.

Age, Gender, and Ethnicity of Reviewers

	Percentage of reviews	Number of reviews

Age (271 reviews)	16 to 25	1%	3
	26 to 35	4%	10
	36 to 45	3%	8
	46 to 55	5%	13
	56 to 65	20%	55
	66 to 75	37%	101
	76 to 85	25%	68
	86 or over	5%	13
Gender (280 reviews)	Female	64%	180
	Male	35%	99
	Other	<1%	1
Ethnicity (283 reviews)	Asian/Asian British: Bangladeshi	<1%	1
	Other Asian/Asian British Background	<1%	1
	White: English/Welsh/ Scottish/Northern Irish/British	96%	4
	White: Irish	1%	273
	Other White background	1%	3
	Other ethnic group	<1%	1

We have continued to share anonymised feedback with other organisations and groups including the CQC, commissioners, service providers, and with Healthwatch England.

We are continuing to receive engagement from service providers with our feedback centre. We received provider responses on our website for 34 different services for a total of 364 reviews in this period.

The services people are talking to us about

Table 2 shows the service types about which people have shared their experiences with us between September and November 2023. The average rating for each service type reflects the overall experience of care the reviewer felt was received.

Table 2.

The service types for which we have received reviews and the rating change from last report

		Service Type	Reviews	Rating (change)
1		GPs	612	4.0 (+0.1)
2		Hospitals	62	4.8 (+1.2)
3		Pharmacies	20	2.8 (=)
4		Carer Support	14	4.4 (+0.3)
5		Mental Health	6	2.2 (+0.2)
=		Social Care	6	3.5 (n/a)
6		Residential Care	3	2.3 (-0.7)
7		Dentists	2	3.0 (+0.9)
8		Opticians	1	1.0 (-4.0)
9		Other	1	5.0 (n/a)

Table 3 shows the top services about which people have shared their experiences with us between September and November 2023. The average rating for each service type reflects the overall experience of care the reviewer felt was received.

Table 3.

The top services for which we have received reviews.

Service	Reviews	Rating

1		Castle Partnership	174		4.8
2		East Norwich Medical Partnership	42		3.2
3		Norfolk and Norwich Hospital	37		4.6
=		East Harling Surgery	37		2.3
5		Heacham Medical Practice	30		4.5
6		Heathgate Medical Practice	25		4.9
7		Swan Lane Surgery	21		4.8
=		Hunstanton Medical Practice	21		4.2
9		Manor Farm Medical Centre	20		4.4
=		Grimston Medical Centre	20		4.8

GP feedback

From September and November 2023 we received 612 reviews for doctors' surgeries with an average rating of 4.0 out of five. Reports from our recent visits to services can be found here: https://healthwatchnorfolk.co.uk/reports/feedback-and-intelligence/.

Castle Partnership

In this period we received 174 reviews for Castle Partnership with an average rating of 4.8 out of five. Castle Partnership told us that they had been actively asking their patients to leave a review following all appointments, including vaccine clinics, along with the friends and family texts.

Most of the reviews we received were experiences of the recent vaccine clinics at the surgery. Patients shared that they found the clinics well organised and efficient, staff were helpful, and they had short waiting times.

East Norwich Medical Partnership

In October 2023 we spoke with patients at a flu clinic at East Norwich Medical Partnership to hear about their experiences with local health and social care services. From this visit we collected 39 reviews for the practice with an average star rating of 3.3 out of five. Healthwatch Norfolk Officers who visited the practice noted:

> They were very welcoming and friendly to us. The flu day was running very smoothly with lots of patients coming through. The car park is large, and the facilities were clean and welcoming.

We heard that patients were impressed with the flu clinic, they often told us how they were in and out quickly and that the clinic ran smoothly. They also told us that staff were mostly kind and helpful and that once they were able to get an appointment the service they received was good.

We also heard that it was sometimes difficult for patients to get appointments, particularly face to face, at the practice. They also told us about long waits on the phone particularly first thing in the morning. Finally, some patients closer to Thorpe Health Centre told us how they found it frustrating when the branch was often closed or had a lack of staff.

A full response to this report from East Norwich Medical Partnership can be found in the report on our website.

East Harling Surgery

We were invited by the Clerk & Finance Officer of Harling Parish Council to visit East Harling Welcome Hub to speak with local residents about their experiences with local health and social care services. We visited the Welcome Hub in November and also visited East Harling Surgery.

From these visits we received 26 reviews for East Harling Surgery, we also received a further five reviews through our website since the start of October 2023 and three reviews through the post which were included in this report. The reviews have an average star rating of 2.2 out of five.

Overall, people we heard from told us that staff at the surgery are kind and considerate, however we heard concerns about many staff leaving the surgery and the impact this was having on patient care. We heard about difficulties accessing services including booking appointments and issues and delays with prescriptions. Some patients told us that this put them off seeking help when they needed it or that they were considering leaving the village.

In response to our report East Harling Surgery said:

> The Practice would like to thank each patient who took the time to provide feedback for the latest Healthwatch Feedback Report. The Practice reviews each piece of feedback as part of our ongoing commitment to continuous improvement of the care we provide for our patients.

Norfolk and Norwich Hospital Feedback

From September to November 2023 we received 37 reviews for Norfolk and Norwich Hospital with an average rating of 4.6.

Norfolk and Norwich Kidney Centre

In September 2023 we visited the Norfolk and Norwich Kidney centre to speak with patients about their experience, what was good and what could be improved. This was

arranged to compliment our work at the hospital for Three Hospitals Three Weeks. From this visit we received 17 reviews for the centre. The reviews have an average star rating of 4.9 out of five.

Healthwatch Norfolk Observations

The Norfolk and Norwich Kidney Centre is in Bowthorpe but you would not know it was there if you didn't need to and that is part of what makes it so special.

The purpose-built centre offers dialysis treatment to patients and is one of the biggest centres in the country. The set-up has bays of four beds/seats with a nurse stationed at each bay.

There are spaces for 30 people to be seen per session (which can last three or four hours depending on the person's treatment) and three sessions a day Monday to Saturday, which means there are over 500 dialysis sessions per week at this Centre.

The patients have access to free Wi-Fi and each bed has its own TV screen. The building is light, airy and cool with patients enjoying a hot drink and biscuit when we arrived to speak to them.

We had a very warm welcome from reception when we arrived and waited in the clean, large and comfortable waiting area to go through and speak with the Senior Sister and then the patients.

The walls in reception were decorated in a bright sunny yellow with large photo prints to brighten the area even more. Information boards were available with support services and upcoming events. The newsletter "The Kidney Bean" is available to all patients and is a wealth of information about their treatment/care and includes recipes and advice. This edition had a really insightful piece from one of the patients about his journey booking and having a holiday in America, which can really help other people who want to holiday when on dialysis.

The plentiful free parking was also welcomed by most people we spoke to, taking away the worry and stress before treatment – and to not have that worry three times a week, every week is important to everyone – both patients and family/carers.

The staff were all very friendly and welcoming, busy but always smiling and laughing with the patients and fully explaining what they were doing (for example adding medicine to the dialysis machine – they didn't just walk up and do it they explained what it was, where it was going and what it did).

The facility was very clean and tidy.

There was a clear appreciation for this centre by all we spoke to, the ease of getting here, rather than a hospital and the focussed care – knowing every patient was going through the same thing as each other gave the impression that everyone knew they were not alone.

Patient feedback

Overall, the patients we spoke to were very happy with their experiences at the Kidney Centre. They told us how "*everyone is very friendly, looks out for each other, you become like a family*", this included staff and other patients in the centre.

The patients really appreciated the facilities, the easy parking, the cleanliness, and the "*china cups and good biscuits!*". However a couple of patients did note that they sometimes found that the air-con "*can be cold first thing in the morning so we have to bring our own blankets*".

Another suggestion for improvement was for the doctor to come and visit the centre more often, patients noted that they will visit the centre on the days they were not there for dialysis which meant they missed out on speaking with the doctor in person:

> "The only minor bugbear I have is the Doctor only comes on a Wednesday and that never varies and that is my day off and the thought of having to come in on my day off - it would be nice if sometimes they could swap and we could go and see them after treatment sometimes but I understand that might be difficult and you can choose a telephone consultation if you want to but I think we all like face to face."

In response to our report the Norfolk and Norwich Kidney Centre told us:

> Although it is a medical facility it is so important for the patients to feel like they aren't coming into a hospital environment. We are so lucky to have these wonderful facilities to care for these patients in, as well as a team who are dedicated and hard working. I feel very privileged in my work- the Kidney Centre is a special place.

Norfolk and Norwich Radiology

In November 2023 we visited the Radiology department at the Norfolk and Norwich Hospital to speak with patients about their experience with local health and social care services. From this visit we received 18 reviews for the hospital, this also included other departments such as Accident and Emergency and Cardiology. The reviews have an average star rating of 4.8 out of five.

Healthwatch Norfolk officers who visited the hospital noted:

> The staff calling patients in for their appointments are very caring – one helped an older gentleman who was very unsteady on his feet. Another came to speak to us to ask who we were and what we were doing and told us she loves her job and working in Radiology. She introduced herself to every patient she collected.
>
> The waiting room was tidy and clean. It is well signposted and clear to patients to understand where they are going. There are informative posters on the walls. The hand sanitiser on the wall was empty but there was a pump on the table.
>
> Patients are called through very quickly after checking in.

People told us how professional and friendly the staff at the hospital were. We heard how staff put them at ease and made them feel comfortable. Frustrations for patients included difficulties with car parking and not enough toilets in Radiology.

Norwich Community Hospital

In October 2023 a Healthwatch Norfolk postbox was available for patients to share their feedback on services at Norwich Community Hospital. The postbox was available in the main hospital reception and the Children's Centre.

From this postbox we received 28 pieces of feedback for Norfolk Community Health and Care services. The most common department we received feedback for was Physiotherapy with 10 pieces of feedback. Only 15 pieces of feedback included a written explanation.

The overall average star rating for services was 4.9 out of five. It is worth noting that no patients who left feedback left an overall rating as less than four out of five.

The comments we received were very positive, praised staff, and none of them suggested any improvements to services.

Figure 1 below shows the average star rating for additional performance indicators. As the graph shows, patients we received feedback from were very satisfied with all indicators. Waiting time was rated an average of 4.7 out of five and all indicators were rated as an average of 4.8 out of five or above.

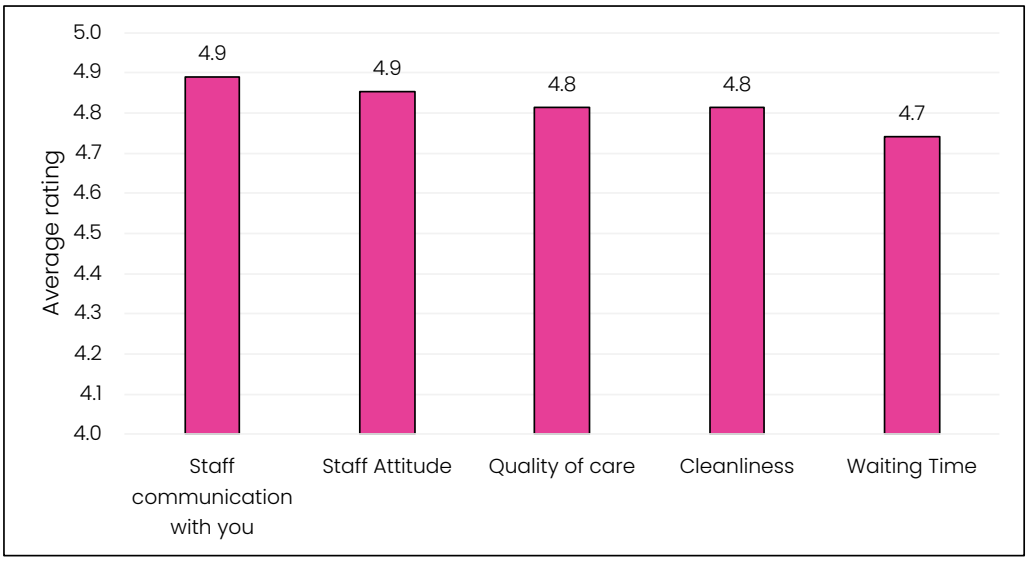


Figure 1. Average star rating (out of five) for performance indicators. Please note that these ratings were not compulsory. Numbers are rounded to one decimal place.

Signposting

In this period we provided information and advice to 74 people who contacted us by enquiries email (33, 43%), telephone (30, 41%), through an own email (1, 1%), at an engagement event (9, 12%), and other (1, 1%). Below in Table 3 is a summary of the type of information we are sharing; most commonly this is information and advice on raising concerns or making complaints (23, 31%) followed by information on accessing dentistry (18, 24%).

Table 3.

Summary of Healthwatch Norfolk Signposting from 1st September to 30th November 2023

23	18	9
Information and advice on raising concerns	Information on accessing dentistry	Information on local support and services
9	3	3
Support accessing a health service (not dentistry)	Advice while on a waiting list	Other information and advice
2	2	2
Information on transport/blue badges	Information on medication	Information on Mental Health support
1	1	1

Information on fees/charges	Information on accessing legal advice	Information on the health system in Norfolk

Dentistry

We continue to receive enquiries about difficulties accessing NHS dentistry in Norfolk as displayed in Figure 2 below.

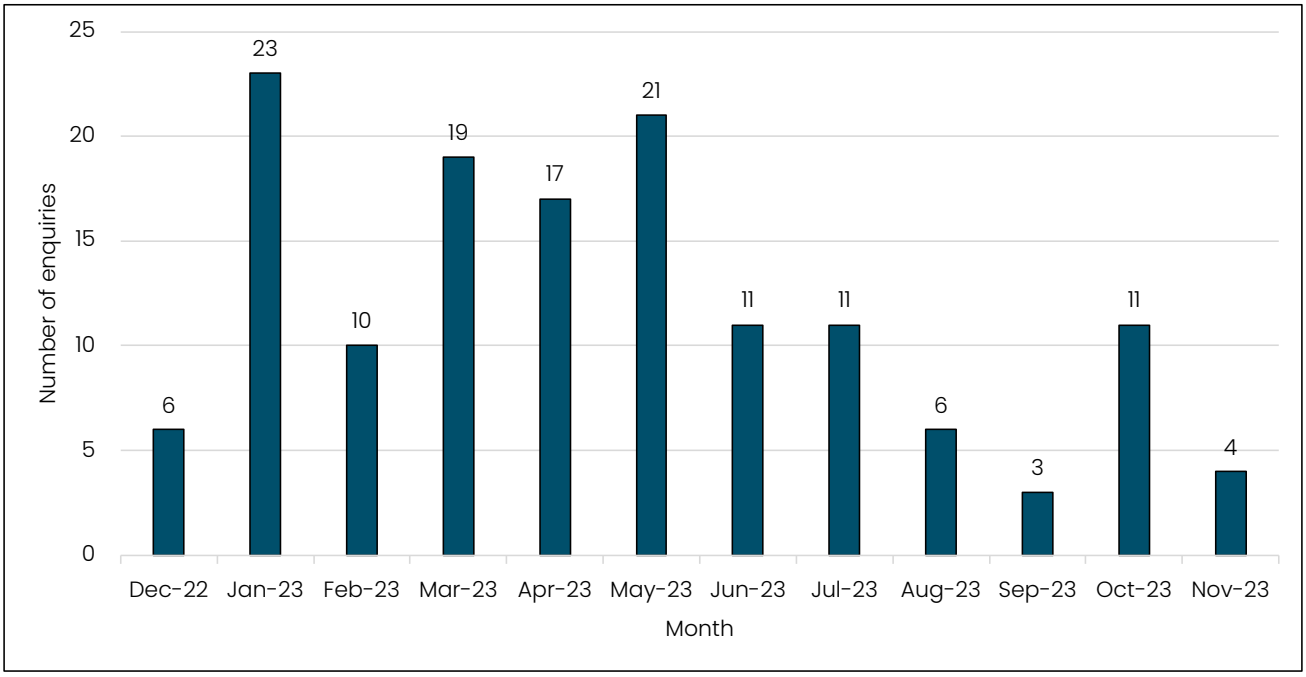


Figure 2. Dental enquiries received by Healthwatch Norfolk in the past 12 months.

From September to November we received 18 enquiries about accessing dentistry in Norfolk. Examples of these enquiries include:

- Five of these were people in pain or had a broken tooth
    - One of these callers has contacted 111 several times but they keep giving him the numbers of dental practices which are not taking on patients. They have also been to A&E and have received antibiotics but they are not having an impact.
- Three were from families with children under 16.
    - One of these has a 22 month old with a milk allergy and their parents are worried about the impact of this on their calcium intake and teeth.

    - One care home in North Norfolk who had been told by Castle and Costa that they have no more capacity for domiciliary dentistry.
- One person with a child with autism & sensory issues who has wisdom tooth issues; they needed to see a dentist to be referred to the hospital for this.

Engagement update

Staff update

We enter the new year with two new members of the engagement team, Faye in the South and Dan in the North, as we welcome them to Healthwatch Norfolk it is an exciting time to see what new ideas they will bring to the team.

Wells-next-the-sea SEND event

In November 2023 we attended an event for people with Special Educational Needs and Disabilities (SEND), their families and carers in Wells-next-the-sea to hear their experiences of health and care.

People shared a range of experiences. Many related to the time taken to access a diagnosis and/or care, and the difficulties and frustrations it causes. One person also raised concerns about the lack of availability of British Sign Language (BSL) interpretation at a doctors' surgery appointment.

Feedback from this event can be found here: https://healthwatchnorfolk.co.uk/report/wells-next-the-sea-send-event-feedback-report-november-2023/

Plans for engagement

The way the CQC operate is changing, with a focus on continuing engagement with patient and residents, this is an idea opportunity for us to offer our service to visit and gather feedback in facilities that may have been in the past resistant or apprehensive about us attending and speaking to people.

We will continue to visit Foodbanks as we have been doing in the last few months and each member will set up a once a month location in their patch so we have somewhere in the community that we will always be on a set day of the month. We have been doing Wymondham Library on the last Friday of the month and will be doing the Alive Church in Norwich at the foodbank and community café.

Healthwatch England are launching a joint campaign with the CQC called "share for better care" which will be about reaching underrepresented communities which we will be keen to get involved in.

Communication Methodologies

Traditional media

The acute hospitals have been the focus of a lot of our comms activity over the last quarter. The publication of the Three Hospitals Three Weeks report created a lot of media interest including coverage on ITV Anglia, BBC Radio Norfolk, the Eastern Daily Press, Greatest Hits Radio and Heart Radio. As well as highlighting the key findings, there was great interest in what happens next with the findings, particularly in the TV coverage.

Our work on the proposed Major Trauma Centre was also the focus of some coverage in the press and radio as well as creating a lot of interest on social media.

We were also asked to respond to a number of breaking stories, most notably the future of the Norwich Walk-In Centre as OneNorwich Practices opted to wind up in the run up to Christmas. While we could not comment directly on the business situation, we pushed for clarity around what would happen to the services provided by OneNorwich while also sharing messages from the ICB for patients and users about the service.

Healthwatch Norfolk also played its part in sharing the key messages around staying safe over the festive season which included some audio clips being featured as part of Heart Radio's coverage.

Social media/digital

Our new website will finally go live imminently and is complete. It will have a much cleaner design and will make it much clearer and easier for people to share their feedback as well as find their way to information and advice, and access our data/reports. In the short term, the new one will link to our current website (which we will pay a bit less for than we do now) so people can still leave feedback in the current way and we can analyse it. We are assessing options for the next financial year to see what would work best in terms of the feedback function, Healthwatch's Head of Communications is assessing various options.

Once the new site is up, we can resume updates of how well the site is working but social media data is looking generally good.

Facebook saw a rise in use partly because of two paid campaigns (one promoting the digital tools engagement and another promoting the part-time comms officer offer) as well as engaging posts around the success of the Carers Identity Passport which reached 2000 people.

While Twitter/X's algorithms remain a bit of a mystery, we did see an average rise in reach of over a thousand over the quarter. Traditionally, when we advertise new roles, that does make a difference but there was also a lot of interest in both health and social care-related posts including the launch of the Caring Together intiative (2900 reach) and promoting a survey on end-of-life support by UEA end-of-life expert and Healthwatch Norfolk Live speaker Guy Peryer (2200 reach).

Our Instagram reach also continued to rise with interest in a number of different posts including a recap of Healthwatch Norfolk Live, the publication of the Three Hospitals Three Weeks report, and the success of the Carers Identity Passport scheme.

Our LinkedIn engagement dropped a bit, which is traditional around Christmas. Individual posts around projects and initiatives still do well but we may rein back on the advice posts going forward as they don't always get the best engagement.

Once the new website is up and running, the analytics we include within this report and report to you will be refreshed in the first quarter of 2024. This is partly through necessity as X/Twitter has changed what we can/can't measure and we have not been able to access our website statistics for some time, but we can also focus a bit more on what people are engaging with us on.

This will be one of the first projects to be worked on by our new part-time communications officer Oliver George, who will continue to build on the great work already started by. He has a strong communications background working in radio, social media, digital communications and event management, as well as

having a keen interest in the NHS for both personal and professional reasons, and joined us in early January.

Health Inequalities Conversation

Improving lives together
Norfolk and Waveney Integrated Care System

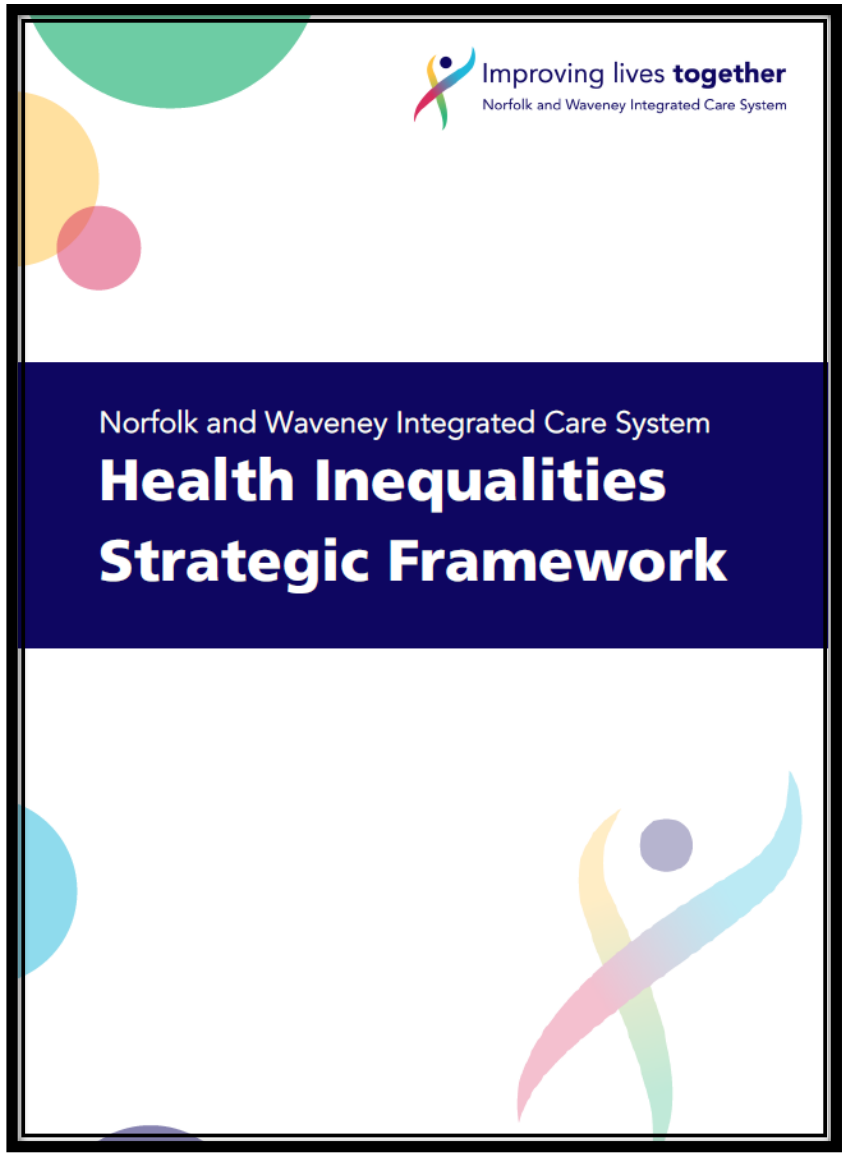
Patients and Communities Committee – 25.3.24
Item 11: Health Inequalities Framework

Health Inequalities Framework – Next steps

Tracy Williams, Clinical Lead for: Health Inequalities & Inclusion Health, NWICB
Nadia Jones, Public Health Principal – Prevention, NCC

Introduction

- This Framework responds to the Joint Forward Plan objective to develop a Health Inequalities Strategy by April 1st 2024.
- Designed through a significant engagement process across our local system, and by reviewing best practice from other systems.
- Over 100 organisations engaged, including all Place Boards, Health & Wellbeing Partnerships, VCSE forums and governance structures .
- Driven by a multi-agency taskforce, with significant input from Public Health colleagues.
- It is designed to be our **first step** in a whole system approach, to lay a strong foundation for the future.
- Went to ICP on 6th March 2024 for endorsement.



Vision

We will come together to address unfair and avoidable differences in health outcomes. We will do this by listening to communities, prioritising prevention, and taking action together, making health inequalities everybody's business.

Our Guiding Principles

- Everyone needs something, some people need more.
- Enabling communities to have a voice is key and requires creativity and persistence.
- We will work as close to people and communities as possible.
- Our approach must be personalised to ensure the right action at the right time for each individual.
- We will ensure accessible services for those in greatest need.
- We know we can make a difference, and this is a long-term commitment.
- We will take an approach that includes consideration for families and all stages of life.
- Leading for change requires shared responsibility, collaboration and enduring focus.
- We will understand who is accessing our services & support, who isn't and why in order to act.
- Recognising the building blocks for good health & wellbeing are not just in health services.
- Building fairer services means supporting change in our organisations.

Priority Action Areas

Building Blocks

Living & working conditions

Housing

Access to services

Employment & Skills

Education

Welfare & Income

Natural & Built Environment

Social Isolation

Lifestyle Factors

Smoking

Inactivity

Food & Diet

Drugs and Alcohol

Healthcare Inequalities

Access, Quality, Experience & Trust

Core20plus5 Frameworks

NHSE 5 Urgent Actions

Legal duties

Foundation

Creating the Conditions for Success

System, organisation, place or community-led approaches

Leadership & Governance

Community Voice & Coproduction

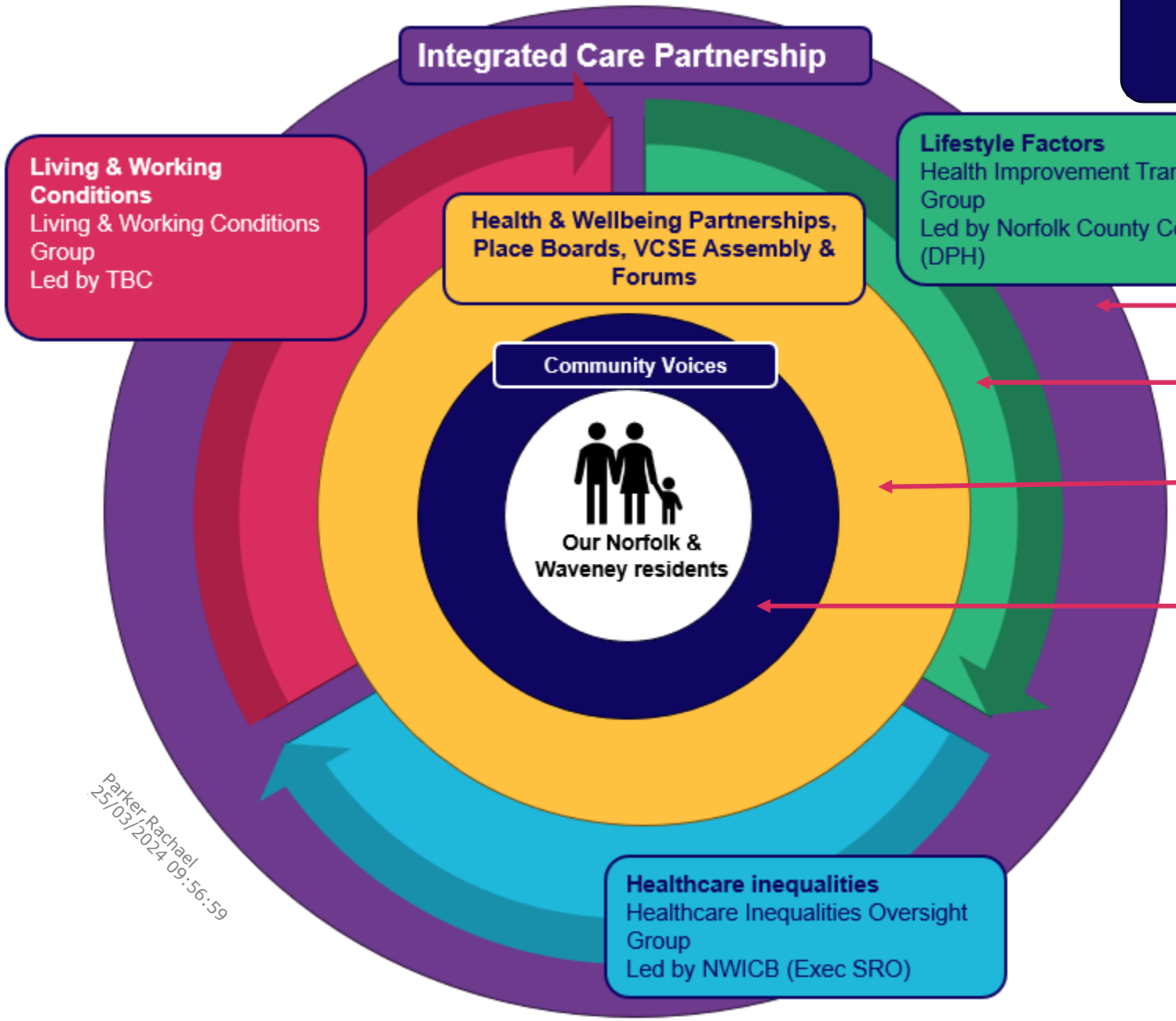
Organisational & workforce development

Intelligence & Evaluation

Policies, Processes and Procedures

Resourcing

How will we organise ourselves?



Parker Rachael
25/03/2024 09:56:59

- Action in our organisations
- Acting together as a system
- Acting locally, as close to communities as possible
- Empowering communities to take their own action

Fundamental actions for year 1 to be undertaken by a multi-agency taskforce/steering group

Action 1

ORGANISATIONAL PLEDGES

We will continue our ‘Health Inequalities Conversation’ and roll out a programme which includes commitments and accountability.

Action 2

GOVERNANCE STRUCTURE

We will identify named Senior Responsible Officers/Leaders, Organisational Leads, Clinical leads and Health inequalities champions.

Action 3

PEER REVIEW & SELF ASSESSMENT

We will assess where we are, what good looks like, what we need to do next. We will include actions for anchor institutions.

Action 4

ACTION PLANS

We will produce action plans for each of our building blocks, building on our existing assets and with our place and system structures working closely together.

Action 5

VCSE INTEGRATION

We will further develop the VCSE Assembly and integrate the VCSE sector into all parts of our planning & decision making.

Action 6

ORGANISATIONAL DEVELOPMENT

Including a suite of tools and training, as well as a learning centre to share good practice and case studies. And establish a health inequalities champions network.

Action 7

RESOURCES

Mapping the flow of health inequalities resources & spend across organisations to further develop our business case for investment.

Action 8

INTELLIGENCE

Get better at collecting data and insights on our population, as well as service data – so that population health management is embedded in our ways of working.

Action 9

PARTICIPATION

Continue to engage with communities that experience health inequalities to enable access to services and ensure voices are heard with equity. We will ensure coproduction with experts by experience.

Action 10

MONITORING

A Health Inequalities Outcomes Framework, with clear metrics and targets identified to keep us on track.

Recommendations

The Patients & Communities Committee is asked to:

1. Endorse the Norfolk & Waveney ICS Health Inequalities Strategic Framework for Action
2. Commit to providing leadership and advocacy to the Framework
3. Receive regular updates of progress and delivery and provide oversight as required

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

Norfolk and Waveney Integrated Care System

Health Inequalities Strategic Framework for Action

2024 - 2034

Forewords

TBC

Introduction

Right now, some people are dying a decade younger than they should. Lives are being cut short because of where someone lives and works, how they are treated and because they might not be able to access services.

This framework for action is designed to change that, to help individuals, families, communities and organisations tackle these issues across the life-course. Nationally, and locally, we know where and what the causes are, but no one organisation can address it alone. That is why this framework will try and map actions and develop tools and commitments so we can act **together** now.

Many people who are passionate about making a difference have contributed to the ideas and information presented within this framework. Our Health Inequalities Conversations have taken place across Norfolk & Waveney and have helped to shape this framework.

There are many people and organisations in Norfolk & Waveney who are working to address health inequalities every day. Action around health inequalities is not new, but the whole Integrated Care System coming together under a common purpose and framework is.

The spotlight on those individuals and communities who have been most affected during the pandemic has meant that we all want to do things differently. Now is the time to act, the creation of our Integrated Care System, and the national drive for change has contributed to the urgency and determination to come together with a common vision, language and goals.

We are focused on our **'building blocks'** for good health, alongside how we strengthen our foundation to **create the conditions for success.**

This is a ten-year framework, which contains within it it a requirement to create annual action plans that are to be reviewed every year. Our initial actions detailed in this framework are the **first steps** towards a whole-system approach, and will be valid for our first 12 months of implementation.

Norfolk and Waveney Vision

We will come together to tackle unfair and avoidable differences in health outcomes. We will do this by listening to communities, prioritising prevention, and taking action together, making health inequalities everybody's business.

What are health inequalities?

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing. The effects of inequality are multiplied for those who have more than one type of disadvantage. (Kings Fund)

Inequalities of what?

This can involve differences in outcomes and in known contributing factors to health:

- **Health status** e.g. life expectancy and prevalence of health conditions
- **Access to care** and non-clinical services e.g. availability or waiting times for treatments, take-up of services, access to information
- **Quality and experience of care**, e.g. levels of patient satisfaction, feeling involved
- **Behavioural risks** to health, e.g. smoking rates
- **Mental wellbeing** and exposure to stressors and adversities (or protective factors)
- **Social economic and environmental conditions** that are 'wider determinants' of health e.g. housing quality, community life, discrimination

Inequalities between who?

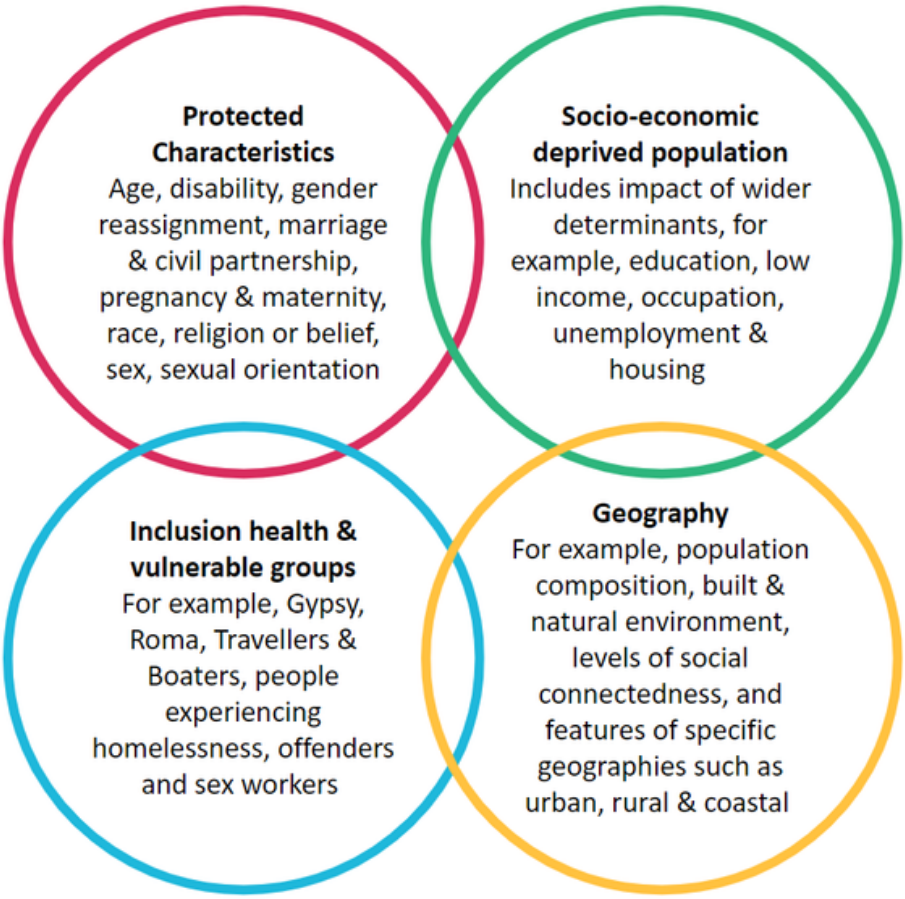


Figure 1:

Keeping healthier for longer

There are lots of studies that show us that where we live and work influence our behaviour, as does how we spend our time and who we spend it with. The chart below is a good starting point for understanding all the factors that go into make up our health and decisions we make about our health, as well as those things we can't influence on our own.

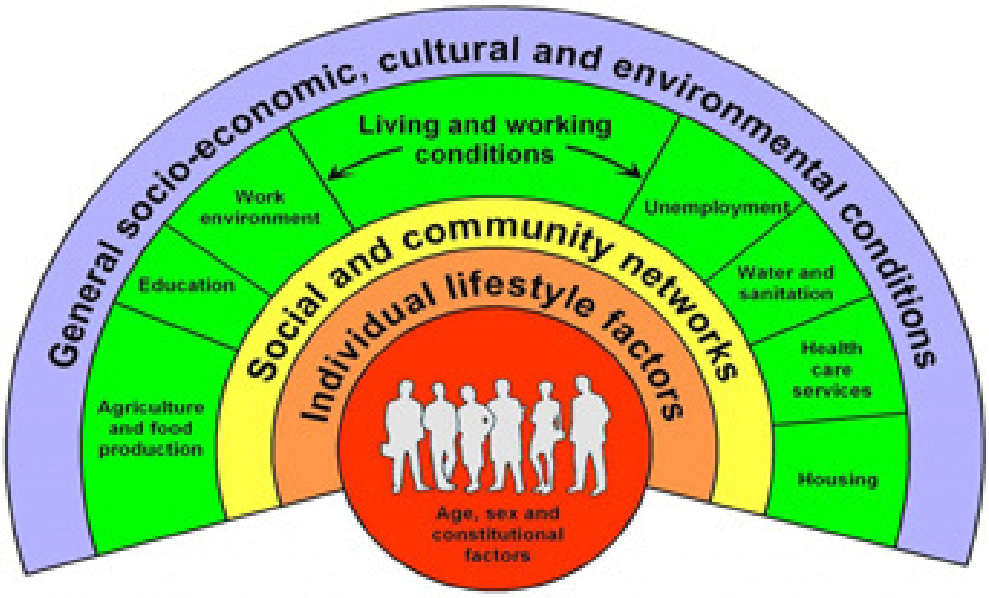


Figure 2: Dahlgren and Whitehead (1991)

Key areas that impact the health and wellbeing of our most vulnerable residents include good work, healthy communities and places, having the best start in life, discrimination and its outcomes, and environmental sustainability (Marmot, 2024).

In the Norfolk and Waveney area, there has been an emphasis on place-based approaches, and the need to address the socio-economic factors and geography outlined in the chart above (Figure 1). These are described locally as **Living and Working Conditions.**

All of us can make a difference to our own health and wellbeing by making good, healthy choices, but sometimes this is not easy to do, especially when faced with a disadvantage because of where you live or if you face discrimination. We have described this as **Lifestyle Factors.**

And of course, when we need help, being able to access services early, and quickly, the same as anyone else with similar issues, but recognising the way in which the services is delivered might need to be different. For example, a person with autism accessing mental health services, someone with a mental health condition accessing stop smoking services, or someone attending a hospital appointment when English is not their first language. We describe this as **Healthcare Inequalities.**

Why are we doing this?

Health equity means everyone should be able to reach their full potential for health and well-being, with fair and just opportunity to do so. Right now, we know this is not happening as some people are dying earlier than we would expect.

The map below shows that people are dying much earlier in some parts of Norfolk & Waveney than others, for reasons that can be prevented. The difference in average life expectancy between residents in one place compared to another is the kind of gap we want to close.

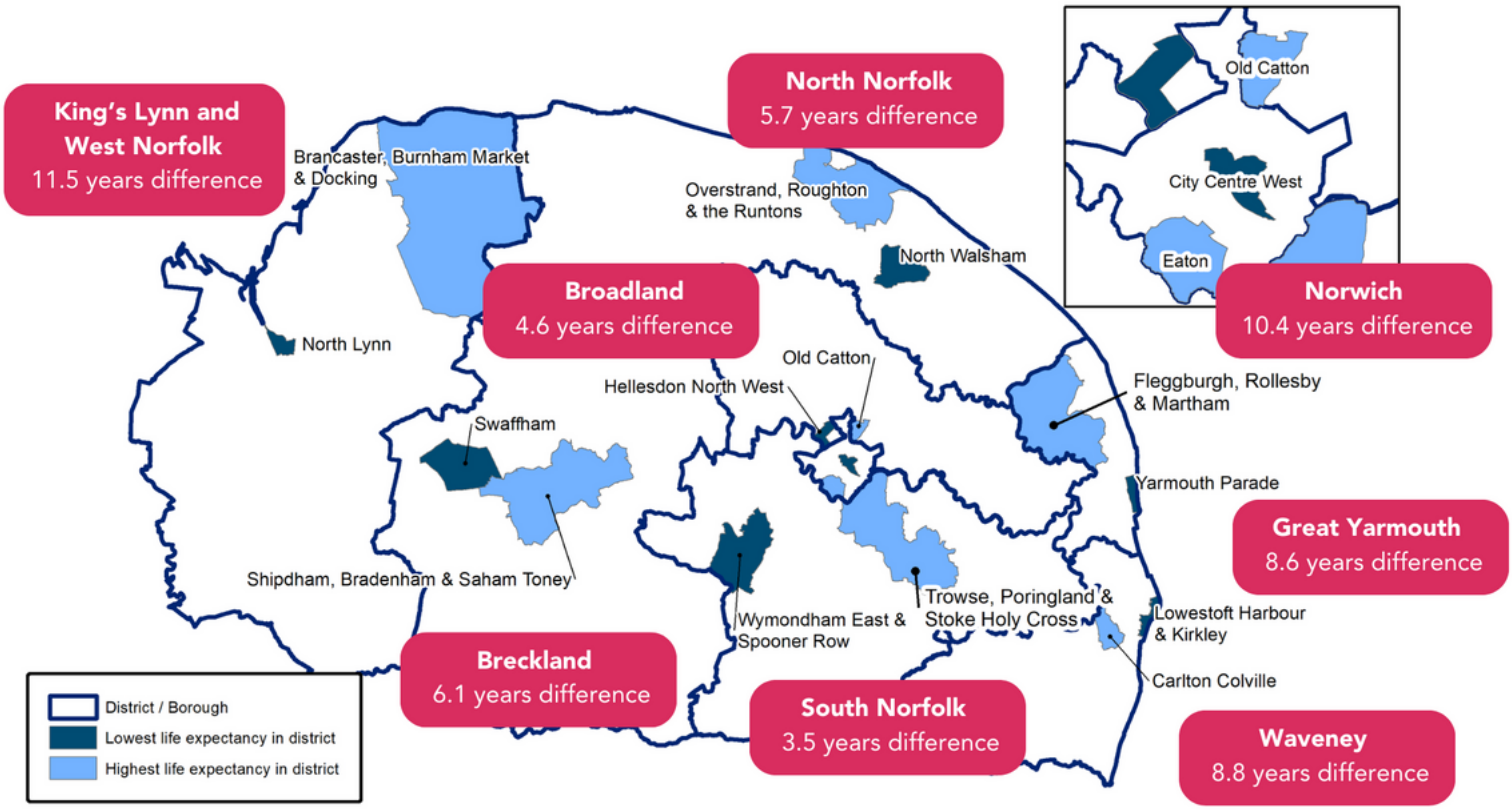


Figure 3:

Across Norfolk & Waveney differences in life expectancy can be seen in each district footprint. There is a 11.9 year age gap between the lowest life expectancy in Norfolk and Waveney (72.2 years as seen in North Lynn & Yarmouth Parade) and the highest (84.1 years seen in Eaton).

This gap in life expectancy is even bigger for some groups, such as those who are homeless, or with a learning disability.

Figure 4:

Norfolk insight is our local data hub where anyone can look online at local data about the population of Norfolk and Waveney. We know who lives in poor health, who dies earlier from preventable illnesses, who has worse health outcomes, where they live and much of the time, why they have worse outcomes.

We know that people are dying earlier from preventable illnesses in some communities, with around half (men) to a third (women) of these due to circulatory diseases and cancer in Norfolk.

You can find more data relating to health inequalities by clicking here.

We have also been speaking to our communities that experience inequalities to better understand the barriers and build a rich picture to help close the health gap between groups.

Who will we reach?

Although we have a lot of data telling us about the different experiences in our communities, we also want to make sure that we are listening, and that people are able to speak for themselves. We have asked people directly, what the issues are that affect them the most.

We have targeted these conversations towards the groups that experience the greatest differences in health outcomes, working with our trusted communicators in voluntary & charitable sector groups through our Community Voices programme.

Community Voices

Using your feedback to improve care

We asked our communities what matters to them in relation to their health and wellbeing. In summary these conversations highlight the importance of consideration of the environment in which our residents live and work, alongside those factors that influence their health behaviours and their ability to access services.
The below highligts some of what we have heard and more information can be found in our summary reports here.

"Living in poor housing adds to (my) health issues and stress"

"Gp has told them they must quit (smoking) due to heart condition. Has tried vapes and tablets (champix) . Finds current living condition very stressful and feels that quitting now would be a huge stress 'on top of everything'..... Has anti social neighbours and black mould caused by an issue with leak in flat above. Doesn't feel in 'right place mentally' to quit"

"Some residents have concerns they are treated differently due to being a migrant or having a language barrier. Many report a lack of trust in the NHS, ofen stemming from miscommunications or feeling unheard"

[recently left prison] he has not been able to sort his benefits for the last 5 months and is living on a very limited budget for food which is also playing a big part in his illness [diabetes] and feels he cannot afford to spend what little money he has on a nutritious diet that he needs to try and keep healthy"

Our Community Voices conversations highlight why action should not be limited to health services alone. The the causes of disease begin long before someone sees a health professional as outlined below. This image clearly shows the '**building blocks'** for good health.

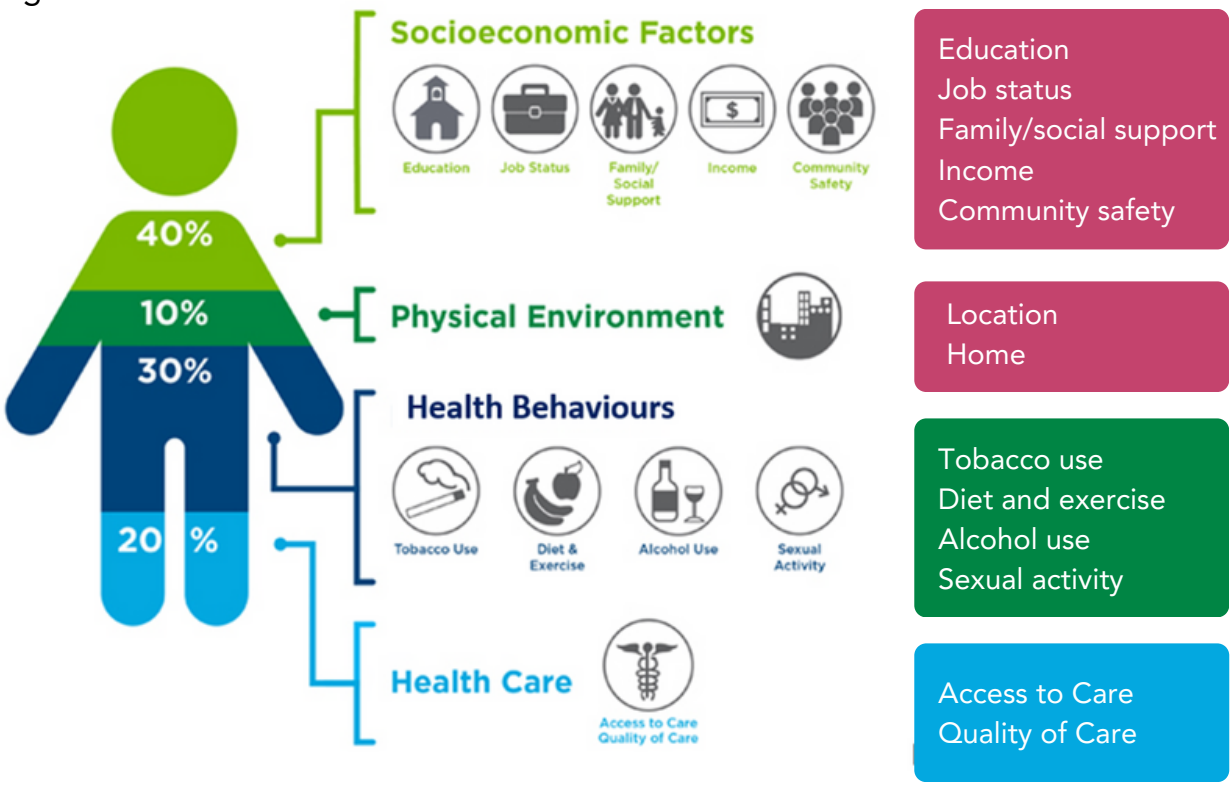


Figure 5: Determinants of health

The NHS has identified the communities and groups we should focus on as the 'Core20plus' communities. These are the people living in the most deprived areas and vulnerable people in the local area, who are referred to as the 'plus groups'. Our most deprived 'Core20' communities are highlighted in the map below.

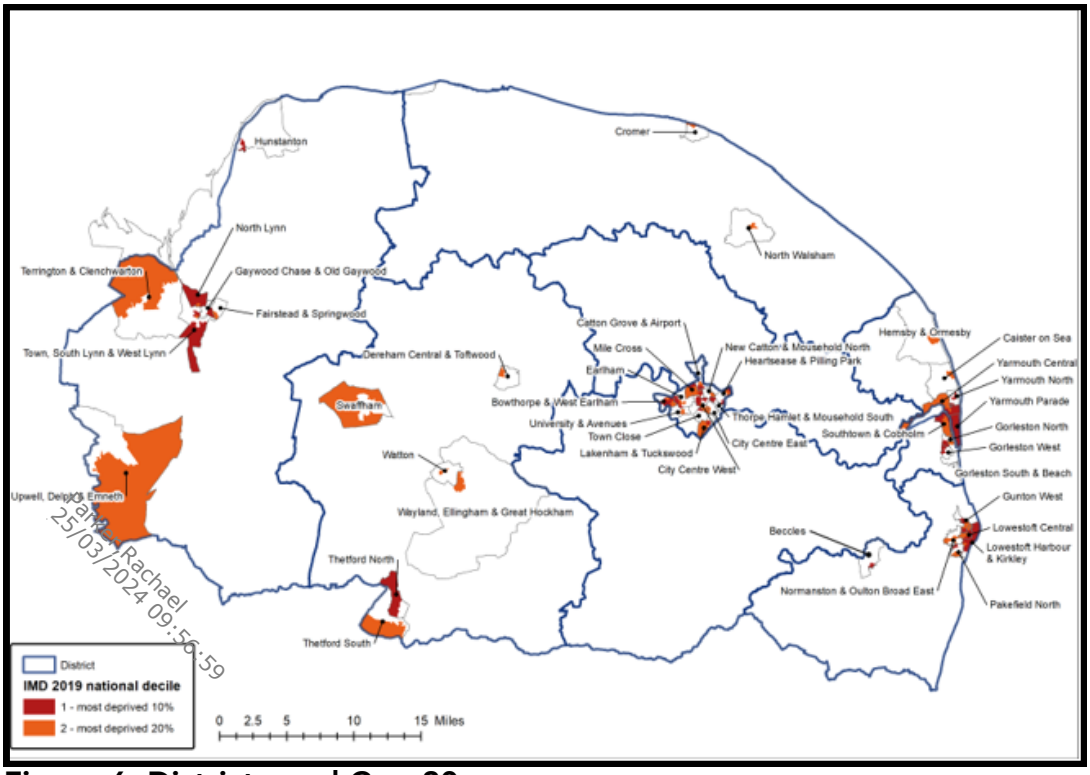


Figure 6: District ward Core20

The Norfolk & Waveney ‘plus’ groups have been locally defined and agreed. These are:

- Ethnic minority communities
- Inclusion health groups
  - People experiencing homelessness
  - Drug & alchohol dependence
  - Vulnerable migrants
  - Gypsy, Roma and Traveller communities
  - Sex workers
  - People in contact with the justice system
  - Victims of modern slavery
- People with a learning disability and autistic people
- People living in coastal and rural communities
- Young carers and looked after children
- Armed forces community

We have produced some fact sheets which give more information about each of our plus groups, which you can find here.

Health services have a clear call to action outlined via the Core20plus5 health equality improvement frameworks, which map where the inequalities are nationally, and what the NHS should focus on locally. The frameworks also include 5 clinical priority areas, and there is a framework for adults and a framework for children and young people. You can find out more information here.

What difference will we make?

Residents who face the worst health outcomes will:

- Be able to access the right services more easily and get the right support to improve their health and wellbeing.
- Have more say about services, especially feedback on whether they are working well.
- Live longer, healthier, happier lives.

Organisations involved in improving the health of residents will:

- All organisations in Norfolk and Waveney commit to working together more effectively to tackle the causes of health inequalities.
- Have a common language and purpose and commit to improving outcomes for residents experiencing inequalities.
- Recognise and respond to risk for specific groups, with good quality information and understanding of need and be supported to enable this.
- Detect and manage need early, targeting resources based on preventing further ill health.
- Increase their effectiveness through a healthy and diverse workforce.
- Improve understanding of the cost of existing health inequalities for all organisations.

Existing commitments

Our organisations and leadership are not new to trying to prevent unfair and avoidable differences in experiences and early deaths from preventable illness. Listed below are the ICS strategies and approaches that include commitments relating to health inequalities. This framework will help to deliver them and a summary of their existing objectives can be found here.

Our Guiding Principles

Health Inequalities Conversation

Through our Health Inequalities Conversation we have developed the following 10 guiding principles that we ask our partner organisations to adopt. These are guidelines for decision making.

Everyone needs something, some people need more.

Enabling communities to have a voice is key and requires creativity and persistence.

We will work as close to people and communities as possible.

Our approach must be personalised to ensure the right action at the right time for the right individual.

We will ensure accessible services for those in greatest need.

We know we can make a difference, and this is a long-term commitment.

We will take an approach that includes consideration for families and all stages of life

Leading for change requires shared responsibility and enduring focus.

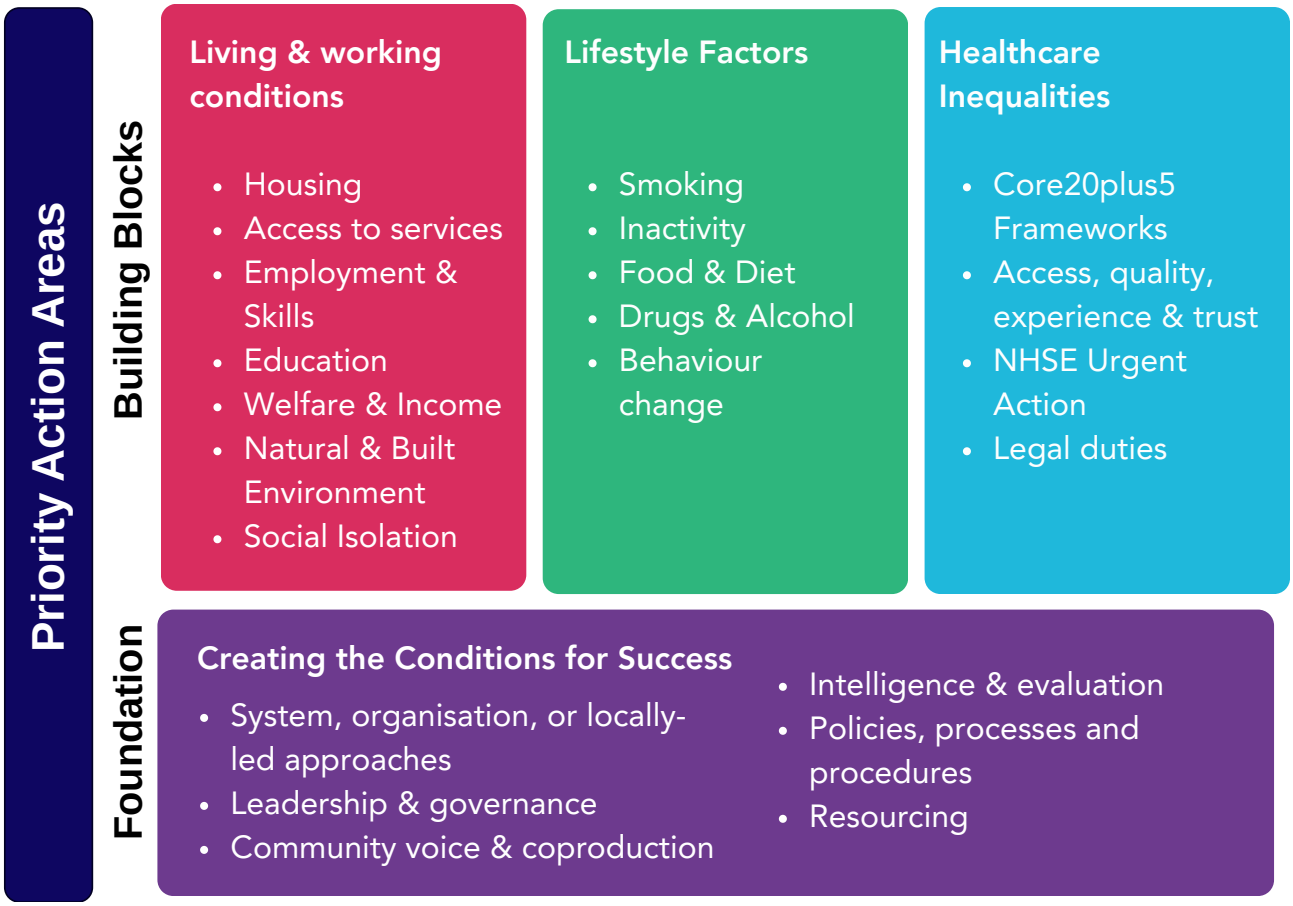
We will understand who is accessing our services, who isn't and why in order to act.

Recognising the building blocks for good health & wellbeing are not just in health services.

Building fairer services means supporting change in our organisations.

Our priority areas for action

Through our Health Inequalities Conversation we have determined our priority areas for action, as described below. We refer to these as our **'building blocks'** and our **'foundation'.**



Living and working conditions

The health outcomes of a population depend on the level and quality of education, living in an adequate house, being able to work, and access to quality health and social care services. These are part of the wider social and economic circumstances that can determine an individual's health throughout their life. The same factors have significant effects on health inequalities (Marmot, 2010). These factors are often linked. For example, a person who is unemployed is more likely to live in poorer housing conditions and may not have access to affordable fresh and healthy food or get out and about in green spaces.

Tackling health inequalities requires a local shift in expenditure patterns to address some of the underlying causes of inequality. Resources should go where there is need, to ensure equal health outcomes (The King's Fund, 2022).

Lifestyle factors

The choices we make in living our lives impact our health and wellbeing. The impact of smoking, choosing unhealthy foods to eat, not getting enough exercise, and drinking alcohol are known as behavioural risk factors. These are a major challenge for health and social care for all residents, not only those communities that experience inequalities in outcomes.

These factors increase our chances of developing chronic conditions like heart disease, cancer or diabetes and can lead to early death. Health inequalities increase the risk of becoming ill and living in poor health among some groups in society and can be seen and measured as a result.

Health and care services

Health and care services are there to maintain and improve our health. The original focus of the NHS was the diagnosis and treatment of disease. Now it plays more of a part in both preventing ill health and improving the physical and mental health of the population.

Health and care services are structured to meet everyone's need which at times makes it difficult for some people to get the service they need. This can be due to examples like services not being available, adjustments not being made for disability, people having challenges being understood because of language barriers, or discrimination.

The NHS has legal duties relating to health inequalities, and there are 5 Urgent Actions that are identified in NHS operational planning guidance, which will require a partnership approach to implement. More information about these duties to address health inequalities can be found here.

HOLD FOR CASE STUDIES

Creating the Conditions for Success

This framework for action is ambitious. We have to work together building on our successes so far, sharing our knowledge, tools and resources to drive change. If we are going to make a difference to health outcomes, so people have a fairer chance to live longer and healthier lives, we have to change the way we work within our organisations and together.

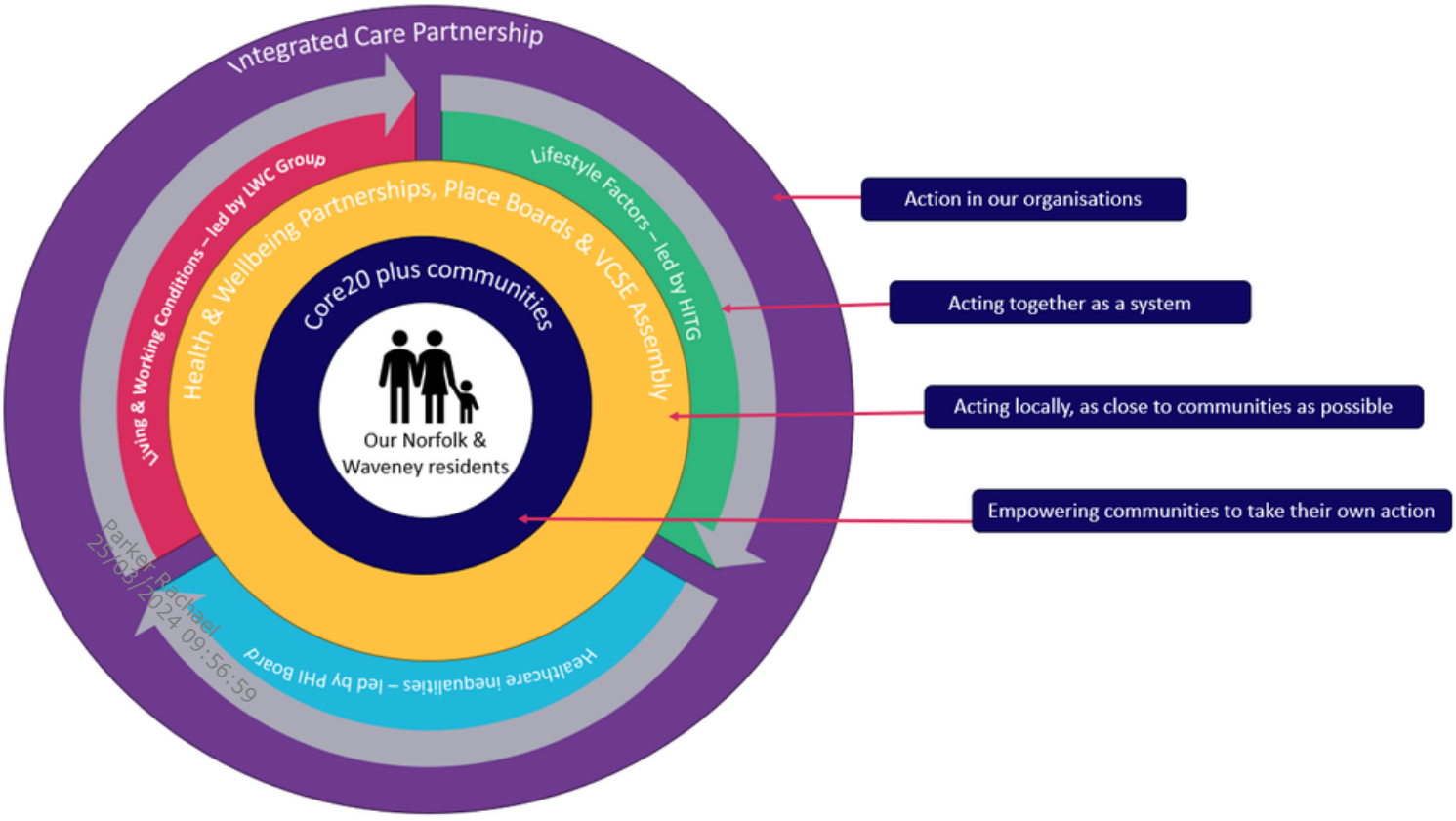
Navigating our different duties, relationships, structures and priorities is going to be difficult. However, this is the chance to work more closely with communities, understanding better how we can do differently, and leading more effectively.

Leadership & Governance

We recommend a leadership and governance structure for health inequalities that maximises our existing resources and expertise and responds to the benefits of working locally.

This proposed structure enables us to share, learn and scale what works and understand what doesn't. This is about what we can do together and all parts of our Integrated Care System have a role to play - this includes our district and county councils, Voluntary Community & Social Enterprise (VCSE sector) and our health services.

Our Norfolk & Waveney Integrated Care Partnership brings together health and social care providers, local government, the VCSE sector and other partners. It will provide ensure the Health Inequalities Framework is delivered.



Action in within our organisations

Our organisations already make a huge difference to the wellbeing of people living in Norfolk and Waveney right now. Closing the gap so that everyone has a fair chance; stopping the early deaths of vulnerable people, will mean doing some things differently. Organisations involved have a number of ways to make this happen, for example:

- By embedding these guiding principles in their organisational action plans and ways of working
- As 'anchor institutions' working locally to lead by example as an employer and estate owner, as well as through buying power.
- Through good quality equality impact assessments, complaints procedures or by embedding a requirement for social value in contracts.
- Through sharing good practice and intelligence to inform action
- Through a commitment to actively listening to people, especially the most vulnerable
- Through robust data collection and sharing

This isn't everything we can do, and we have outlined below what some of this might look like. UCL Partners, working alongside NHS organisations, have produced a useful toolkit that you can find here, which helps anchor organisations understand 'how strong is your anchor' currently.

Acting as close to communities as possible

Organisations often come together around a 'place'. This might be a few streets, a neighbourhood, a council footprint or a health system boundary. There are ways in which people in communities and organisations can plan their place together, that helps identify where the greatest need is, and what the best approach is for that place.

Place-based partnerships are an important vehicle for tackling health inequalities. They bring together organisations at a local level, including district councils, VCSE organisations and health and care services, to enable greater understanding, connectivity and collaboration.

Place-based partnerships will be supported to close the gaps between groups, through the update and production of tools and guides. Place-based structures will play a key role in developing the action plans for each of the building blocks, with the **Health & Wellbeing Partnerships** coordinating action relating to Living & Working Conditions and Lifestyle Factors, and Place Boards coordinating action relating to Healthcare Inequalities and Creating the Conditions for Success.

Empowering communities

The Voluntary, Community & Social Enterprise (VCSE) sector also plays a crucial role in addressing health inequalities. Collaborating with the VCSE sector allows for new solutions to local health issues, they are rooted in communities and have established relationships with residents meaning they can act as 'trusted communicators' and have a sound understanding of community need. They can offer creative and cost-effective approaches and connect with people that experience the greatest health disadvantage.

In summary, collaboration with the VCSE sector is a powerful tool for transforming health inequalities. promoting community wellbeing and ensuring equitable access to healthcare.

As such it is vital that the VCSE sector are integrated into all parts of our governance as an **equal partner** and that they are empowered where possible to provide a leadership role.

In support of our work to address health inequalities we will commit to the development of a VCSE partnering work programme, as well as the continued development of a VCSE Assembly that complements our local VCSE infrastructure arrangements and existing thematic forums.

Acting together as a 'system'

The word system has different meaning for different people. Simply put it means organisations coming together to tackle a common goal, considering the desired outcome rather than individual organisational interests.

We need to better coordinate our action to tackle health inequalities as a 'whole system' , so that we can join up and coordinate our existing work, share best practice, scale what works and understand better what doesn't.

Our proposed structure recommends 3 groups all of which are to be representative of our Integrated Care System, that will drive further action relating to our building blocks:

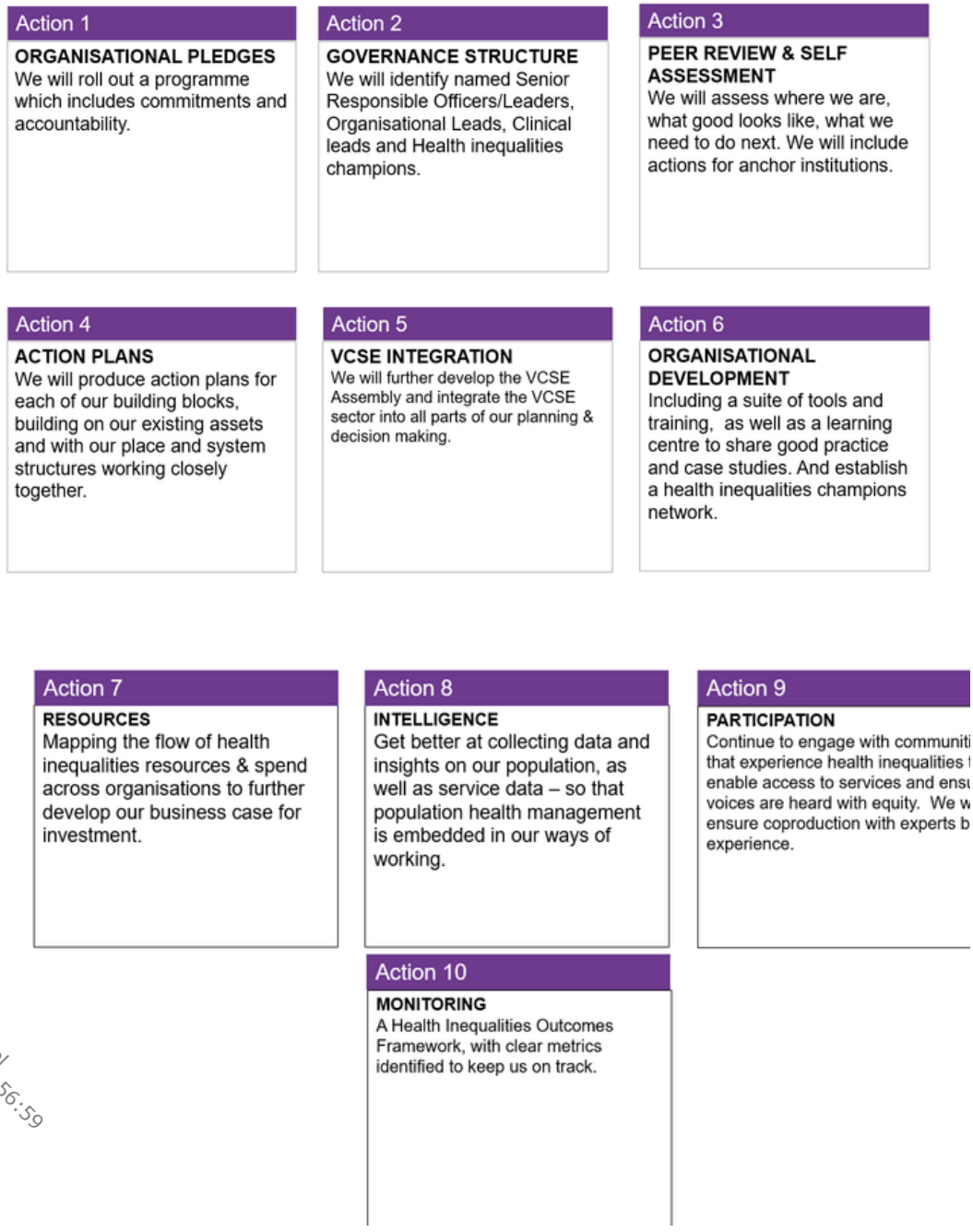
- Living & Working Conditions Group to drive action relating to Living and Working conditions - Chaired by TBC
- Health Improvement Transformation Group to drive action relating to Lifestyle Factors - Chaired by the SRO for Prevention
- Population Health & Inequalities Board to drive action relating to Healthcare Inequalities and the tools required to create the conditions for success - Chaired by the SRO for Healthcare Inequalities

Summary of key actions

We have set out here what actions we think need to take place first so that people across all organisations are confident they can tackle local health inequalities. These are based on our Health Inequalities Conversations - what we need to do to make this commitment happen.

We plan to take these **10** actions in the first **12** months of implementation, by April 1st 2025.

The ICS Health Inequalities Oversight Group will be responsible for making sure they happen, with responsible organisations for each action to be agreed. More detailed action planning is available separately.



Action over time

Short term actions (year 1)

- Focus on our foundation – improving our ways of working to create the conditions for success
- Strengthen our leadership, governance and partnership working
- Understand our baseline - map and coordinate existing activity and identify gaps
- Clarifying the actions required around our building blocks to further our impact

Medium term actions (2-5 years)

- Implementing our action plans, and understanding our impact
- Organisations taking action utilising the tools provided
- Aligning the action between our building blocks - creating a Health Equity focus
- Measurable differences in our ways of working – improvements on our baseline

Long term actions (5 – 10 years)

- Tackling health inequalities part of our 'business as usual' via a confident and competent workforce
- Demonstrable impact on the metrics within our outcomes framework

Improving lives **together**

Norfolk and Waveney Integrated Care System

Appendix

Hold for Outcome metrics for each building block

Suggested actions for our building blocks

It is now up to the system to come together to build on existing activity and take coordinated action around our building blocks. During our engagement we identified a number of potential actions, some of which are provided below as examples.
For a more detailed report about what we heard during our Health Inequalities Conversation please go to xxxxx.

Living & Working Conditions

Lifestyle Factors

Healthcare Inequalities

Action plan template

Norfolk and Waveney
Integrated Care Board

Agenda item: 12

Subject:	**Population Health & Inequalities (PH&I) Board – 20/02/2024 – Assurance & Escalation Report**
Presented by:	**Dr Frankie Swords**
Prepared by:	**Dr Frankie Swords**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**25 March 2024**

Purpose of paper:

To provide assurance and escalate any issues of concern from the Population Health & Inequalities (PH&I) Board to the Patients and Communities Committee.

Executive Summary:

The Population Health & Inequalities Board (PH&I) Board meets bi monthly and was last held on Tuesday 20 February 2024. The report details points of assurance and escalation as well as a high level risk overview summary.

Report

Please find attached document.

Recommendation to the Committee:

To review points for assurance.

Key Risks	
Clinical and Quality:	Health inequalities are avoidable, unfair and systematic differences in health between different groups of people, which impact on longer term health outcomes and a person's ability to access healthcare. Population Health Management is a systematic way of working to understand the health and care needs of our population and put in place new models of care to deliver improvements in health and well-being. This work is fundamental to the delivery of our ambitions in relation to Prevention and addressing Health Inequalities. There is a risk we do not achieve the impact we seek if we do

	not develop the infrastructure, the culture and approaches advocated as best practice.
Finance and Performance:	None identified
Impact Assessment (environmental and equalities):	N/A
Reputation:	None identified
Legal:	None identified
Information Governance:	None identified
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	1. The NHS provides a comprehensive service, available to all 3. The NHS aspires to the highest standards of excellence and professionalism 4. The patient will be at the heart of everything the NHS does 5. The NHS works across organisational boundaries 6. The NHS is committed to providing best value for taxpayers' money 7. The NHS is accountable to the public, communities, and patients that it serves
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	BAF 06

Governance

Process/Committee approval with date(s) (as appropriate)	

Population Health & Inequalities (PH&I) Board - Points of Assurance / Escalation [20/02/2024]

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

Item No.	Meeting Name	Date of meeting where item was raised	Details of Item for Escalation	Requested Outcome/Support	Financial Implication (if any)	Is item recorded on Risk Register	"EXAMPLE" Board Decision	Fed back to Meeting Group Date
10.	PH&I Board	10/10/2023	ICS PHM Strategy & HI Framework for Action	The PH&I Board supported the ongoing progress with PHM and HI Strategy. Both on track for completion March 2024. **Update 20/02/2024:** The PH&I Board endorsed both the PHM Strategy & HI Framework for Action	N/A	N/A	For assurance	
19.	PH&I Board	20/02/2024	PHM software procurement	Previous challenges around the budget and appropriate support for the procurement of a PHM software supplier have now been addressed. The regional procurement hub is now proceeding with this, with the advert going live March 2024.	N/A	No	For assurance	
20.	PH&I Board	20/02/2024	HI05 No ring fencing of NHSE health inequalities funding allocation	The PH&I Board are escalating this risk to the Patient & Communities Committee. The Funding for Community Voices, & Asylum Seeker Healthcare Team is due to expire March 2024 (funding has been found until June 2024). This risk is scoring at 16.	Yes	Yes HI06	For escalation	
21.	PH&I Board	20/02/2024	No substantive funding for Community Voices programme	The CVP has funding for current projects until June 2024, but long-term funding for this has not been agreed. Implications and mitigations to be reviewed March and risk may need to be escalated	Yes	Not at present	For escalation	
22.	PH&I Board	20/02/2024	Successful vaccination programme	The success of the COVID & Flu vaccination programme was noted which are known to directly reduce health inequalities and prevent harms. N&W ranked first in EoE and 3rd in England in the winter campaign.	N/A	No	For assurance	

PH&I Board - New Risks [20/02/2024]

Improving lives together
Norfolk and Waveney Integrated Care System

Programme Risks as of 20/02/2024 – PH&I Board

The PHM and HI January 2024 versions of risk registers were reviewed at this meeting.

The overarching BAF06 PHM &HI risk continued to score at 12.

The PHM team reported 4 risks, no new risks were added, no risks scored above 15 and 3 of the risk scores were reduced. PHMI02 'Practice DPIA Sharing' was reduced from a risk score of 6 to 4. PHMI09 'Procurement of PHM System – Lack of ICB Resource' was reduced from a risk score of 12 to 9. PHMI14 'ICB BI Capacity' was reduced from a risk score of 8 to 6.

The HI team reported 7 risks, no new risks were added, 1 risk scored above 15 and 1 of the risk scores were reduced. HI01 'Not completing HE Strategy as per JFP ambition / objective' was reduced from a risk score of 9 to 6
'HI06 No PMO process for Equality Impact Assessments (EIAs)'risk has been reviewed and a paper provided to the 19/12/2023 PH&I Board. An update will be provided at the PH&I Board in April 2024 (see item 13 of the assurance report).
'HI05 No HI ring fencing of NHSE funding allocations' this risk is still scoring at a 16. The 20/02/2024 PH&I Board have requested to escalate this to the Patient & Communities Committee (see item 19 of the assurance report)

Norfolk and Waveney
Integrated Care Board

Agenda item: 13

Subject:	**Norfolk &Waveney Ageing Well Programme Board Report**
Presented by:	**Dr Frankie Swords**
Prepared by:	**Dr Frankie Swords**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**25 March 2024**

Purpose of paper:

To provide assurance and escalate any issues of concern from the Norfolk and Waveney Ageing Well Programme Board to the Patients and Communities Committee.

Executive Summary:

The Ageing Well Programme Board meets bi-monthly and was last held on 7 March 2024. The report details points of assurance and escalation as well as a high-level risk overview summary.

Report

Please find attached document.

Recommendation to the Committee:

To review points for assurance.

Key Risks	
Clinical and Quality:	
Finance and Performance:	None identified
Impact Assessment (environmental and equalities):	N/A
Reputation:	None identified

Legal:	None identified
Information Governance:	None identified
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	

Governance

Process/Committee approval with date(s) (as appropriate)	

PMO
Project Management across Norfolk and Waveney

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

N&W Ageing Well Programme

Programme on a Page
18th March 2024

PMO
Project Management across Norfolk and Waveney

Ageing Well Programme Summary
Headline Scope and Priorities

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

Programme	**Ageing Well Programme**	**SRO**	**Ian Hutchison**

Programme Workstreams	Workstream Lead	Key Workstream Milestones	Workstream Objectives	Workstream Progress Update (7th March 2024)
Frailty Acute Care	Dr Katie Honney (QEHKL)	Set up of N&W Clinical Ageing Network	1. Undertake a survey of frailty services and assessment tools across the 3 Trusts 2. Create and run a Clinical Ageing Network 3. Agree upon a system wide definition of Frailty and single assessment tool	• Established the N&W Clinical Ageing Network – inaugural meeting 18th March. Focusing on identification of current services provided by the acutes. • QEH colleagues have submitted presentation slide detailing available frailty services • Identification of services provided at each acute to support frailty care • Survey to identify frailty screening tools used in primary and secondary care
Prevention	Lee Watson (Norfolk County Council)	Project scope and documentation signed off by Public Health Senior Management Team. **COMPLETE** Creation of team with identified leads, regular meetings diarised. **COMPLETE**	1. To define public health approach to healthy ageing in Norfolk 2. To understand current position of preventative commissioned and non-commissioned services 3. To make evidence-based recommendations for future preventative activity.	• Development of Public Health strategic review scope, process and framework for defining Public Health approach to healthy ageing in Norfolk. • Initial workstreams developed and leads ID'd
Care Homes (including Housing with Care)	Paul Benton (Norfolk & Waveney ICB)	The sign off from Quality and Safety Committee to introduce digital monitoring technologies into the care market following successful pilots	1. Reduction in inappropriate conveyance from care market to the acute 2. Support the promotion of healthy living across the care market 3. Supporting EEAST to sign post to clinical pathways 4. Support development of pathway redesign to support care at home	• Market Engagement sessions taking place • Education and Training has focussed on Nutrition Hydration, Oral health, Vaccination and Immunisation • RESPECT Training and education is taking place across the care market
Dementia	TBC	Ensure practice level Dementia Diagnosis Rate data is used alongside the presumed dementia prevalence (from NHSE) is available to use in practices	1. System Wide Leadership 2. Education & Upskilling 3. Data	• Agreement to include Dementia Programme into wider Ageing Well Programme structure. • Dementia Charter has been drafted (developed on best practice principles and person-centred system outcomes developed by Alzheimer's Society). • Development of options to increase consistency of training for staff working with people living with dementia. • An understanding of the available datasets to support tracking the use of health and care services by people living with dementia.
Education & Training	TBC	TBC	TBC	• Newly created, following Ageing Well Programme Board on 7th March 2024

PMO
Project Management across Norfolk and Waveney

Ageing Well Programme Summary
Risks & Interdependencies

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

Programme	Ageing Well Programme	SRO	Ian Hutchison

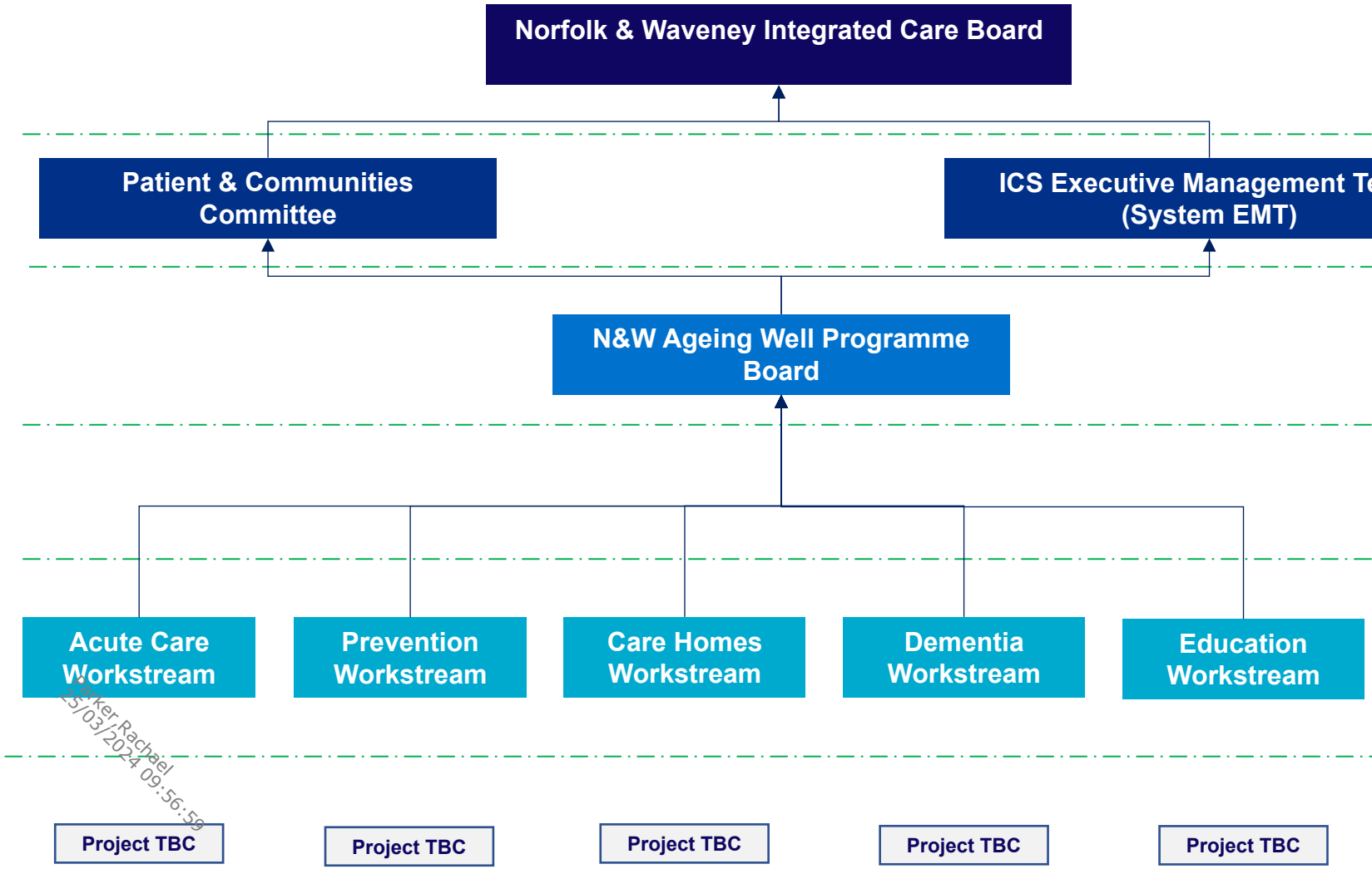
Interdependent Programmes/ Workstreams	Board /Workstream Lead	Interdependent Projects	
Medicines Management / Prescribing	Michael Dennis / Jessica Adcock	Existing projects identified: 1. Dependence forming meds 2. Prescribing of broad-spectrum antibiotics 3. DOAC monitoring	Pipeline projects identified: 1. Review of psychotropic meds in people with dementia 2. Targeted SMRs for patients with polypharmacy 3. Reducing anticholinergic burden
Palliative and End of Life Care	Caroline Barry / Stephanie Dibley	TBC	
Health Inequalities / Population Health	Shawn Haney	TBC	
UEC Programme Board	Ross Collett	TBC	

Key Programme Risks (Description)	Mitigation Action	Issues to be escalated	RAG
Capacity of colleagues within the acute setting	TBC		AMBER
Dementia Drugs (financial, implementation, capacity)	TBC		AMBER
Capacity and programme support in relation to Dementia programme	TBC		AMBER

N&W Ageing Well Programme Governance Structure
Current Structure

PMO
Project Management across Norfolk and Waveney

Improving lives together
Norfolk and Waveney Integrated Care System



Tier 1 ICB Board
Strategic oversight and escalation to CEOs (>5m)

Tier 2 Committee
Information transfer shared to local committees on transformation

Tier 3 Escalation and Performance Management
Accountable for delivery of national mandates (up to 1m)

Tier 4 Programme Management
Operational management, **oversight**, and **risk management** for programmes

Tier 5 Steering Groups
To create and **embed transformation** across system and within organisations, for the duration of the programme lifecycle

Tier 6/7 Project / Task & Finish Groups
To **review and progress work** allocated by the steering group
Project – Duration 6mths to 18mths
Task & Finish – Duration 6wks to 6mths