Patients & Communities Committee

Mon 24 July 2023, 15:00 - 17:00

Virtual

Agenda

15:00 - 15:00
0 min

Chairs Welcome and Apologies for Absence

Aliona Derrett

00. Patients and Communities Committee Agenda 24.07.23 FINAL.pdf (1 pages)

15:00 - 15:00
0 min

Declarations of Interest

Aliona Derrett

To declare any interests specific to agenda items

For noting

02. ICB Patients and Comm Committtee -V2.pdf (2 pages)

15:00 - 15:00
0 min

Minutes from the previous meeting and matters arising

Aliona Derrett

To approve the minutes of the previous meeting held on 22 May 2023 and any matters arising

For approval

03. NW ICB PC Committee Minutes 22.5.23 draft V2.pdf (13 pages)

15:00 - 15:00
0 min

Action Log

Aliona Derrett

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

For review, update and approval

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

15:00 - 15:00
0 min

Updates from Healthwatch Norfolk and Healthwatch Suffolk

Alex Stewart, Rachael Green and Andy Yacoub

For discussion and noting

15:00 - 15:00
0 min

Spotlight on: Children and Young People

Rebecca Hulme

For discussion and noting

06. 2023.07.24 Patients and Communities.pdf (14 pages)

15:00 - 15:00
0 min

Population Health and Equalities Board Report

Mark Burgis

For discussion and noting

- 07.i 2023.06.20_PHI Board Report Cover Sheet.pdf (2 pages)
- 07.ii 2023.06.20_PHI Board Assurance-Escalationsv1.1.pdf (3 pages)

15:00 - 15:00
0 min

Health Inequalities: NHS Core20PLUS5 Improvement Framework - Defining the 'Plus' Groups for Norfolk and Waveney

Tracy Williams

For discussion and noting

- 08. Health Inequalities - Core20PLUS5 - Plus groups 170723.pdf (7 pages)

15:00 - 15:00
0 min

Discharge Transformation Programme Update

Catherine Withers

For discussion and noting

- 09. ICB P&CC Report Powerpoint Discharge Presentation.pdf (8 pages)

15:00 - 15:00
0 min

Community Voices Update

Shelley Ames, Amrita Kulkarni, Clare Yates, Rob Jakeman

For discussion and noting

15:00 - 15:00
0 min

People and Communities Update

Paul Hemingway

For discussion and noting

15:00 - 15:00
0 min

Any Other Business

Aliona Derrett

Improving lives together
Norfolk and Waveney Integrated Care System

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

Monday 24 July 2023, 1500-1700hrs

Meeting to be held via MS Teams

Item	Time	Agenda Item	Lead
1		**Chair's welcome and apologies for absence**	Chair
2		**Declarations of Interest** To declare any interests specific to agenda items *For noting*	Chair
3	15:00-15:10	**Minutes from previous meeting and matters arising** • To approve minutes of the previous meeting (22.5.23) *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	15:10	**Healthwatch Norfolk and Healthwatch Suffolk Updates** *For discussion and noting* • Patient and professional experiences of using digital tools in primary care	Alex Stewart Andy Yacoub Rachael Green (Healthwatch Norfolk)
6	15:25	**Standing Item: Spotlight on: *Children and Young People*** • Each meeting, there will be a focus on one of eight corporate and wider system priorities. Attention will be given to how the voice of people and communities has or will shape these priorities, and what has or will change as a result *For discussion and noting*	Rebecca Hulme
7	15:45	**Standing Item: Population Health and Equalities Board Report** *For discussion and noting*	Mark Burgis
8	15:55	**Health Inequalities – NHS "Core20PLUS5" Improvement Framework – defining the "PLUS" Groups for Norfolk and Waveney** *For discussion and noting*	Tracy Williams
9	16:05	**Discharge Transformation Programme Update** *For discussion and noting*	Catherine Withers
10	16:20	**Community Voices Update** *For discussion and noting*	Shelley Ames Amrita Kulkarni Clara Yates Rob Jakeman
11	16:35	**People and Communities Update** *For discussion and noting*	Paul Hemingway
.12	16:50	**Any other business**	Chair
Date, time and venue of next meeting: Monday 25 September 2023, 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 Hospitals 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 for Norfolk	X			Direct	I am the Chief Executive 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
		Norfolk and Waveney 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	Ongoing		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
Catherine Armor	Non-Executive Member, Norfolk and Waveney ICB	Brundall 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
		Norwich University of the Arts			X	Direct	Deputy Chair of Council, Norwich University of the Arts	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
		Evolution Academy Trust			X	Direct	Trustee, Evolution Academy Trust	2022	Present	
		Cambridge University Press		X		Direct	Trustee, Cambridge University Press Pension Schemes	Ongoing		
		East of England Ambulance Service NHS Trust	N/A			Indirect	Daughter-in-law is Technician for East of England Ambulance Service NHS Trust	Ongoing		
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	
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
		Castle Partnership				Indirect	Partner is a practice nurse at Castle Partnership	Ongoing		
Suzanne Meredith	Deputy Director of Public Health, Norfolk County Council	Norfolk County Council		X		Direct	Deputy Director of Public Health, Norfolk County Council	Ongoing		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.
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	TBC								
Dr Frankie Swords	Executive Medical Director, Norfolk and Waveney ICB	Norfolk and Norwich University Hospitals NHS FT		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.
		N/A			X	Direct	Ad-hoc Clinical Advisor of multiple patient charities - Addison Self Help Group - Pituitary Patient Support Group - Turner syndrome Society	2008	Present	
		Long Stratton Medical Partnership			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		British Medical Association		X		Direct	Member of the BMA	Ongoing		Inform Chair and will not take part in any discussions or decisions relating to BMA
		N/A				Indirect	Husband is a counsellor and undertakes voluntary work with 2 VCSE providers in N&W MIND and Emerging Futures	2008	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services
Tracy Williams	Health Inequalities Advisor	Bacon Road 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
		One Norwich Practices	X			Direct	Employed 10 hours a week by One	Jul-20	Present	For any related items, individual would not
		Norfolk and Waveney training hub	X			Direct	One day a week session as clinical adviser for the Norfolk and Waveney training hub	Jul-21	Present	All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc
		Health inequalities and CYP N&W ICB	X			Direct	Clinical lead for Health inequalities and CYP N&W ICB , Attend Quality and Safety Committee and ICP Partnership/H&WB Board	Aug-22	Present	All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc
		Queens Nursing Institute		X		Direct	Member of the Queens Nursing Institute	2012	Present	All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc
		Royal College of Nursing		X		Direct	Member of the RCN	1987	Present	All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc
		Homeless and Health Inclusion		X		Direct	Member of the Faculty of Homeless and Health Inclusion awarded an Honorary fellowship March 2022	2021	Present	All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc
		Norfolk and Norwich University Hospitals NHS FT				Indirect	Sister employed registered nurse at NNUH	2000	Present	All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc
		Norfolk and Norwich University Hospitals NHS FT				Indirect	Brother employed in an administration role at NNUH	2021	Present	All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc
Andy Yacoub	Chief Executive, Healthwatch Suffolk	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 May 2023

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
- Mark Burgis (MB), Executive Director of Patients and Communities, NHS Norfolk and Waveney Integrated Care Board
- Dr Frankie Swords (FS), Executive Medical Director, NHS Norfolk and Waveney Integrated Care Board
- Suzanne Meredith (SM), Deputy Director of Public Health, Norfolk County Council
- Judith Sharpe (JS), Deputy Chief Executive, Heathwatch Norfolk *(representing Alex Stewart)*
- Andy Yacoub, (AY) Chief Executive Officer, Healthwatch Suffolk
- Paula Boyce (PB), Strategic Director, 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
- Emma Ratzer (ER), Chair of the Norfolk and Waveney Voluntary, Social and Community Enterprise (VCSE) Assembly

Participants and observers in attendance:

- Rebecca Champion (RC), Senior Communications and Engagement Manager – Partnerships, NHS Norfolk and Waveney Integrated Care Board (for item 10)
- Andrew Palmer (AP), Deputy Chief Executive and Executive Director of Performance, Transformation and Strategy, NHS Norfolk and Waveney Integrated Care Board (for item 5)
- Jon Punt (JP), Complaints and Enquiries Manager, NHS Norfolk and Waveney Integrated Care Board (for item 7)

Attending to support the meeting:

- 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 Alex Stewart, Cathy Armor, Stuart Lines and Paul Hemingway.	
2.	**Declarations of Interest**	
	None declared	
3.	**Agree Minutes from the Previous meeting and Matters Arising**	
	The minutes were reviewed and approved as an accurate account of the meeting. There were no matters arising.	
4.	**Action Log**	
	The action log was reviewed and the updates added to the log accordingly.	
5.	**Joint Forward Plan**	
	Andrew Palmer (AP) attended the meeting to update on the work to develop the 5-Year Joint Forward Plan (JFP) for Norfolk and Waveney, including the engagement undertaken with local people and communities. The draft JFP had been circulated prior to the committee and was taken as read. AP began by thanking Rebecca Champion for the work she has led on the engagement, and also Liz Joyce for the coordination of this very complicated piece of work. AP also acknowledged the contributions from leads from across the whole system, and also partners from every sector. AP highlighted this was the first JFP the ICS had had to do; there are two parts – part one is the main body of the plan, and part two deals with the legal requirements. AP recognised there is still work to do around the language and making it accessible to everyone. AP invited questions from the committee. AD asked two questions. Firstly, in relation to the engagement exercise and 700 responses, was it possible to give a flavour of the responses received and understanding of who we engaged with. The second question related to the eight priorities and prevention and early intervention, and could AP provide reassurance that within the eight priorities early intervention and prevention is being discussed and addressed within each priority. AP acknowledged AD's question about the eight priorities and commented that there was more work to do on this in order to have that golden thread running through the document. However AP will push back in the conversations with the leads and the various boards that have developed the objectives, particularly under each ambition to ensure early intervention and prevention is in everyones minds. In response to ADs first question about engagement, RC commented that it was an anonymous survey and was promoted heavily with the public and also staff, so there were a lot of detailed responses from people working in the system, and there were approximately 20 responses from other organisations. Several people shared personal stories; there were also responses from service users and carers, and a lot of feedback from staff.	

	TW queried, in relation to the objectives and ambitions, whether there is a means of checking with the population of Norfolk and Waveney that these are the right objectives for them? AP responded that he felt it would be difficult to do this directly with the population in a constructive way, but there is an opportunity to take this back through the various boards again in order to get a different eye on it. AP reiterated the process wasn't complete yet and if anyone had any thoughts or comments about the JFP to please get in touch with him. Shelley Ames (SA) commented via the meeting chat: There are now approximately 1400 conversations on the Community Voices insight bank from those communities experiencing the greatest inequalities. We need some additional human resource to help with the analysis of these insights, but there is potentially lots of useful insight there to help inform JFP. Potentially useful to cross reference with those insights generated through the survey. FS commented that the JFP is a great piece of work however it is an enormous plan and what we are really keen to get across and share is the eight priority areas and the 21 ambitions beneath the priorities. Twenty-one ambitions is a lot and there are many more missing because we can't cover everything. FS gave an example of urgent and emergency care and focussing on improving ambulance response times, virtual ward and discharing people earlier – in the plan it looks like that's all we're doing but there are many other important topics in that arena and just because they're not in the plan doesn't mean they're not important, and we're not doing them. It's just these are the three most high profile things that we're going to measure and you can hold us to account for. AP added that he will be working with the ICB Comms and Engagement team to produce additional materials to help make the plan more accessible and to pull out key messages. AD agreed that an accessible version of the plan would be helpful and picking up on FS earlier point, there is nothing to stop us bringing to this committee updates on work which may not look obvious in the plan, in order to emphasise it is happening and that the improvement work is making a difference to local communities. We must ensure the public is aware of what we're doing and has the opportunity to contribute and give opinions on whether something the system is working on is actually going to be helpful or if it needs to refocus. PB commended AP and his team for the JFP and from a non-NHS perspective it is an easy read and is well laid out. PB had two specific suggestions relating to including (in objective 4a) HWB, district councils and the DWP to support the NHS in bringing health services closer to peoples communities. In relation to objective 4b on dentistry, PB suggested being more ambitious around this objective and not just addressing existing dentistry services but thinking about how we bring additionality into the system. MB responded that Norfolk and Waveney has some very substantial challenges but the ICB team do think there are areas that we can collaborate on as an organisation, working with partners across the system, to make some improvements for our population. AD thanked AP for joining the meeting and asked him to share the commitees thanks with colleagues who have been working on the plan. AD also thanked RC and her colleagues for supporting the engagement work.	

6.	**Healthwatch Updates**	
	AD welcomed Judith Sharpe (JS) from Healthwatch Norfolk and Andy Yacoub (AY) from Healthwatch Suffolk, and invited them to provide updates on the work currently in progress. JS provided the following update. Healthwatch Norfolk have been successful in agreeing several multi year programmes of work with key providers; NCC Adult Social Care, NSFT and NCHC. The projects will evolve over their duration but will initially focus on engaging with patients, service users, carers and sometimes staff on their experiences of accessing services looking at key themes such as carer involvement, communication, discharge, virtual care amongst others. Healthwatch Norfolk welcome these longer-term projects. In March 2023 Healthwatch Norfolk published its NHS Health Checks report. Healthwatch Norfolk was asked by Norfolk County Council's Public Health team to gather the public's opinion, uptake and experiences of NHS Health Checks in Norfolk. The aim was to develop a greater understanding of why uptake is low and what could be done to improve this. Feedback was gathered from 410 individuals and the report can be found on the Healthwatch Norfolk website. JS was pleased to share that Healthwatch Norfolk had started 'Three Hospitals Three Weeks' which will see the entire Healthwatch Norfolk team spend a week gathering feedback at the Queen Elizabeth Hospital in King's Lynn, the James Paget University Hospital in Gorleston, and the Norfolk and Norwich University Hospital. It is a first for a Healthwatch organisation in the country and aims to gather information from patients, family members and staff. Further information and details about the digital version of the surveys can also be found on the Healthwatch Norfolk website. AD thanked JS for the update and invited questions from the committee. In relation to the Health Checks report, TW commented that Health Checks were being completed by the Wellness on Wheels programme so perhaps, for some of those communities that find it really difficult to access the checks in primary care, we can encourage that take up and offer with underserved communities, and also look at what we can provide in the Wellness Hub at Castle Quarter. TW continued that the Healthwatch Report would really inform how we work and how we can promote health checks to enable more people to access them. MB was particularly interested in those people who felt they hadn't received the invite and what can we do around that. However, it was noted that when health checks do happen there is lots of positive feedback, but we want to ensure that everyone gets the opportunity, and if that's not happening we need to do something about it. Suzanne Meredith (SM) added that public health are using the results from the report as part of their commissioning of the whole NHS health check programme, and they will be taking steps to see how they can improve both the invitation process and the uptake because it is really important. In relation to SM's comment about the invitation process, AD added that some patients are not always receiving text messages so we really need to think about how we actually reach people and it's not all by text or email. In relation to the project to hear the voice of older persons, PB commented that the district councils and Health and Wellbeing Partnerships (HWP) are really delighted	

	that Healthwatch Norfolk have been commissioned by Adult Social Care to undertake this piece of work. PB felt it would be helpful for Healthwatch Norfolk to join the HWP meetings across Norfolk and Waveney to enable district councils to contribute, as they have local housing authority responsibilities and it will be helpful in terms of setting strategy. JS responded that Healthwatch Norfolk should already have representation at the HWP meetings and Norfolk County Council has supported Healthwatch Norfolk to ensure it is linked in to these meetings. PB clarified that her point regarding Healthwatch Norfolk representation was in relation to the specific piece of work about the older persons voice as this is really key. JS confirmed that Healthwatch Norfolk was happy to support this. For the Healthwatch Suffolk update, AY had invited Susan Balaam (SB), a research officer at HWS to join the meeting to talk about a dementia report which HWS had recently published. SB explained that last May, HWS were approached by Suffolk Dementia Action Partnership to help them gather people's experience of living with or caring for someone with dementia. This work would then inform the development of the Suffolk Dementia Strategy. Twenty interviews were undertaken and 100 feedback forms completed. The responses were analysed and from that 36 learning points were identified across seven main areas of focus including: diagnosis, support from health professionals, social care support, hospital care, and services working together. SB shared a short video in which Suffolk residents Peter and Teresa shared their experiences of living with dementia in Suffolk. They highlighted the challenges including living in rural communities and accessing services and support. Peter and Teresa likened their experience to 'coming to a roundabout with no signposts'. SB added that one of the key messages taken from this piece of work is why don't we treat dementia like any other illness? AD thanked SB for her presentation and commented that it is a worrying situation, but work has begun looking at dementia provision and how it can be improved.	
7.	**Complaints Report**	
	AD welcomed Jon Punt (JP) to the meeting to provide an update and overview of complaints and enquiries received by the ICB during quarter four of the previous financial year, and the themes arising from those concerns raised and lessons learned. A paper had been circulated prior to the meeting which was taken as read. JP highlighted some key areas from the report as follows: • The high level message in the report is that the volume of work the team is processing has significantly reduced during the financial year, which is really positive because during 2021/22 it became particularly difficult to ensure all inquiries received the time and attention they deserve • However, volumes are probably about to exponentially increase. The full delegation of commissioning for primary care services came to the ECB on 1 April, but that didn't include complaints and concerns which currently are only with the ICB in shadow form. Essentially that means that NHS England prepare the responses which the ICB chief executive signs. From 1 July that will change and the ICB will handle everything. Two full time members of staff will also transfer from NHSE to the ICB. The unknown element currently is the volume of telephone or email contacts the ICB will receive. Currently the NHSE contact centre handles many contacts at first point and can give	

that person the answers that they need right away. We don't know if those people are going to gravitate towards ICBs as they become a bit more learned around where the commissioning arrangements lie, so this is something that will be closely monitored and NHS England have committed to regular conversations about that.

- 45% of complaint responses went out on time. The target working timescale is 30 working days. Responses can be delayed for various reasons such as information being delayed coming back to the complaints team which could be internal ICB departments, but quite often the team manage large multi provider complaints which are quite complex in nature. Therefore responses from providers might be delayed in coming back to us or they might have slightly different time scales that they work to. However, JP reassured the committee that in future the complaints which are delayed or are about to breach their target time will be escalated to ICB EMT for review and support to resolve the delays.

AD thanked JP for the update and invited questions from the committee.

FS shared her disappointment regarding the response timescales and felt strongly that the committee need to address that there is currently no robust escalation for this. FS added that a complaint is a gift, someone has taken the time to complain about a sub optimal experience and we're taking more than a month to provide a response. FS also felt that inquiries should have a target timescale similar to complaints. In relation to MP inquiries, FS commented that she hoped these were not being treated any differently to anyone else and were in accordance with timescales and targets.

FS also thought that dental complaints should be logged separately because they may be very different and difficult and this could be reflected in response rates.

JP responded and agreed with FS statement regarding unacceptable response times. However, JP was confident there was regular dialogue with those complainants to update on progress. JP added that some of the complaints that arrive at ICB level are more complicated and take a bit more time to unpick. The Ombudsman's guidance is really clear that you can take up to six months but, where prudent, to provide a response as soon as possible.

JP continued and advised that the landscape is about to change in terms of complaints and concerns handling, as the new guidance relating to complaints handling has been published. The guidance will mean a lot of information concerns and inquiries will be recategorised and will start to become complaints, so it might be that our complaints numbers start to shoot up, but actually our inquiry numbers will reduce as a reflection of that.

For MP inquiries, JP gave reassurance that they are treated no differently and received the same service as any other constituent.

AD commented, in relation to MP inquiries, that in her experience people in communities may try to solve their complaints with the provider but they get nowhere. They don't know about the ICB complaints route and they go to their MP because that's what they know. AD is very aware that MPs pass on a complaint rather than just an inquiry and asked JP how easy is it to separate within the complaints report which are just general questions e.g. about waiting times and how many of them are

	complaints where the person didn't get anywhere. There is also the questions about how do we advertise and let people know how to complain to the ICB if that is the route they feel comfortable taking, as many people are unaware of it. JP responded that MP inquiries can be categorised by complaint, and also if a complaint has already been brought to the attention of a provider or the ICB and the MP comes to us as well, although these will be double counted as it's come via two different mechanisms. In this circumstance the MP is advised the ICB already has the complaint, and the MP will be copied into the response, which further reaffirms that MP inquiries not treated any differently. In response to primary care complaints, JP advised the NHSE guidance has provided all systems with a communications toolkit and he will talk to the comms and engagement team about ensuring the route for making complaints about primary care is well publicised. Regarding the escalation of response delays to EMT, MB said he and FS would ensure that this is supported by EMT. MB added that the complaints are very important at an individual level, but also collectively, and the themes and trends element is what's really critical. MB asked JP how he thought we might do better at identifying areas we need to be focussing on in the future. JP responded there are three areas that are flagged in the report to the committee - Continuing Healthcare, access to appointments in terms of GP face to face, and the walk in centre consultation, which were themes in quarter four. But it's also about bringing together the other elements and the other contacts that we receive and the other really important feedback. For example, the ICB is often sighted on provider to provider feedback which the complaints team doesn't see. There are also the serious incidents that are raised at ICS level but are investigated at provider level. The triangulation of all of those areas doesn't happen as effectively as a system as we need it to. If we can improve that in future that will help quality improvement programmes and will inform commissioning cycles too. MB acknowledged the difficult job that JP had and thanked him and his team for the work they do, recognising that some of the cases are quite upsetting as well. JS commented that we should keep in mind that the feedback received from patients and the public is so incredibly valuable. JS asked JP if he was able to change two or three things in the system that would reduce complaints, what would they be? JP identified GP access (face to face) and elective waiting times. JS added that Healthwatch does hear a lot of comments about access to GPs, however a piece of work Healthwatch did in the summer and autumn last year revealed that actually quite a lot of people are happy with their GP, and it tends to be the focus on certain GP surgeries. These are often the ones where there's been big housing development and the infrastructure is not really thought out. Do we look at the contracts with those GP practices and the commissioning, and report on that because if we know it's just a handful of GPs, we should be doing something with that handful and not tarring all GPs with the same brush. TW commented that whilst the triangulation of complaints and working with both providers and the ICB is great, it is hard to make a complaint. In TW experience of managing any complaints, it is vital that people feel listen to and that they are heard. Sometimes when you're going through a complaint and if there's e-mail or letter	

	correspondence, that can be quite challenging. So is there an element in the process where there's a personalised approach for people. Does JP have the opportunity to actually meet people face to face, because sometimes the elements of talking through and bring the right people together often is really helpful. JP responded that this was a really good question and reflected that the world had changed over the past three year with many people working remotely. But actually we should see that as an opportunity more than anything, as you can see people face to face via video calls and hear people. However, a personalised approach is the one that JP would agree with the most. The ICB is fortunate to have a really experienced complaints and enquiries team and JP is a huge advocate of making sure that we treat each complaint on its merits, whether that means a face to face or a virtual meeting or whatever, and we'll always be open to postal responses too. If someone wishes to to meet after they've received a complaint response, they remain dissatisfied, or they just want more clarification in certain areas, there is definitely senior support within the organisation to meet with complainants as well. It shouldn't just be the complaints team, it should be the appropriate people also. AY commented that there have been tens of thousands of complaints received over the years at Healthwatch, and due to the state of play nationally, people would be fairly dissatisfied, but it's still averages at over three stars out of five across the board. It shows that people are prepared to compliment and even when they do comment and they have an issue, they recognise the context. There's a really fine line between a comment about a poor experience and a complaint. So if you do get trends in your complaints, it really is worth checking with your local Healthwatch whether they have any comments that match this as it might actually be something that's a bit more common. AD commented on the rich conversation today which shows we are passionate about patients receiving good experiences from our services, and it is a very important piece of work JP's team is doing. If we can learn from JP findings and we can make changes in the system to reduce the unfortunate events where people may have struggled or may not get what they would have hoped for then that would be great. The committee looks forward to hearing from JP in the future and about the trends in particular areas. It was noted that changes had been made to the Complaints and Enquiries Policy to reflect primary care complaints transferring to the ICB from 1 July. JP asked the committee to approve the policy. Subject to some typo corrections being made, the committee approved the Complaints and Enquiries Policy for implementation from 1 July.	
8.	**Urgent and Emergency Care Update**	
	Mark Burgis (MB) provided an update on the key aspects of the work around urgent and emergency care (UEC) and what it means for the Norfolk and Waveney population. A slide pack had been circulated prior to the meeting and was taken as read. MB began by highlighting that every year there is an awful lot of work undertaken across the NHS, social care and wider system to identify how patients can be best supported during periods of extreme pressure in UEC e.g. winter pressures. Often, when we talk about emergency care, we tend to think about the challenges and	

	things not working, however there are some positives across the system and Norfolk and Waveney has been identified as a national exemplar in some areas. These areas include trying to keep people well and out of hospital, reducing ambulance response times and considering alternative treatment and care options rather than just sending an ambulance. MB quoted some statistics relating to ambulance disptatches and in 2022/23 there were 28,000 fewer ambulances dispatched compared to 2019/20. Similarly, 22,000 fewer ambulances have taken people to hospital. Emergency admissions had also reduced and there were 8,500 fewer admissions last year compared to 2019/20. This is testament to the work that many people have done including the HWP and the work of place which are both a large part of delivering work in communities - keeping people well and keeping people at home. MB also highlighted areas which are not performing as well, in particular category two (C2) ambulance response times (which includes heart attacks, strokes, sepsis and burns) and this is an area of focus, along with waiting times at our hospital accident and emergency departments. However it was noted there had been an improvement in the four hour response time. MB concluded by acknowledging the journey the system is on and we know there are some big areas in which we need to make improvements. AD thanked MB for his update and asked, in relation to category two ambulance response times, whether there was any scope that the category will be subcategorised as AD's understanding is the category is very wide and in a way is affecting the way we measure the response time, due to the many conditions it covers and the slightly different need in terms of the response required. FS responded that the categories are nationally defined and each ambulance service is held to account against these categories. FS continued that call handlers are highly trained and supported by clinical advisors within the call centres, who regularly reivew and check that a category is still appropriate or if it needs reprioritising. MB added that clinical triage is another area of focus and it is particularly pleasing how our 111 and 999 services are now working closer together. There is also the Clinical Advice Service which is mainly GP led but nurse practitoners and others run and staff the service. AD sought reassurance, in relation to patient admission delays due to there being no beds available, that the work ongoing in this area is linked in to the discharge work, and there is synchronicity between the two. MB confirmed this was happening and is a critical piece of work and work is ongoing with regional and national colleagues around this, including looking ahead to next winter and what capacity is required to meet demand. However, hospital admissions aren't always the answer, it is better for patients to be in their own home with the right care wrapped around them.	
9.	**Spotlight on: Children and Young People**	
	This item was deferred to the next meeting	
10.	**People and Communities Approach update**	

	Rebecca Champion (RC) provided an update on the people and communities approach. A presentation has been circulated prior to the meeting which was taken as read. RC updated that the co-production hub will be launched during co-production week at the start of July. The hub will offer a central place to support some of the system wide work, for example the mental health transformation co-production strategy. Work is also being aligned with Norfolk County Council, and a joint event is planned during co-production week, as part of the councils Making it Real Board. The council has some co-production training for their staff so this will be an opportunity to engage with staff and services users, and there will also be people with lived experience attending too. RC also highlighted there are always live projects on the go and these can be found in the live project section of the website. Talking Therapies engagement is starting in June which will focus on people who have access to the service but also those that don't. There is also some engagement around the SOS bus and Castle Quarter as the contract for the SOS bus is ending soon. This is the first time that we will be engaging with patients about the SOS bus, and also the vaccination centre at Castle Quarter which is changing to a wellness hub. This engagement ends on 11 June. The results of the Walk In Centre (WIC) consultation are also on the website under the 'you said, we did' section. There was a huge response to the consultation and a lot of support for the WIC which will remain open. The annual assessment that ICBs have will also include an element around patients and communities work, and that will be centred around the people and communities hub on the website. Indications are that the assessment will take place during the summer so we will be working with colleagues, partners and local people to ensure we are telling our story as clearly as we can. AD thanked RC for the update and asked, in terms of the coproduction hub, will it be on the ICB website or is there going to be a portal where people can go? RC responded that it will be part of the patients and communities hub, the aim is to have a centralised place for people to access. MB acknowledged the really good work that is taking place and asked RC if she had any thoughts on how the co-production work could be developed further. RC felt there is lots more that could be done as a system, the HWP, the VCSE and Healtwatch are trying to do more but are very limited by time and resources. Another area RC felt could be developed is the Insight Bank which is part of the Community Voices Project. The Insight Bank is a really great way to hear from some of the people the NHS don't traditionally hear from, which could then provide the basis to develop a portal for data and pulling in insight from a range of different places. RC continued that we're learning that the feedback is so important to the people who are part of the projects, and it's great for them to hear what and how it's being used for a range of purposes. Shelley Ames (SA) commented in relation to the Insight Bank, that there is increasing emphasis on qualitative insights, but these take human resource in terms of the analysis. It's not easy to automate and we put a huge amount of emphasis in stock	

	in our system on the quantitative side of things, for example business intelligence, data, Norfolk insight platforms, but they often define the problem, not necessarily the solution and these qualitative insights can help with that. One of the challenges we're experiencing with Community Voices and some of the conversations we've had today is we're collecting a huge amount of qualitative insight and if we're going to make that useful and usable, and be able to respond to it, we've got to invest resource into the analysis of those insights which is a challenge. SA is working with Great Yarmouth Borough Council and PB's team, who have been helpful in helping us with our thinking from an independent viewpoint, specifically about what can we do with these insights? How do we present them back to the system? How do we respond to them? But in order to make it work a lot more resource is required in the qualitative space. There is lots in the community voices bank that could help with Community services review, talking therapies and IAPT review. However, we have to be able to do the analysis of it - we need to maximise what we're currently collecting. AD commented that we might need to think about resources as it had been mentioned several times during today's meeting, and we don't want to be talking in future meetings about still not having resources, so something needs to be done. TW reflected on the the current consultation around Castle Quarter and the wellness hub. From TW involvement in the Norwich locality, what we've been able to do is work with Norwich City Council who have agreed through their insights that they gather through their place plus programme, is to have their community connectors within the vicinity of Castle quarter in some of those areas which are called RIETAs (reducing inequalities in target areas) and capturing conversations but not leading the conversation about what they would like to see in a Wellness hub, to just be around in that space and talk about it. This is an example of joining up with other things that are happening to make best use of everybody's resources as well. And that insight is also linking to the other community voices work, which SA is involved in. This is something that before we wouldn't have had the additionality to include that with one of our surveys in an engagement exercise so TW is really pleased that we can do that on this occasion. AD thanked RC for her update and acknowledged the complexities of the work that RC is doing and the skills and knowledge required to reach the right people and engage with them.	
11.	**Any Other Business**	
	i. Population Health and Inequalities Board: Assurances and Escalations Report FS presented this item. It was noted that an update from the Population Health and Inequalities Board (PH&I Board) would be a standing item at future Patient and Communittee committee meetings. FS explained this is a new board; the first meeting was held recently and the terms of reference were approved. FS highlighted to the committee that the ICS does have statutory duties to use population health management techniques to address inequalities and to improve health. The Board is the engine room to oversee the work of our population health management oversight group and the health inequalities oversight group.	

	FS ran through the key areas of escalation that the PH&I Board felt it was important for this committee to know about or require the committees help. The report had been circulated prior to this meeting and was taken as read. FS was keen for the Patients and Communities Committee to be cited on why prevention and early intervention is so important. FS shared some statistics relating to the growth of our population and by 2040 there will be 36% more people over 65, most of them will be over 75. But there will only be a 4% increase in working age adults, and there will actually be a 1% reduction in children and young people. So our birth rate overall is is falling and because of the deprivation within our areas, those Core20 populations - the people living in the 20% most deprived areas - are responsible for 2000 more emergency admissions with lung disease and 6000 more severe mental illness than there ought to be. FS continued that if we do not make changes within the next five years, the demand for GP appointments is going to have increase by more than 1000 per day. However there is a framework for how to prioritise and there is also excellent input from public health and PHM colleagues who have identified the scale of the problem, and the areas where we will get the best outcomes in terms of improving our population's health FS highlighted a particular area of focus for the board is coordination, to prevent overlap and duplicating the multiple strands of work that are happening in other groups and boards. Our business intelligence teams also need a bit more time to refine the data set but there is a collaborative approach in setting this up at the moment. AD thanked FS for the update and invited questions from the committee. MB commented that this population health management work will very important for in the future. MB shared some additional statistics in relation to GP access and stated that whilst actually we've never been offering more appointments in primary care than we are now, the figure in March was 600,000 appointments offered across Norfolk and Waveney which is the equivalent of well over half the entire population of Norfolk and Waveney having appointments at their GP surgery, which is quite a staggering statistic. MB added he was looking forward to this committee really supporting the population health and inequalities board's work. AD asked, in relation to the number of GP appointment offered in March, what was the number Did Not Attends (DNA). FS responded it was about 24,000 appointments per month which is a high proportion. MB added it was a similar situation in dentistry with a very high number of last minute cancellations or non-attendance. AY commented that something that Healthwatch's across the country have called for, including in Suffolk and Norfolk, is a far simpler way for a patient to cancel or rearrange an appointment. It is just as difficult to get through to make an appointment as it is to cancel an appointment, and if you're working Monday to Friday, you won't have the opportunities to wait on the phone to get through. So if we can somehow manage to do that then the DNAs will probably reduce. AD added there is a practice in Norwich which has an automated system for cancelling appointments. There is no need to speak to anyone and you receive confirmation within minutes that the appointment has been cancelled therefore	

	providing reassurance that it has been dealt with. So there are practices already locally which are solving some of those problems. AD continued that from her work with Norfolk Deaf Association she can see first hand how very disheartening it is for practitioners who are waiting to see patients and they're not turning up, when there are patients who do need that support and help and they can't get it in a timely manner, so it is a problem. AD added that although the NHS is a 'free' to receive service, it's not free because there's lots of resources put into it to make it available to our people. **ii. Ageing Well Workshop – 23 May 2023** FS highlighted the forthcoming Ageing Well Workshop. This is a really interesting piece of work and the intention is for the older people framework to feed into this committee.	
Date, time, and venue of next meeting: Monday 24 July, 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

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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	Date Closed
3	30.1.23	Community Voices	RJ / SA	Summary of actions taken as a result of Community Voices to include learning, what has been done differently, introduced or changed as a result of the feedback	25.4.23: Update coming to July meeting 22.5.23: Agenda item for July's meeting	24.7.23 ~~22.5.23~~		
4	30.1.23	Lived experience representative	PH	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	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.	22.5.23 ~~23.3.23~~		
6	30.1.23	ICS organogram	PH	ICS organogram to be produced to show who does what from the comms and engagement team	This is a work in progress and will be shared once finalised. This is a big task to do this across the ICS. The ICB structure was shared with HWN previously 22.5.23: Ongoing.	~~24.7.23~~ ~~May~~		
8	30.1.23	Include national patient surveys & HW reports in forward planner	PH / RP	Incorporate a calendar for all national patient surveys as well as planned HW reports into the Patients and Communities forward planner	In progress. HWS and HWN will share a list of work underway at any particular time 10.7.23: HWN and HWS forward reporting plans added to Patients and Communities Forward planner. **Action complete**	24.7.23 ~~22.5.23~~		
9	27.3.23	Agree committee objectives and forward plan	RP	Development session to be arranged for committee members to agree objectives and plan	27.4.23: Session arranged on 11.5.23 22.5.23: Once finalised, draft forward plan to be shared with committee members 21.6.23: Plan shared with committee members for comment; some minor tweaks required following feedback. Final version will be shared with committee members w/c 24 July	24.7.23 ~~22.5.23~~		

flourish

Babies Children and Young People in the Joint Forward Plan

Patient and Communities Committee

Rebecca Hulme

24 July 2023

Norfolk and Waveney Children and Young People

- Approximately 290,000 individuals aged between 0-25 years
- Approximately 25% of the Norfolk and Waveney population
- C500 state funded school and nursery education settings
- C1400 children in care
- 70 children eligible for Children's Continuing Care funding
- 50% mental health problems established by age 14
- 75% mental health problems established by age 24
- 9000 births per year
- 12.1% rate of smoking at time of delivery
- 3.8% of school age population with social, emotional and mental health need
- Above average rates of emergency admissions for 0-4

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What is FLOURISH?

FLOURISH is the overarching system ambition for all children and young people in Norfolk.

The FLOURISH ambition has been developed and endorsed by Children and Young People Strategic Alliance members (including young people) and will form the basis of the Children and Young People Strategy as well as underpinning the work of partner organisations – ultimately making a difference for children and young people.

We want Norfolk to be a county where every child can **flourish:**

family and friends
Children and young people are safe, connected and supported through positive relationships and networks

learning
Children and young people are achieving their full potential and developing skills which prepare them for life

opportunity
Children and young people develop as well-rounded individuals through access to a wide range of opportunities which nurture their interests and talents

understood
Children and young people feel listened to, understood and part of decision-making processes

resilience
Children and young people have the confidence and skills to make their own decisions and take on life's challenges

individual
Children and young people are respected as individuals, confident in their own identity and appreciate and value their own and others' uniqueness

safe and secure
Children and young people are supported to understand risk and make safe decisions by the actions that adults and children and young people themselves take to keep them safe and secure

healthy
Children and young people have the support, knowledge and opportunity to lead their happiest and healthiest lives

flourish

The NHS Long Term Plan (LTP) recognises that the health of children a young people is determined by far more than healthcare. Household in education, housing, stable and loving family life and a healthy environm significantly influence young people's health and life chances.

The first 1001 days of a child's life are critical, and the NHS plays a cru in improving the health of children and young people: from pregnancy, the early weeks of life; through supporting essential physical and cogni development before starting school; to help in navigating the demandin transition to adulthood (NHS LTP)

flourish

“Our collective Ambition is that all babies, children and young people (BCYP) will have the best start in life, achieved through person and family centred, high quality support to enable them to ‘Flourish’. We will focus on collaborative working with system partners to promote the importance of a strong start in life for children and young people.

We will prioritise the voices, needs and ambitions of children and young people so they can live their happiest, most rewarding lives and meet their potential.

Start for Life and Family Hubs

All families need support from time to time to help their babies and children thrive, whether that's from friends, family, volunteers, or practitioners. Our ambition is for every family to receive the support they need, when they need it. All families should have access to the information and tools they need to care for and interact positively with their babies and children, and to look after their own wellbeing. Local services, working together and in partnership with the voluntary, community and faith sectors, all have a vital role to play in supporting families. Professionals often face practical and organisational barriers to working together. Organisational geographical boundaries don't always align when it comes to delivery of services, which can add to the complexity. Improving join-up between state and non-state services and taking a whole family approach better supports families to access the help they need.

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Norfolk and Waveney Integrated Care System

Does your family need some advice and support?

family hubs bring services together to offer support to families from conception, through childhood, into teenage years and up to 25 for young people with SEND

Here's how to access support

Self Help & Advice
Visit our online virtual family hub providing information and advice on the support and activities available across the Norfolk family hub network.

Speak to a family hub professional
Our network of family hub professionals from a range of different organisations will be available to advise and connect you to the right support.

Self referral
Complete a self referral and one of our family hub professionals will contact you to get ensure the right advice & support is provided.

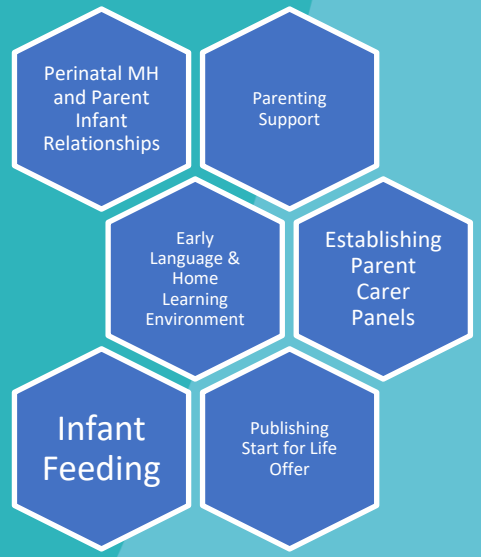
Targeted Support
Using data and intelligence to identify families and cohorts who may need support and proactively engaging with, and offering support and services

Family Hub Offer
Across the Family Hub network you can access a range of support including:

- Home Learning
- Parenting Support
- Adult & Family Learning
- Infant feeding Support
- Perinatal Mental Health
- Debt & Welfare advice
- Early Education Financial Support
- Reducing Parental Conflict

Early
For more information on what's available visit the family hub webpage

The majority of the funded elements of the Family Hub Programme focus on the 'Start for Life' Offer and comprise the following priorities:



Family Hubs and Start for Life

Why is this a priority?

Evidence is clear that identifying risks early and preventing problems from escalating leads to better long-term outcomes. Universal services which are available to all local families who need them can help to spot and respond to issues before they develop into more complex problems. Some families with babies, children and young people will need additional, targeted help.

Whatever the need, early identification, support which is easily accessible, and strengthened relationships help to address problems before they get worse. Investing in supporting families to care for their babies, children and young people has an important role to play in reducing health and education disparities right from the start, and improving physical, emotional, cognitive and social outcomes longer term

What do we need to do?

Using whole family approach we will provide a single access point to family support services that is integrated across health (physical and mental), social care, VCSE organisations and education settings.

The emphasis will be on support for families in local areas, there will be a designated physical family hub site in each of the seven districts, which includes a site in each of the four largest urban areas of Norwich, King's Lynn, Great Yarmouth/Gorleston, and Thetford, where 37% of Norfolk's overall population reside, and which also contain the most deprived areas in Norfolk.

Virtual services will also be available through the family hubs approach

How will we know its worked?

- We will collect feedback from families on Start for Life a family hubs offer (inclusive, 90% accessible, co-ordinate approach, greater connection through services, easier t navigate access services)
- Families will tell us they were able to access the advice information and guidance they need
- feedback from parent and carer panel
- More Practitioners across agencies work in a whole fam approach (data single view – data sharing agreements)
- Recruitment of additional 70 peer support volunteers recording families receiving support and recruitment numbers by 2025/26.
- Aim 250 of families supported via Every Relationship Matters
- Families receiving help to manage financial challenges (measured through DWP advisors embedded in family hubs)
- Measured increase in number of families receiving support & increase in school attendance.
- reduction in EHCP & needing access Alternative provision.
- Improved health & development outcomes for babies & children with focus on most deprived 20% of Norfolk population (measured by aligned public health outcome

Long Term Conditions

The conditions in which we are born, grow, live, work and age can impact our health and wellbeing. These wider determinants of health impact significantly on the health and development and outcomes of babies, children and young people in particular and can have life-long impact.

The Norfolk and Waveney system supporting BCYP and families are working together to promote a strong start in life for our citizens. The CORE20Plus5 approach for reducing health inequalities for CYP will support the system to ensure that healthcare inequalities improvement is built into into our strategies, policies, initiatives and programmes. Our ambition is for exceptional quality health and care for all ensuring equitable access, excellent experience and optimal outcomes. Working together we will take action to address the wider determinants of health and to support BCYP to Flourish in Norfolk and Waveney

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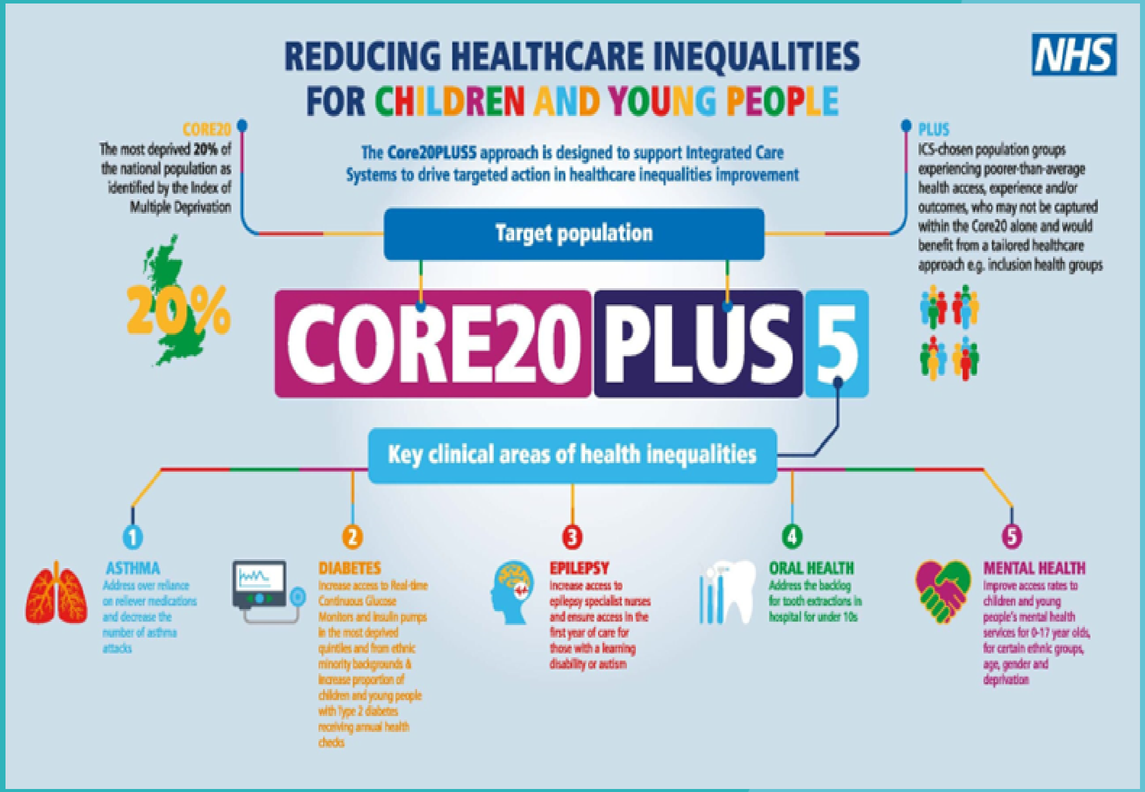

Long Term Conditions

Why is this a priority?

Community-based mental health services for children and young people are now expanding, and the number of children and young people with well-controlled diabetes has improved substantially over the last five years.

However, 7 million children have longstanding illnesses, including asthma, epilepsy and diabetes, and England lags behind international comparators in some important aspects of child health.

Our Long Term condition programme commenced fully in 2022/23. Our local intelligence shows high levels of attendances at ED for those with LTC and early data from local schemes has highlighted significant knowledge gaps for self managing their conditions.

A whole system approach is necessary to ensure all services supporting children and their families understand the impact that wider determinants have on health outcomes

What do we need to do?

We will establish clinically led professional networks who will work together to implement the recommendations of two bundles of care;

Asthma https://www.england.nhs.uk/wp-content/uploads/2021/09/B0606-National-bundle-of-care-for-children-and-young-people-with-asthma-phase-one-September-2021.pdf

and Epilepsy (expected June 2023).

Over the next two years, we will increase access to psychological support for those affected by epilepsy, raise awareness of the conditions across universal services and improve support available to children and families.

How will we know its worked?

Children and young people with long term conditions will have access to better care through;

Training and support for the wider workforce

Improved awareness across universal and targeted services on the impact of wider determinants on health outcomes
Improved ability to self manage their long term condition

Decreased admissions for asthma for young people aged 10-18

Decreased admissions for epilepsy for children and young people aged 0-19

Link for indicators is here: https://fingertips.phe.org.uk/indicator-list/view/paGkBr8vy0#page/1/gid/1/pat/15/ati/167/are/E38000239/iid/93136/age/288/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

Occupational Therapy

Norfolk and Waveney are piloting the impact of integration across children's occupational therapy services. Regardless of where you live, the aim is that access to specialist support should be consistent and of a high quality, able to meet the needs of children and young people.

Occupational Therapists can play a significant role in managing the physical and mental health of children with long term health needs. Often under-resourced, they cannot provide the necessary therapy required to address early needs and improve outcomes.

The commissioned offer does not adequately meet needs for all children, particularly those who are neurodiverse. This increased demand for Education, Health and Care plans and unplanned spend on independent therapy.

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Occupational Therapy

Why is this a priority?

Occupational therapists help babies, infants, children and young people grow, learn, have fun, socialise and play – so they can develop, thrive and reach their full potential.
The focus could be on self-care, like getting ready to go out, eating a meal or using the toilet. It could be around being productive – going to nursery or school, or volunteering. Or it could simply be about improving their ability to play with friends, compete at sport or take part in hobbies.

Current provision and access to occupational therapy in Norfolk and Waveney for children, young people and families is uncoordinated and difficult for families to access.

Service specifications vary across the system and this has led to inequality of access and the system is not benefitting fully from the potential of this important resource

What do we need to do?

We are working with a dedicated clinical working group and colleagues across the system to;

improve independence to self-manage conditions and provide access to skilled high-quality advice and support to reduce the need to specialist interventions.

ensure that children with sensory needs can access clinical support through an NHS pathway.

work with parents and carers to ensure those with lived experience play an integral part in the co-production of the improved service.

Within a joint commissioning strategy, individual pathway teams will work to a consistent service specification with good partnership working across the Norfolk and Suffolk local authorities

How will we know its worked?

- Increased and expanded skill mix of the clinical workforce.
- Increased access to advice, support, and training for universal services
- Publication of a joint commissioning strategy involving Norfolk and Suffolk local authorities
- Increased levels of investment to expand the workforce in order to meet need.
- A reduction in the number of children who require exceptional treatment options by providing access to targeted training for school staff and parents and carers to create inclusive school and home environments.
- Children with complex needs will be supported sooner through the implementation of a graduated model of support.
- Access to a digital offer of support and training will enable universal services to provide better support to children and young people.

Key partners

- Children and Young people
- Children Services – Norfolk and Suffolk
- NHSE – Regional Networks
- Acute Hospital Trusts
- Maternity Services
- Mental health providers
- East Anglian Children's Hospice
- Community Nursing Teams
- Health Child Programme
- Norfolk and Suffolk Police
- Education settings
- Independent providers specialist care for children
- Community paediatrics
- Voluntary, Community, Faith and Social enterprise Sector
- Youth Groups
- Families
- Office for Health Improvement and Disparities

Links to 7of 8 other ambitions of the Joint Forward Plan

1. Transforming Mental Health services
2. Improving Urgent and Emergency Care
3. Elective Recovery and Improvement
4. Primary Care Resilience and Transformation
5. Improving Productivity and Efficiency
6. Population Health Management, Reducing Inequalities and Supporting Prevention
7. Improving services for Babies, Children and Young People and developing our Local Maternity and Neonatal System (LMNS)
8. Transforming care in later life

flourish

ICB statutory duties

Child safeguarding

- ICBs have a statutory duty to safeguard children as set out in Working Together to Safeguard Children (2018) statutory guidance.
- The NHS England Safeguarding Assurance and Accountability Framework clearly sets out safeguarding roles and responsibilities and will apply to all ICBs.
- ICBs will be required to set out how they have discharged duties in relation to child safeguarding in their annual report.
- To ensure that statutory duties in relation to child safeguarding receive sufficient focus in ICBs, responsibility for functions will be delegated to an ICB executive lead.

Children and young people with special educational needs and disabilities (SEND)

- ICBs must continue to deliver the commissioner duties set out in Part 3 of the Children and Families Act 2014 and the SEND Code of Practice (2015) statutory guidance. This includes jointly commission services for children and young people with SEND, with local authorities.
- To ensure that statutory duties in relation to SEND receive sufficient focus in ICBs, responsibility for functions will be delegated to an ICB executive lead

Looked after children

- ICBs have a statutory duty to meet the health needs of looked after children, as set out in the Promoting the health and well-being of looked-after children (2015) statutory guidance.

Children in the justice system

- ICBs have a statutory duty to co-operate with LAs, police and probation services on the provision and delivery of local youth justice services, as set out in Modern Youth Offending Partnership Guidance (2013) statutory guidance.

Mental health

The statutory duties which apply to ICBs for mental health, including children and young people's mental health, are imposed by the NHS Act 2006 (which requires CCGs to commission healthcare services to meet people's needs) and the Mental Health Act 1983. They are explained in the Code of Practice (2015).

Norfolk and Waveney
Integrated Care Board

Agenda item: 07

Subject:	**Population Health & Inequalities (PH&I) Board – 20/06/2023 – Assurance & Escalation Report**
Presented by:	**Mark Burgis**
Prepared by:	**Suzanne Meredith**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**24th July 2023**

Purpose of paper:

The Population Health & Inequalities (PH&I) Board is a bi-monthly meeting. As per the Terms of Reference, the PH&I Board is accountable to the Patients and Communities Committee and will provide an assurance and escalation report after each meeting.

Executive Summary:

The second Population Health & Inequalities Board (PH&I) Board took place on Tuesday 20 June 2023. The report details points of assurance and escalation as well as a high level risk overview summary.

Report

Please find attached document detailing points of assurance/ escalation and risk summary.

Recommendation to the Committee:

To review points for assurance and for the patient representation feedback to be taken into consideration.

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 [20/06/2023]

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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
1.	PH&I Board	18/04/2023	PH&I Board / PHMOG / HIOG Terms of Reference (TOR)	TOR Approved – to be reviewed again at PH&I Board on 15/08/2023 Update 20/06/2023: Latest version agreed. To be reviewed again at 10/10/2023 PH&I Board	N/A	N/A	For assurance – Decision 1 – PH&I Board	
7.	PH&I Board	20/06/2023	Patient Representation across PH&I Board, PHMOG, HIOG (Action 4 of PH&I Board Action Log)	Consideration of arrangements for patient/carer/parent representation on the PH&I Board Healthwatch Norfolk and Suffolk representation arranged for PH&I Board, and supporting groups - HIOG and PHMOG but may not have capacity to attend all 3 meetings.	N/A	N/A	For escalation Request from the PH&I Board for this feedback to be considered as part of the Patient & Committees ongoing piece of work re arrangements for representation	
8.	PH&I Board	20/06/2023	Recommendation of N&W "Plus" groups identified as part of the Core20Plus5 Health Inequalities improvement framework	The PH&I Board and the HIOG were in approval of the groups detailed within the paper. Separate paper provided to inform the Committee	N/A	N/A	For assurance –	

Population Health & Inequalities (PH&I) Board - Points of Assurance / Escalation [20/06/2023]

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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
9.	PH&I Board	20/06/2023	PHM Maturity Matrix Review	Overview of the Norfolk and Waveney ICS baseline position against the National Population Health Management (PHM) Maturity Matrix, undertaken in collaboration with NHSE East Of England PHM Programme provided. PH&I Board members in agreement of next steps – Recommendations to inform strategy development, development of evaluation framework, regularly meet with regional team, sharing of good practice as part of Regional PHM forum and refresh of quarterly progress	N/A	N/A	For assurance	

PH&I Board - New Risks [20/06/2023]

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Programme New Risks as of 20/06/2023 – PH&I Board	Mitigation	Lead	RAG
No new risks were raised at the PH&I Board on 20/06/2023 The overarching BAF06 PHM &HI risk continued to score at 12 The PHM team continue to report 7 risks, no change to risk descriptions, with 2 reducing in their scoring and no risks scored above 15 The HI team identified 7 risks at their first HIOG (on 30/05/2023) and no risks have scored above 15.			
			RED
			AMBER
			GREEN

Norfolk and Waveney
Integrated Care Board

Agenda item: 08

Subject:	**Health Inequalities – NHS "Core20PLUS5" Improvement Framework – defining the "PLUS" Groups for Norfolk and Waveney**
Presented by:	**Tracy Williams, Norfolk and Waveney ICB Clinical Lead for Health Inequalities & Inclusion Health**
Prepared by:	**Tracy Williams, Suzanne Meredith, Alice Vickers, Shelley Ames**
Submitted to:	**N&W ICB Patient and Communities Committee**
Date:	**24th July 2023**

Purpose of paper:

To provide an update regarding the "PLUS" groups defined for Norfolk and Waveney, as part of the NHS "Core20PLUS5" Health Inequalities Improvement framework. These were agreed at the Population Health and Inequalities Board on 20th June 2023.

Executive Summary:

Tackling inequalities in outcomes, experience and access is one of the four core purposes of an ICS.

The "Core20PLUS5" is a NHS England approach to reducing healthcare inequalities. The approach defines a target population – the 'Core20PLUS'.

The PH&I Board have recently agreed the locally defined **"PLUS" groups** as part of this approach – those groups of people who may not live in the most deprived 20% areas of Norfolk and Waveney, but who are known to experience inequalities in health outcomes, experience or access in care, and for whom consideration should be given when delivering health and care services.

For Norfolk and Waveney these groups include:

- **Inclusion Health groups** (including people experiencing homelessness, drug and alcohol dependence, Asylum seekers and vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups)- *all age*
- **People living with a learning disability and autistic people**- *all age*
- **People from Minority Ethnic groups**, such as Eastern European, Black and Asian Communities- *all age.*

- **Coastal and rural communities** where there are areas of deprivation and where we find pockets of hidden deprivation amongst relative affluence- *–all age*
- **Young carers and looked after children/care leavers**- *CYP*
- In addition, ongoing consideration will be given for any selected population at a locality/PCN level if identified from population level data as a group experiencing inequalities as per the "PLUS" group definition.

Care was taken to ensure that the chosen "PLUS" groups for Norfolk and Waveney align with those already chosen for Suffolk as a whole (due to the overlap with the Waveney area).

Further work will be needed to identify existing gaps in services and any further recommendations for development. These next steps will form part of the development of the Norfolk and Waveney Health Inequalities strategy, which we plan to co-develop with system partners and underpin its development with community voice from people who represent the "PLUS" groups.

1. Background

Tackling inequalities in outcomes, experience and access is one of the four core purposes of an ICS.

The Norfolk and Waveney ICS Joint Forward Plan sets out the rationale for why tackling health inequalities is so important, the legal duty to tackle health inequalities and our ambitions for improvement in relation to population health management, reducing inequalities and supporting prevention. Over the next few months we are committed to developing a Norfolk and Waveney Health Inequalities strategy to deliver the "Core20PLUS5" approach.

The "Core20PLUS5" is a NHS England approach to reducing healthcare inequalities at both a national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement for adults and 5 for children and young people (see Figure 1).

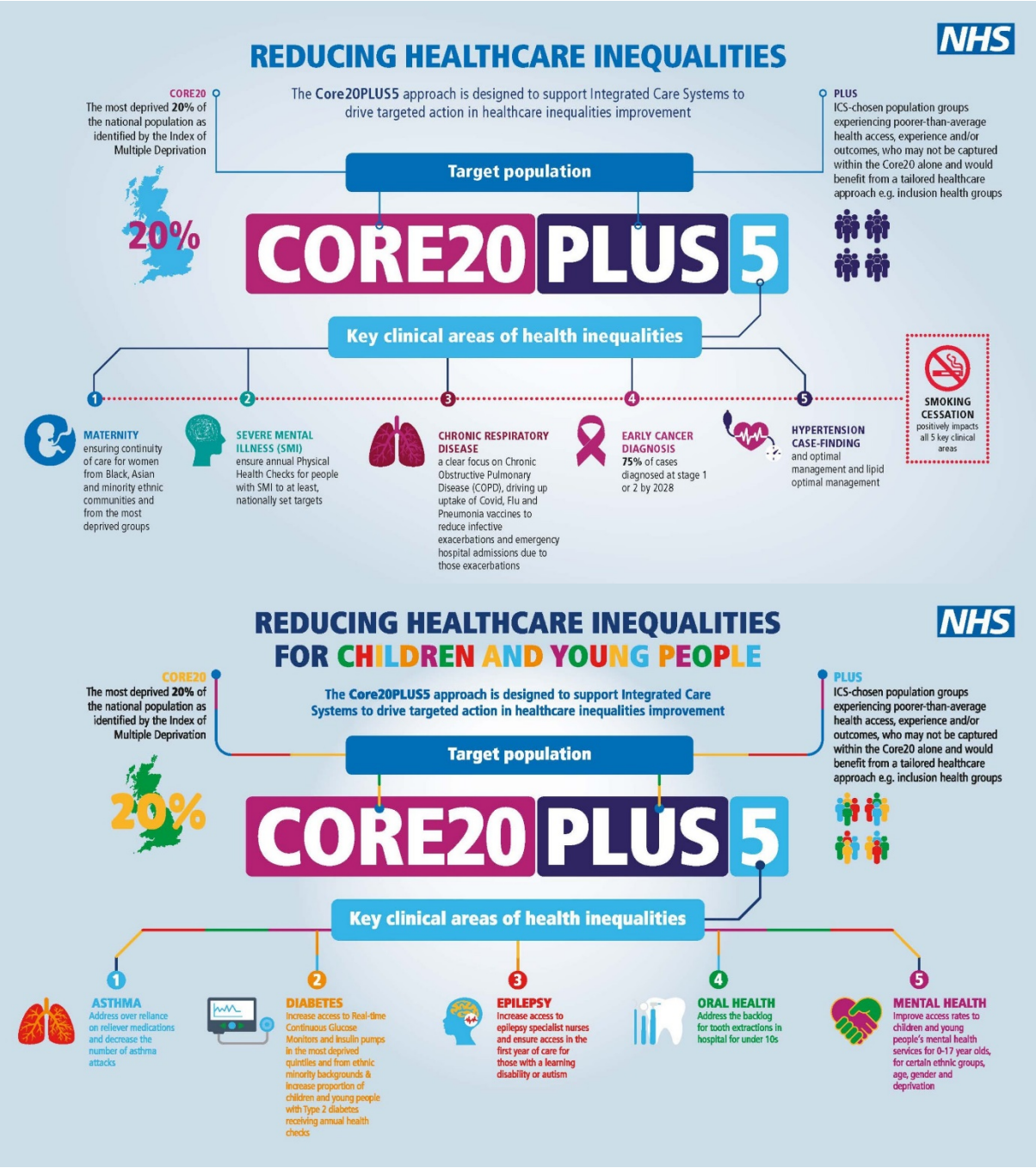
In terms of the target population, the "**Core20**" is defined as the "most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). Figure 2 identifies the "Core20" population for Norfolk and Waveney.

The **"PLUS" groups** are those additional groups of people living in Norfolk and Waveney who may not be part of the "Core20" population but who are known to experience inequalities in health outcomes, experience or access in care, and for whom consideration should be given when delivering health and care services, with the aim of addressing health inequalities.

The national guidance determines that "PLUS" populations should be identified at a local level. However, the guidance includes a list of populations that are "expected" to be included. These are ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; other groups that share protected characteristics as defined by the Equality Act 2010; groups experiencing social exclusion, known as inclusion health groups; coastal

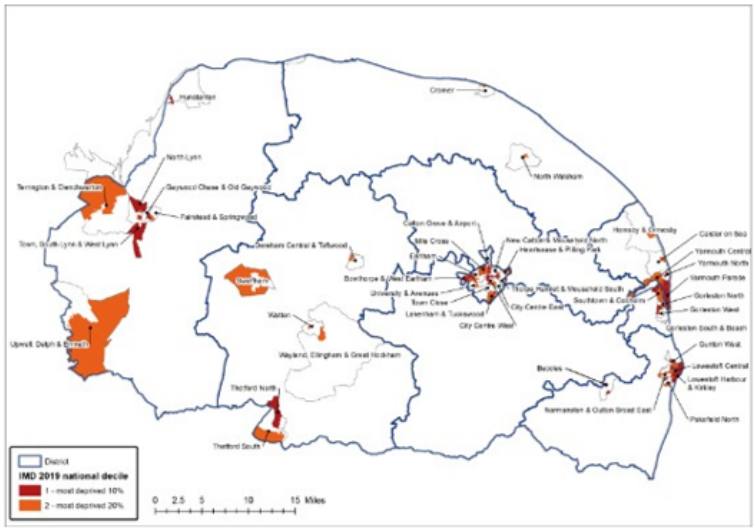
communities (where there may be small areas of high deprivation hidden amongst relative affluence). Specific consideration should also be taken for the inclusion of young carers, looked after children/care leavers and those in contact with the justice system.

Figure 1: The NHS Core20Plus5 framework for Adults and Children and Young People



Source: [NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities]

Figure 2: The "Core20" population in Norfolk and Waveney



There are 42 communities across Norfolk and Waveney where some or all the population live in the 20% most deprived areas in England. However, none of these communities are in Broadland or South Norfolk

Approximately 48% of the populations of Great Yarmouth and Norwich live in the most deprived 20% of areas in England compared to 16% for Norfolk and Waveney as a whole.

District	Most deprived decile 1 Core 20	Most deprived decile 2 Core 20	Other deciles	Core 20 Population
Breckland	2,500	12,300	126,500	14,700
Broadland	0	0	131,900	0
Great Yarmouth	26,900	12,800	59,500	39,700
KLWN	12,100	11,200	127,900	23,300
North Norfolk	0	2,800	102,400	2,800
Norwich	27,400	28,100	86,700	55,500
South Norfolk	0	0	143,100	0
Waveney	16,000	11,800	90,700	27,900
Norfolk and Waveney	84,900	78,900	868,800	163,800
England	5,603,900	5,697,200	45,249,000	11,301,100

District	Most deprived decile 1 Core 20	Most deprived decile 2 Core 20	Other deciles	Core 20 Population
Breckland	1.7%	8.7%	89.6%	10.4%
Broadland	0.0%	0.0%	100.0%	0.0%
Great Yarmouth	27.1%	12.9%	60.0%	40.0%
KLWN	8.0%	7.4%	84.6%	15.4%
North Norfolk	0.0%	2.6%	97.4%	2.6%
Norwich	19.3%	19.7%	61.0%	39.0%
South Norfolk	0.0%	0.0%	100.0%	0.0%
Waveney	13.5%	10.0%	76.5%	23.5%
Norfolk and Waveney	8.2%	7.6%	84.1%	15.9%
England	9.9%	10.1%	80.0%	20.0%

Source: https://www.norfolkinsight.org.uk/jsna/health-inequalities/

2. Defining our "PLUS" groups - methodology

Three main sources of information were used when considering the "PLUS" groups for Norfolk and Waveney:

1. The guidance issued from NHS England with a list of "expected" groups https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

2. Information prepared by Norfolk County Council Public Health team with information on the estimated numbers and experience of the proposed groups (attached below)

3. The Suffolk Director of Public Health Annual report 2022, which focusses on the Core20PLUS5. The evidence pack that supports this report (attached below) provides an extensive rationale for choosing PLUS groups in Suffolk (which includes Waveney), and this also applies to Norfolk (slides 22-28).

Care was taken to ensure that the chosen "PLUS" groups for Norfolk and Waveney align with those already chosen for Suffolk as a whole (due to the overlap with the Waveney area).

Discussions were held at the Health Inequalities Oversight Group on 30th May 2023, and the final list was approved by the Population Health and Inequalities Board on 20th June 2023.

3. Identified "PLUS" groups for Norfolk and Waveney

The **"PLUS" groups** are those additional groups of people living in Norfolk and Waveney who may not be part of the "Core20" population but who are known to experience inequalities in health outcomes, experience or access in care and for whom consideration should be given when delivering health and care services, with the aim of addressing health inequalities.

For the Norfolk and Waveney system-wide these groups include:

- **Inclusion Health groups** (including people experiencing homelessness, drug and alcohol dependence, Asylum seekers and vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups)- *all age*
- **People living with a learning disability and autistic people**- *all age*
- **People from Minority Ethnic groups**, such as Eastern European, Black and Asian Communities- *all age.*
- **Coastal and rural communities** where there are areas of deprivation and where we find pockets of hidden deprivation amongst relative affluence- *–all age.*
  Note: These are often hidden in our data, and are in addition to our identified Core20 populations, which generally already include most of the urban areas within Norfolk and Waveney.
- **Young carers and looked after children/care leavers**- *CYP*
  Note: Included in the NHSE guidance - these groups differ in relation to older carers due to the life-long impact their experiences have on their health and well-being
- In addition, ongoing consideration will be given for any selected population at a locality/PCN level if identified from population level data as a group experiencing inequalities as per the "PLUS" group definition.

There is evidence to show that all of these groups of people experience inequalities in health outcomes, access or experience of care and there are significant numbers of people in these groups living in Norfolk and Waveney.

However, it is not possible to prioritise the needs of one group over another at this time. The groups vary in size in each sub-category, but it would be difficult to put a value on the experience of one group over another. Further work will be needed to identify existing gaps in services and any further recommendations for service development.

4. Next steps

Health Inequalities Strategy development - our plans to reduce health inequalities and implement the actions arising from the Core20PLUS5 framework, including for our "PLUS" groups, will form an important part of our emerging health inequalities strategy which will be developed over the next few months. We plan to co-develop the strategy with system partners and underpin its development with community voice from people who represent the "PLUS" groups and with oversight from the PH&I Board and Health Inequalities Oversight group. (To be completed by March 2024)

Stock-take of existing programmes – there are already work programmes and system-wide initiatives in place to support health improvement and reduce health inequalities for some of the specified groups. Work will be undertaken to gather the relevant information and assess the need for further work to address any identified gaps. (Summary report to HIOG by October 2023)

Data and Information – For many of the "PLUS" groups it is difficult to obtain local information, quantify population sizes and make meaningful comparisons. We will be exploring how we can improve our local data and how we can report progress and improvements. If required, Health Needs Assessments will be undertaken as part of the Joint Strategic Needs Assessment (JSNA) process. (Ongoing as part of HIOG work programme)

Workforce - development of knowledge, skills and awareness raising- as part of our Health Inequalities strategy development we will be considering how our ICS workforce, providers of health and social care, our population health management approaches and wider system stakeholders actively consider "PLUS" groups when commissioning and delivering services. (Timescales aligned to strategy development, to be completed by March 2024)

There will be resource requirements associated with regard to these actions. A future paper will be presented to EMT to outline a case for change to support the implementation of the health inequalities strategy once the resource requirements have been quantified.

Recommendation to the Committee:

Members are invited to note the 'PLUS' populations agreed by the Population health and Inequalities Board as part of the Core20Plus5 programme and to support the planned 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. The "PLUS" groups experience some of the greatest 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:	N/A
Impact Assessment (environmental and equalities):	A full EIA has not yet been undertaken; however, the evidence shows these groups are subject to some of the most significant inequalities.
Reputation:	The ICB has a duty of care to support these groups and has been identified through the Core20Plus as a priority area for reducing health inequalities.

Legal:	The ICB has a legal duty to address inequalities.
Information Governance:	None identified
Resource Required:	There will be associated resource requirements regarding the identified next steps and actions, both in staff capacity and supporting programmes of work. A future paper will be presented to EMT to outline a case for change to support the implementation of the health inequalities strategy, once those resource requirements have been quantified.
Reference document(s):	1. NHS England guidance https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/ 2. Information prepared by Norfolk County Council Public Health and Health intelligence teams (in development)  CORE20%20plus%20 groups%20-%20draft 3. Evidence pack supporting the Suffolk Director of Public Health Annual report 2022 (see slides 22-28)  Suffolk Core 20plus5 evidence base.pdf
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:	None identified
Reference to relevant risk on the Board Assurance Framework	BAF06 Health Inequalities and Population health management;

Governance

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

NHS
Norfolk and Waveney

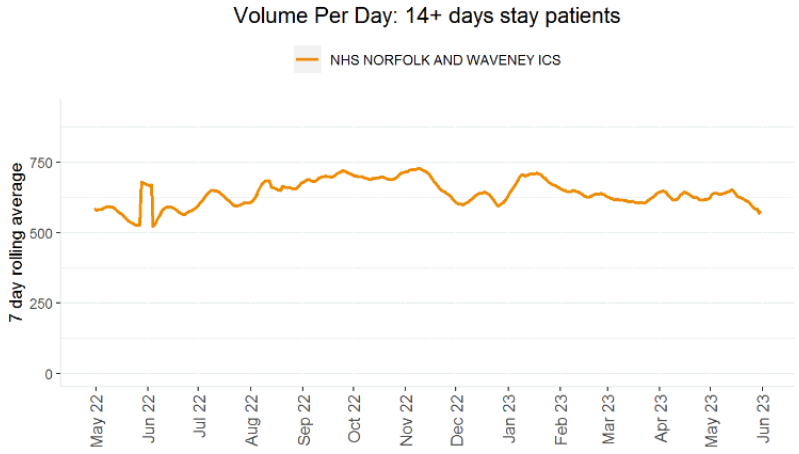
Patients and Communities Committee
24 July 2023

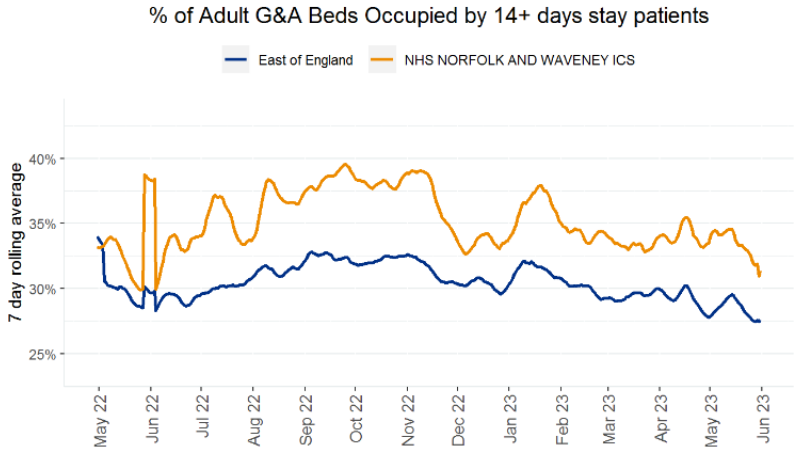
Item 9:
Discharge Transformation Programme

Catherine Withers, Associate Director

>14 day LOS

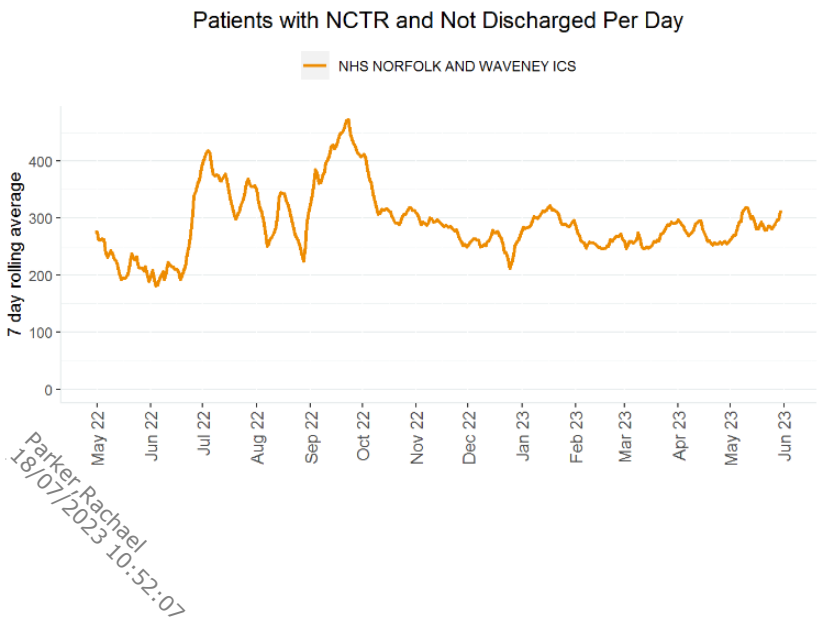
At NHS Norfolk and Waveney ICS, 33.2% of beds were occupied by 14+ day stay patients on average per day during May 2023, equating to a total of 619 patients. This was 8 fewer than last month and 30 more than the same month last year.

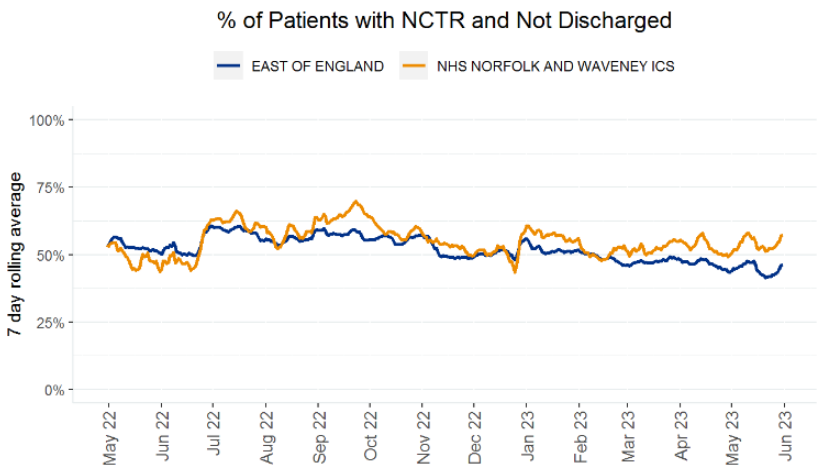




No Criteria To Reside

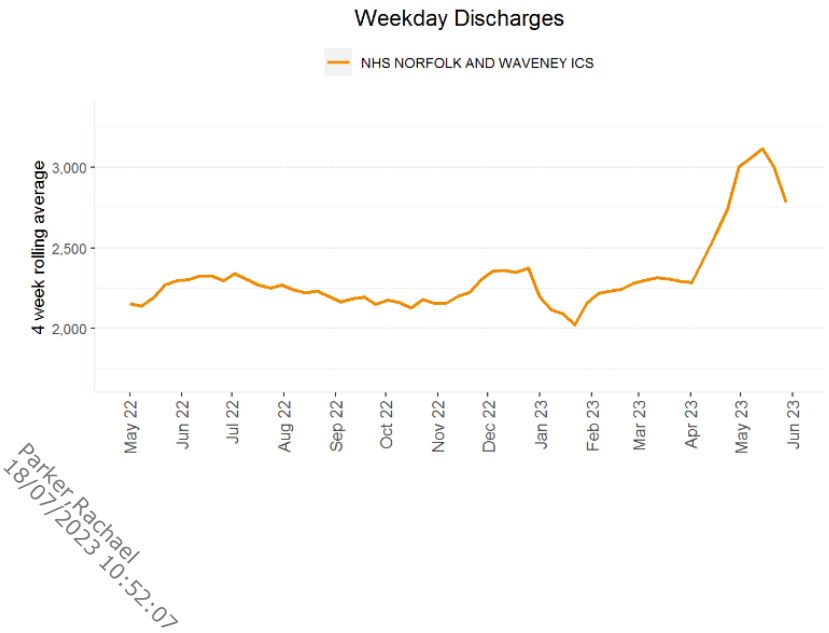
In NHS Norfolk and Waveney ICS, an average of 542 patients did not meet the criteria to reside per day in May 2023, 31 more last month and 94 more than the same month last year.

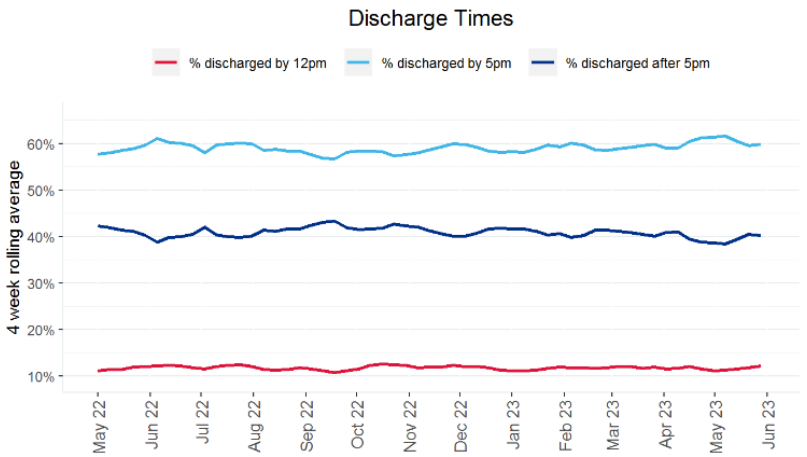




Discharge Activity

•At NHS Norfolk and Waveney ICS, an average of 2,782 patients per week were discharged between Monday to Friday during May 2023, 76 fewer than than last month and 491 more than than the same month last year.
•12.3% of patients were discharged before midday, increasing by 1.2% versus last month.
•59.9% of patients were discharged before 5pm, decreasing by -0.6% versus last month.
•There is a data error in the chart below and the weekday discharges have actually remained fairly static month on month.





Parker Rachael
18/07/2023 10:52:07

Paper Governance

Purpose of Paper: To update the SQG on the work of the Discharge Programme Board and to provide assurance that systems are in place to make improvements for patients to reduce length of stay and associated deconditioning, ensure that there is a Home First approach through discharging patients on appropriate pathways to maintain independent living where possible and ensure that system partners are integrating wrap around the patient and be truly patient lead.

Recommendation to SQG: To note the content of the report.

Key Risks	
Clinical and Quality:	Deconditioning. Potential overprescription of pathway 1-3.
Finance and Performance:	Increased LOS and NCTR. Unclear demand and capacity requirements.
Impact Assessment:	Will be understand throughout programme delivery where commissioning changes required.
Reputation:	Currently N&W are one of 7 system sin Tier One UEC Support from DOHSC including support from National Taskforce team.
Legal:	
Information Governance:	IG is an identified issue for integration with voluntary sector and between organisations. The introduction of a digital patient tracking list will improve this to some degree.
Resource Required:	Resource in place from NHSE, ECIST, Newton Europe
Reference Document(s):	Discharge Transformation Plan
NHS Constitution:	Patients have the right to receive care and treatment that is appropriate to them, meets their needs and reflects their preferences.
Conflicts of Interest:	None known
Reference to relevant risk on the Board Assurance Framework and Significant Risk Register:	

Process Committee approval with date(s):	Paper submitted to Committee for discussion.

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

Norfolk and Waveney Urgent and Emergency Care Priorities 2023/24

Why must we change

We want people requiring Urgent and Emergency Care to receive **the right care, in the right place, at the right time**. Everyone should receive the best care for their individual needs, whether the care system is accessed via 111, 999, a GP or by walking into an Emergency Department. Our UEC 'system' should assess and triage patients to the service best placed to managing their needs, rather than provide treatment in the setting the patient has accessed which can often be multiple settings due to hand-offs. This means we need to change where urgent care responses are provided and transfer patients between services where a health and care assessment determines another part of the system may be best placed to respond to that need. We need to do more to change where activity is seen, how teams integrate and increase capacity in the community to support patients and to give the patient an outcome to avoid them telling their story more than once.

This is set out in the national NHS England Delivery plan for recovering urgent and emergency care services. The targets and patient commitments set out in this plan are built into our Norfolk and Waveney Urgent and Emergency Care Priorities for 2023/24.

Where we are now

How and where in the health and care system urgent activity presents is slowly changing, however the system remains congested with the worst ambulance C2 performance to date, rising length of stay and long delays in ambulance handovers. Delays in transfers of care at the point of discharge causes bottlenecks in hospitals resulting in congested EDs which in turn traps ambulance crews in queues for handover reducing the capacity the ambulance service has to reach the most critically unwell patients in the community.

Measurements

The 23/24 Planning Priorities and UEC Recovery Plan set out four targets to achieve in 23/24 to begin recovery of UEC services and improve patient outcomes.

- 76% 4 hour ED performance
- 92% (or lower) Occupancy
- 80 % Virtual Ward utilisation (occupancy)
- 30-minute Mean response time for C2 ambulances

Risks and challenges

- Culture & behaviours – Working collaboratively / 'trusted assessor' model
- Finance – Finance to follow patients
- Workforce – Building capacity and capability
- Structure – "Place" is underdeveloped
- Duplication – Triage/patient handoffs

What we will change

In 23/24 we have three urgent and emergency care priorities which align with the national UEC Recovery Plan targets and transformation priorities and build on the progress we have made in 22/23:

Reduce Length of Stay across all settings

Reduce length of stay across all inpatient settings to improve flow

Metric: 92% occupancy by April 2024, 76% 4 hour ED performance by April 2024

How we will deliver: We will improve and expedite discharge across all in-patient units by

- Expanding Virtual Ward step down pathways and capacity
- Implement the national 100 day discharge challenge
- Continue to develop our Home First Hub capacity and capability
- Review capacity purchased through winter capacity funding and determine how we can create a stable and sustainable D2A offer
- Complete demand and capacity analysis

Improve ambulance C2 response time

Increase the number of patients transferred from 999 services to community services

Metric: 30 minute Mean C2 response time by April 2024

How we will deliver: Building on Access to Stack and Open Room, using the national HARIS Framework we will work with the ambulance service to develop a framework of alternatives to ambulance dispatch, alternatives to conveyance and access to advice for crews on scene brought together in an "urgent care hub"

Suitable C2, C3, C4 & C5 calls will be transferred to community services for response, including 2 hour urgent community response services. We will work with "Place" to design how responses will be coordinated / deployed in each locality.

Expand Virtual Ward

Expand step down virtual ward capacity and develop new step up provision

Metric: Increase to 80% utilisation by Sept 2023

How we will deliver: We will continue to work with the provider collaborative to expand capacity and utilisation of step down virtual wards in the agreed pathways, reducing length of stay and releasing physical bed capacity to in-patient wards.

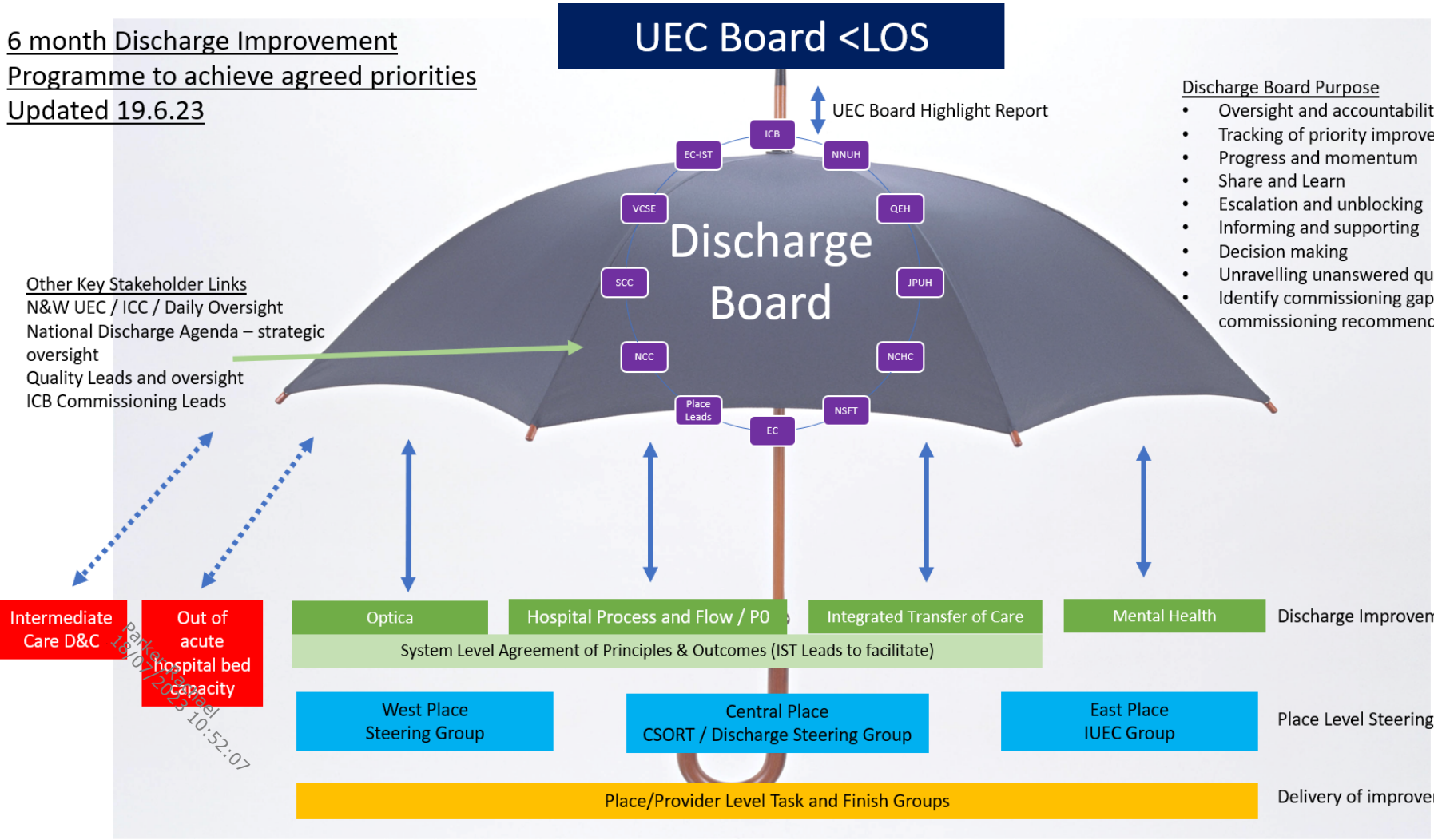
By summer 2023/24 we will launch step up virtual wards hubs to provide alternatives to emergency admission. We will develop links between UCR, SDEC, ED and the ambulance service to refer patients who will receive senior clinical oversight and remote monitoring at home instead of an admission to hospital.

How we will change

We will work at both place and system level to bring together the right partner organisations to build on work started in 22/23. "Place" will be the forum to design and plan the majority of the work, utilising the "Place" UEC Steering Groups/SORTs which report into the system UEC Board. The ICB UEC Team will provide a level of consistency for equitable patient outcomes across Norfolk and Waveney while "Place" teams ensure services are designed to meet local needs.

Enabling work will cut across a number of functions, creating a need to have a programme board as well as project delivery groups. The programme board will have Digital, Workforce, Finance and Contracting workstreams and will need to have a strong relationship with regional teams who will be leading on a portfolio of 999 and discharge work.

Paper Title: Structure & Governance of Discharge Transformation Programme



Priorities for Discharge Transformation Programme

Optica System Improvement Lead: Paul Martin Digital Patient Tracking System	Acute and Community Hospital Internal Process System Improvement Lead: Catherine Withers	Integrated TOC Process System Improvement Lead: Catherine Withers	Non Acute Bed Demand and Capacity	Mental Health Flow
•Beginning of phased rollout to (West Pilot site) then 2 other acutes & community. •Support red to green process. •Real time tracking of patients through discharge. •Reduces then eliminates TOC form. •Improve 7 day tracking of patients. •Assessments completed in parallel. •Early sight of patient by hubs to start planning complex discharge needs. •Reduction of deconditioning to improve patients leaving on most appropriate pathway planned. •Reporting ability on utilisation of pathways. •Reduction of NCTR LOS.	•Earlier discharge planning from day of admission. •Red to green process optimisation. •Criteria Lead Discharge improvement. •Voluntary sector integration and utilisation by wards and discharge teams. •Improve ward staff input to discharge with less reliance on therapy staff. •TOC training to improve completion. •Improve right to reside LOS •Reduction of overall LOS for non elective. •Increase of discharge on P0 (vol sector support). •Increase in weekend discharges (CLD) •Increased same day discharge.	•Agreed system principles, aligning goals and purpose with place based delivery inc hours of operation. •Relationship building & seamless communication. •ITOC 'team' at each place to include acute, community, voluntary, transport, social care, pharmacy, therapies. •Trusted assessor model to be increased. •Utilise Optica when available for patient tracking. •Reduction of patients NCTR LOS and bed days.	•Demand and Capacity plan to be in place. •Funding disseminated to place level. •Implementation of modular build. •Understanding of impact of virtual ward increase. •Mitigations put into place for gaps identified while the improvements in LOS and discharge processes are implemented.	•Improved MDT working to tackle complex LOS patients in hospital beds. •Currently work in progress with NSFT.