

Patients and Communities Committee (Part One)

Mon 25 November 2024, 14:30 - 16:30

Virtual via MS Teams

Agenda

14:30 - 14:30 **Meeting Agenda**

0 min

📄 00. Patients and Communities Committee - Agenda 25.11.24 - FINAL.pdf (2 pages)

14:30 - 14:30 **1. Chair's welcome and apologies for absence**

0 min

Aliona Derrett

14:30 - 14:30 **2. Declarations of Interest**

0 min

Aliona Derrett

📄 02 Patients and Communities Committee ICB Master Register 2023-24.pdf (3 pages)

14:30 - 14:30 **3. Minutes from previous meeting (23.9.24) and matters arising**

0 min

Aliona Derrett

📄 03 NW ICB PC Committee Minutes 23.09.24 Part One - DRAFT.pdf (13 pages)

14:30 - 14:30 **4. Action Log (no outstanding actions)**

0 min

Aliona Derrett

📄 04. Patients and Communities Committee - Action Log MASTER 4.pdf (1 pages)

14:30 - 14:30 **5. Risk Register**

0 min

Mark Burgis

📄 05i Risk Register cover sheet November 2024.pdf (2 pages)

📄 05ii Appendix 1 - P&CC Risks - November 2024.pdf (5 pages)

14:30 - 14:30 **6. Spotlight on: Mental Health**

0 min

6.1. Patient Experience

Emma Ratzer

6.2. Healthwatch Perspective

Alex Stewart

Parker Rachael
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6.3. Patient Feedback

Jon Punt

- 06iii Nov 24 P & C Committee report - Mental Health One Pager.pdf (3 pages)

6.4. Strategic Mental Health Team

Mark Payne

- 06iv a MH Coproduction Strategy Cover Sheet Nov 24 P&C Committee.pdf (2 pages)
- 06iv b NW Coproduction Strategy final version Sept 2024.pdf (13 pages)

6.5. A View from Place

Claire Leborgne

- 06v PCC 25.11.24 Norwich MH Presentation FINAL no notes.pdf (15 pages)

14:30 - 14:30 7. Community Voices In Practice

0 min

Shelley Ames, Amrita Kulkarni, Steve Gray, Alison Matthews

- 07i Cover sheet PCC Community Voices- 25.11.24.pdf (6 pages)
- 07ii P&CC update Nov 2024.pdf (23 pages)

14:30 - 14:30 8. Communications and Engagement Update

0 min

Chris Williams

14:30 - 14:30 9. Urgent and Emergency Care: Resilience and Winter Planning

0 min

Mark Burgis

- 09 NWICB H2 Plan 2024 (Summary).pdf (15 pages)

14:30 - 14:30 10. Population Health and Inequalities Board Update

0 min

Dr Frankie Swords

- 10i 2024.10.15_PHI Board Report Cover Sheetv1.pdf (2 pages)
- 10ii 2024.10.15_PHI Board Assurance-Escalations- v5.pdf (2 pages)

14:30 - 14:30 11. VCSE Assembly Update

0 min

Tim Gardiner

- 11i VCSE Assembly Nov 2024.pdf (3 pages)
- 11ii Assembly progress highlight report_Nov24.pdf (7 pages)
- 11iii VCSE Roundtable Forging Integration.pdf (12 pages)
- 11iv 07.11.24_VCSE Assembly Summary Notes.pdf (3 pages)

14:30 - 14:30 12. Healthwatch Suffolk Update

0 min

Andy Yacoub

Parker Michael
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14:30 - 14:30
0 min

13. Healthwatch Norfolk Update

Alex Stewart

14:30 - 14:30
0 min

14. Any Other Business and Reflections on the Meeting

Aliona Derrett

14.1. Revised Committee Terms of Reference - for approval

📄 14i NW ICB Patients and Communities Committee TOR v3 Sept 24.pdf (8 pages)

14.2. Patients and Communities Committee Policies - for noting

📄 14ii For info only - 2024.11.25-Pt and Communities Comm policies.pdf (2 pages)

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

Monday 25 November 2024, 14:30-16:30hrs

Part One – Meeting Held in Public

Meeting to be held via MS Teams

Chair: Aliona Derrett

Purpose of the Patients and Communities Committee

The Committee provides the ICB with assurance that it is delivering its functions in a way that meets the needs of patients and communities, that is based on engagement and feedback from local people and groups, and that takes account of and reduces the health inequalities experienced by individuals and communities.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.

The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit. Further information about the Committee can be found [here](#).

Item	Time	Agenda Item	V – Verbal P – Paper Pr - Presentation	Lead
1	14:30-14:45	Chair's welcome and apologies for absence	V	Chair
2		Declarations of Interest	P	Chair
3		Minutes from previous meeting and matters arising	P	Chair
4		Action log	P	Chair
5	14:45	Risk Register	P	Mark Burgis
6	14:50	Spotlight on: Mental Health – Patient experiences, and uptake of services i. Patient Experience ii. Healthwatch Perspective iii. Patient Feedback iv. Strategic MH Team v. A View from Place	Pr	Emma Ratzer Alex Stewart Jon Punt Mark Payne Claire Leborgne
7	15:25	Community Voices in Practice	Pr	Shelley Ames, Amrita Kulkarni, Steve Grey, Alison Matthews
8	15:40	Communications and Engagement Update	V	Chris Williams
9	15:50	Urgent and Emergency Care: Resilience and Winter Planning	Pr	Mark Burgis
Standing Items				

10	16:00	Population Health and Inequalities Board Update	P	Dr Frankie Swords
11	16:10	VCSE Assembly Update	P	Tim Gardiner
12	16:15	Healthwatch Suffolk Update	V	Andy Yacoub
13	16:20	Healthwatch Norfolk Update	V	Alex Stewart
14	16:25	Any Other Business and Reflections on the Meeting <ul style="list-style-type: none"> i. Revised Committee Terms of Reference - for approval ii. Patients and Communities Committee Policies – for noting 	P	Chair
Date, time and venue of next meeting: Monday 27 January 2025, 14:30-16:30hrs via MS Teams				
Any queries or items for the next agenda please contact: rachael.parker9@nhs.net				

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

Declared interests of the Patients and Communities Committee

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Aliona Derrett	Non-Executive Member, Norfolk and Waveney ICB	Norfolk and Norwich University Hospital			X	indirect	My son-in-law, Richard Wharton, is a consultant surgeon at NNUHFT	2004	To date	Will withdraw from any discussions and decision that might directly involve the department or
		Norfolk Deaf Association	X			direct	I am the Chief Executive Officer of Hear for Norfolk (Norfolk Deaf Association). The charity holds contracts with the N&W ICB	2010	To date	Not involved in any discussions and decisions that might benefit Hear for Norfolk
		Derrett Consultancy Ltd	X			indirect	I am the Director of Derrett Consultancy Ltd	2018	To date	Low risk. In the unlikely event that a risk arises I will discuss the mitigation actions with the Chair of the ICB Board.
		Norfolk & Waveney MIND	X			indirect	My husband, Robin Derrett, is the HR Director at Norfolk & Waveney MIND. MIND holds contracts with the N&W ICB	2021	To date	Not involved in any discussions and decisions that might benefit N&W Mind
		MoldovaDAR Ltd	X			indirect	I am Director of MoldovaDAR Ltd	2019	To date	Low risk and highly unlikely that a risk will arise. The company is being dissolved.
		St Stephens Gate Medical Practice				X		Patient at a Norfolk and Waveney GP Practice	Ongoing	
Cathy Armor	Non-Executive Member, Norfolk and Waveney ICB	Brundall Medical Practice			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		Educational Association			X		Trustee, Workers Educational Association	Dec-23	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Council, Norwich University of the			X		Deputy Chair of Council, Norwich	2019		
		Evolution Academy Trust			X		Trustee, Evolution Academy Trust	2022		
		Cambridge University Press Pension Schemes		X			Trustee, Cambridge University Press Pension Schemes	2018		
		East of England Ambulance Service NHS Trust					Indirect	Daughter-in-law is Technician for East of England Ambulance Service NHS Trust		
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	
Patricia D'Orsi	Executive Director of Nursing, Norfolk and Waveney ICB	Royal college of Nursing			X	Indirect	Professional Body - RCN Union			
Mark Burgis	Executive Director of Patients and Communities, Norfolk and Waveney ICB	Lakenham Practice	X			Indirect	Wife is Nurse Prescriber who is currently undertaking occasional locum work at Lakenham Practice in Norwich. Wife receives an income from the practice when undertaking locum shifts at the practice	Aug-21	Present	Declare at any relevant meetings and remove myself from any significant discussions or decisions relating to the practice
		Drayton Medical Practice			X			Patient at a Norfolk and Waveney GP Practice	Ongoing	

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Suzanne Meredith	Associate Director – Population health Management	Norfolk County Council	X			Direct	Employed by Norfolk County Council as Deputy Director of Public Health	2014	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		UKPHR		X		Direct	As part of Public Health professional requirements - Fellow of the Faculty of Public Health and professional registration on UKPHR	2014	Present	
		Hellesden Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Alex Stewart	Chief Executive, Healthwatch Norfolk	Member of Holt Medical Practice			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Dr Frankie Swords	Executive Medical Director, Norfolk and Waveney ICB	Long Stratton medical partnership			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		Norfolk and Norwich University Hospital			X	Direct	Honorary Consultant Physician and Endocrinologist at Norfolk and Norwich University Hospitals NHS FT (1 day a week)	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Multiple patient charities			X	Direct	Ad hoc Clinical Advisor for multiple patient charities - Addison Self Help Group - Pituitary Patient Support Group - Turner syndrome Society	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		British Medical Association			X	Direct	Member of the British Medical Association	1999	Present	Inform Chair and will not take part in any discussions or decisions relating to BMA
		Better Help, and VCSE provider: St Martin's Housing Trust	X			Indirect	Husband is a mental health counsellor and undertakes work independently and with the private provider Better Help, and VCSE provider: St Martin's Housing Trust	2022	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of counselling services by St Martin's Housing Trust or Better Help
Tracy Williams	Health Inequalities Advisor	Norfolk Primary Care CIC P	X			Direct	Employed 12 hours a week by Norfolk Primary Care CIC P as a clinical Lead in the Inclusion Hub for vulnerable adults service in Norwich.	Dec-23	Present	All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc
		Norfolk and Waveney Integrated Care Board		X		Direct	Employee of Norfolk and Waveney ICB	Apr-23	Present	All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions
		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 for all of these
		Royal college of Nursing			X	Direct	Member of the RCN	1987	Present	
		Faculty of Homeless and Health Inclusion			X	Direct	Member of the Faculty of Homeless and Health Inclusion awarded an Honorary fellowship March 2022	2021	Present	
		Norfolk and Norwich University Hospital				Indirect	Sister employed at NNUH as a nurse	2020	Present	
Norfolk and Norwich University Hospital				Indirect	Brother employed at NNUH in Dept diabetes and endocrinology	2021	Present			

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		Norfolk and Norwich University Hospital				I have type 1 diabetes under the care of NNUH. LTC under the care of a commissioned provider of the ICB and	Present	
Andy Yacoub	Chief Executive, Healthwatch Suffolk	Nothing to Declare	N/A			N/A	N/A	N/A
Timothy Gardiner	Partner member - VCSE	Rouen Road Health Centre			X	Patient at a Norfolk and Waveney GP Practice	Ongoing	To be raised at all relevant meetings where discussions/decisions relate to the conflict declared

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NHS Norfolk and Waveney Integrated Care Board

DRAFT Minutes of the Patients and Communities Committee meeting

Held on Monday 23 September 2024

Meeting in Public

Committee members present:

- Aliona Derrett (AD), Non-Executive Director and Chair of the Patients and Communities Committee, NHS Norfolk and Waveney Integrated Care Board
- Cathy Armor (CA), Non-Executive Director and Deputy 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
- Suzanne Meredith (SM), Associate Director of Population Health Management, NHS Norfolk and Waveney Integrated Care Board, and Deputy Director of Public Health, Norfolk County Council
- Tracy Williams (TW), Clinical Lead for Health Inequalities and Children, Young People and Maternity, NHS Norfolk and Waveney Integrated Care Board
- Andy Yacoub (AY), Chief Executive Officer, Healthwatch Suffolk
- Dr Frankie Swords (FS), Executive Medical Director, NHS Norfolk and Waveney Integrated Care Board
- Mark Hitchcock (MH), Chief Executive, Norfolk Citizens Advice attending on behalf of Emma Ratzner and representing the VCSE
- Alex Stewart, (AS), Chief Executive, Healthwatch Norfolk
- Tricia D'Orsi (TD), Executive Director of Nursing, NHS Norfolk and Waveney Integrated Care Board
- Paula Boyce (PB), Executive Director – People, Great Yarmouth Borough Council and representing the Health and Wellbeing Partnerships
- Karin Bryant (KB), Associate Director of Commissioning, Norfolk and Waveney Integrated Care Board

Participants and observers in attendance:

- Karen Watts (KW), Director of Nursing and Quality, NHS Norfolk and Waveney Integrated Care Board
- Janice Shirley (JS), Head of System Clinical Transformation Programmes, NHS Norfolk and Waveney Integrated Care Board (for item 12)
- James Allen (JA), Clinical Programmes Senior Manager, NHS Norfolk and Waveney Integrated Care Board (for item 12)
- Liz Withington (LW), carer for a relative with Dementia (for item 6a)
- Heather Farley (HF), Acting Associate Director, North Locality, NHS Norfolk and Waveney Integrated Care Board (for item 6d)
- Shelley Ames (SA), Head of Health Inequalities and VCSE Partnering, NHS Norfolk and Waveney Integrated Care Board (for item 8)
- Susan Balaam (SB), Research Officer, Healthwatch Suffolk (for item 6b)
- Michael Ogden (MO), Communication and Information Services Manager, Healthwatch Suffolk (for item 9)

Attending to support the meeting:

- Rachael Parker (RP), Executive Assistant, NHS Norfolk and Waveney Integrated Care Board (Minutes)

1.	<p>Chairs welcome and apologies for absence</p>	
	<p>Aliona Derrett (AD) began by welcoming everyone to the Patients and Communities Committee.</p> <p>Apologies for absence had been received from:</p> <p>Emma Ratzer - Chief Executive Officer, Access Community Trust and VCSE representative</p>	
2.	<p>Declarations of Interest</p>	
	<p>None declared.</p>	
3.	<p>Agree Minutes from the Previous meeting and Matters Arising</p>	
	<p>The minutes of the previous meeting were approved as an accurate record.</p>	
4.	<p>Action Log</p>	
	<p>The action log was reviewed and updated accordingly.</p>	
5.	<p>Risk Register</p>	
	<p>Mark Burgis (MB) highlighted the two risks which the committee has oversight of:</p> <ul style="list-style-type: none"> • BAF01 which is around the health inequalities and population health management and the risk highlighted about the ICB not meeting its statutory duties, particularly about reducing health inequalities and how we use population health management to its greatest potential. • BAF05 which is about the increasing numbers and complexity of the ageing population in Norfolk and Waveney, for example around the pressure on services and increased costs and that's something we need to be very mindful of. <p>MB also highlighted the Operational Risk Register (ORR) and that some risks that had been on previous risk registers will be included in the Board Assurance Framework and these risks will be highlighted to the committee.</p> <p>Comments and questions from members of the committee:</p> <p>Tracy Williams commented in relation to BAF01 there are close links between the Population Health Management Oversight Group and the Health Inequalities Oversight Group. A meeting is planned with the corporate governance team to review the risk and identify what work is required on the operational and strategic risks,</p> <p>AD asked for reassurance around the gaps and controls, that the five bullet points listed in the gaps of control section of the detailed risk register are being picked up, that there are actions against them and there is a plan.</p> <ul style="list-style-type: none"> • Embedding resources at Place level to co-ordinate the mechanisms needed to address HI and deliver PHM. • Further work required to develop the data hub and dashboards. • NHSE HI funding not ring-fenced to support emerging work programmes and respond to system priorities. 	

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	<ul style="list-style-type: none"> • Agreed governance for Equality health impact assessments but uniform process not yet established. • Dashboard of indicators to monitor progress for PHM and HI under development as part of ICB datahub. <p>TW confirmed there was alignment with the Health Inequality Strategic Framework for Action and the Population Health Management Strategy.</p> <p>AD asked MB for reassurance regarding gaps and controls for BAF05. MB advised this was covered but acknowledged there was still work to do to ensure the Place elements are coordinated. FS added that today's agenda items on dementia and the South Norfolk Place update are examples of what we are already doing together and what else we'd like to be able to do, so FS hoped this would provide assurance.</p> <p>The update was noted.</p>	
6.	<p>Spotlight on: Dementia</p>	
	<p>a. Dementia – Carer Perspective</p> <p>Liz Withington (LW) shared her personal experiences of providing full-time care for her mum who, until very recently, had been living with LW for the past 11 years, but had recently gone into residential care.</p> <p>LW also shared what she thought were some of the challenges faced by families caring for a loved one with dementia. It was noted that LW works locally in the north Norfolk community to support dementia awareness and training.</p> <p>Key highlights:</p> <ul style="list-style-type: none"> • Length of time taken to get a social services assessment, in the end LW had to pay for daycare at a local daycare centre for nearly eight months, which put an increasingly difficult financial burden on LW. • When LW become unwell and was hospitalised with pneumonia, it was incredibly difficult getting through to social services to arrange some respite. On admission to hospital LW made it clear she was a carer for her mum. LW was reliant on friends to care for her mum and when LW was discharged and could barely look after her own needs, she had to go home to look after her mum. It was about a week later social services gave LW mum's a week in respite. • In January 2024 LW acknowledged she needed more help so she contacted social services and explained that things were at a point where LW didn't feel she could manage anymore, and her mum needed to go into a home. That was a difficult decision to make. LW contacted social services again, but it was almost impossible to get hold of them and she had to constantly call them back. However, the only way to access the service is to email and complete another time-consuming referral. Finally in July 2024 after having pneumonia again, LW managed to get her mum into a care home that immediately understood LW situation and couldn't have been more helpful including supporting LW to get the final assessment done. • The whole situation has been incredibly traumatic and LW feels she has been let down by the system, and she is someone who knows how the system works. LW feels the discharge processes in hospital don't work 	

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either - it was always someone else's job when LW said to them she was a carer and what will happen to her mum when LW goes home? No one ever did anything. So LW doesn't feel the dementia pathway is working.

The four points LW would like the committee to take from what she has said today, and help understand some of the difficulties that people do face when they're full-time carers are as follows:

1. The fact that you have a social worker and it's for one little item. It's for that week of respite and then they say to you, I'm not your social worker from tomorrow so you'll need to call in and make a new referral and start the whole process all over again. When you are a full-time carer in that sense, you need that support. You need that connection and consistency.
2. The portal is very difficult to manage, particularly once you're into it, there's very few ways that you can find out what's going on with your case. You've not heard from anyone for three months. What's happening? You've got to go through that process all over again. LW feels this needs looking at and for people who are not online, it must be horrendous if you're an older couple who are trying to care for someone too.
3. Respite needs to be planned for people and an emergency system that's working for people when they need it and following that through with discharge because it's certainly not happening at the moment.
4. Unsafe discharges back into the community. People are going back into the community who aren't capable of being on their own.

Comments and questions from the committee:

- AD thanked LW for sharing her experiences which are fundamental in helping us ensure that what we go forward with the right thing for people.
- Tricia D'Orsi thanked LW for sharing her experiences which TD felt was a catalogue of where things could have been done better to support LW and her mum. TD picked up LW comment about the discharge pathway and acknowledged it's not working as it should, but there is a lot of work going on to improve it across the system, but it hasn't had the impact yet that is needed. TD also acknowledged the hand offs between different people and not being able to get through on phone lines which is something that need to improve because if we don't provide a responsive service, then how do we build trust and confidence that we're actually listening.
- TW thanked LW for sharing her experiences adding it made her sad to hear the experience that LW had particularly as LW had some level of understanding of some of the systems and processes. It made TW think about the quieter voices in some of our communities who won't understand the system and won't have a voice. TW asked LW from her perspective what more can be done to support carers in those circumstances. LW commented it's very difficult because most people aren't actually even connected with Norfolk County Council, so they don't even really know that route is there. It is important to get messages out into the community groups that are doing the support work, e.g. Community supermarkets are often running support groups. There must be a real concerted effort to get

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information out into communities so that carers know what is available and where they should go to access support.

- Karin Bryant (KB) thanked LW and explained that part of her role as Associate Director of Local Commissioning is to look at opportunities to work with Norfolk County Council and Suffolk County Council in terms of a joint approach, how can we do better together. Carers is certainly something that KB will be picking up with county council colleagues when they next meet.
- Mark Hitchcock (MH) questioned whether there is a root cause analysis that can be undertaken to go through LW story and understand the process. MH added it is concerning that somebody like LW could get that sick with her knowledge of the system.
- Frankie Swords (FS) echoed thanks to LW for sharing such a personal experience, but also added that unfortunately LW was not alone. There is a round table event this week to go through a few personal stories to really map out where are we not serving our community, where are there gaps in the pathway because in fact there is no pathway to support people diagnosed with dementia, so we need to address that.

b. Healthwatch Perspective

Healthwatch Norfolk: Alex Stewart (AS) provided an insight on dementia from Healthwatch Norfolk perspective. AS highlighted:

- In Norfolk and Waveney, 11,030 people over 65 have received a dementia diagnosis but people have dementia but do not have a formal diagnosis.
- There are estimated to be around 17,946 people over 65 living with dementia in Norfolk and Waveney (NHS Digital).
- All people with dementia should have an annual review with their GP including discussing planning ahead and how Carers might be best supported. In Norfolk and Waveney, 39.2 per cent of Carers reported having had an annual review in 2022 (Fingertips Public Health data).
- NHS Digital data from the latest Survey of Adult Carers (2021-22) suggests that dementia has a significant impact on Carers, with 66.2 per cent in Norfolk and Waveney saying that they felt stressed, 27.1 per cent saying that they felt socially isolated, and 41.4 per cent saying that they spend more than 100 hours a week supporting their cared-for person (NHS Digital. (All statistics in this paragraph are cited [here](#)).

In this context, in which dementia is so widespread and people and their Carers are so severely affected by it, Healthwatch Norfolk wanted to better understand the experiences of people with dementia in Norfolk, and their carers, to discover how they might be better supported by adult social care. More specifically, to discover the experience of people with dementia (and their carers) who are using NCC commissioned social care services (domiciliary care, residential homes and nursing homes), and what challenges people living with dementia and their carers face. In summary, HWN found that a significant proportion of people feel alone (as LW has alluded to) because of the lack of help and information available on the progress of their condition, concerns regarding costs of care and who pays for care, and support from professionals.

Healthwatch Suffolk: Susan Balaam (SB), Research Officer at Healthwatch Suffolk provided an insight on dementia from Healthwatch Suffolk perspective. SB began by thanking LW for sharing her story, and how it really resonated with a lot of

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things that HWS heard within its work, in particular around the lack of support after a diagnosis and that feeling of being left on your own to cope. It's quite a traumatic time for everybody involved.

SA went on to talk about some work HWS did in February 2022 working with the Suffolk Dementia Action Partnership, to understand what was working well and what was not working well, looking across the whole dementia pathway and the aim was to feed into the development of a Suffolk dementia strategy and action plan. The top messages which came out of the project and were included in the plan included:

- Guidance and support to find the information that is needed for individual circumstances.
- To be taken seriously when they ask for help and not just feel like they were being dismissed and to be recognised for the knowledge and experience that they have.
- The importance of continuity of service for people with dementia to be able to build those trusted relationships and the need for improved access to services.
- Services that work together, drawing on each other's skills and knowledge that work with them and not against them and prevent the 'ping ponging' backwards and forwards between different services.

AY added that the CQC picked up on the dementia work in Suffolk and are including some of this work in their own dementia strategy.

c. Ageing Well Programme Board – Dementia Workstream

Janice Shirley (JS) highlighted a roundtable event which is being held for the dementia workstream to identify what needs to change across the whole of the ICS to improve care for patients living with dementia. There is an ambition to collaborate services around the patient to improve outcomes and experience.

JS advised some new specialty advisors for frailty, older people and dementia had recently joined the ICB – Dr Katie Honney and Dr James Casson who are consultant geriatricians.

The Dementia Charter is being promoted and organisations are completing their self-assessment forms and completing their care gap analysis. Work will continue to develop a dementia dashboard. The new speciality advisors will be working on new innovations to help identify patients earlier in the process. This will involve working with the University of East Anglia and looking at screening software for cognitive decline.

Comments and questions from members of the committee:

AD asked JS what the current biggest challenge is the workstream is facing and is there a plan to engage all the providers in signing the Charter. JS responded the biggest challenge is getting information together, identifying patients at risk and earlier involvement with these patients. The workstream will work with population health management as well as primary care teams to get the patients identified,

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and then work can start on identifying the resources that are required to take that next step.

Cathy Armor asked JS about the timeframes for mobilising the charter once providers had signed up to it. JS responded that as part of the dementia work stream there is a need to ensure things get going as quickly as possible and are reviewed regularly. The target timescale is the end of March 2025.

d. Place Based Dementia Focus

Heather Farley began by explaining the slides she was presenting today were the work of a colleague Emma Boore from the North Norfolk team who had now transferred to another team within the ICB. Liz Withington was also heavily involved in the Dementia Working Group.

HF said what struck her was that it's an incredibly frightening environment to be in and yet people with dementia are in hospital twice as long if they're over age 65 than other people, and 43% of them are initially admitted with things like urinary tract infections and chest infections, which are perfectly treatable in the community. So not only are they going in, but they're going in inappropriately and that must be a terribly frightening environment.

HF spoke about the North Norfolk Dementia Working Group which was set up as part of the North Place Board structure, but also has strong links into the North Health and Wellbeing Partnership. The group only received a small amount of funding (£3000) but what the group has achieved is far greater - identifying, mapping, promoting, and maximising what's already out there and not trying to come up with new things that are going to cost more money. There is a mixed membership including representatives from local groups in North Norfolk, people living with dementia and their carers. One of the groups key projects was a dementia leaflet which pulled together information about all the things that were already available in North Norfolk. They also produced the dementia infographic, which takes the individual through talking to their GP, receiving a diagnosis and what they can expect, and their health and well-being, their home, their friends and family, and their future plans.

HF also highlighted Protect NoW proactive dementia support calls which involved 14 GP practices. There were 1056 eligible patients and there were 422 requests for support from social prescribers.

Simon Boar, who is Integrated director for NCC and NCHC is now looking after the group as a holding position and the group will have the Protect Now data presented back to them at a future meeting and there are some really good plans looking forward as well.

In terms of feedback to the wider system, those living with dementia need is not complicated, it is the system that makes it complicated and basically, we just need to get the fundamentals in place. Some final thoughts from the group that the importance of the support and experience provided by loved ones in the Community should never be underestimated or undervalued.

Comments and questions from members of the committee:

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	<p>AD commented that she had been receiving very good feedback about the group and what it has demonstrated is that if you get the right people together and communicate the right way, you don't need lots of money to change what's available and how people access it.</p> <p>The updates were noted.</p>	
7.	<p>Place Board Report South Norfolk</p>	
	<p>Dr Olga Tsirogianni (OT), Acting Associate Director of Primary Care Network Development for South Norfolk joined the meeting to provide an update on the work of the South Norfolk Place Board. OT referenced the presentation which had been circulated in advance of the committee which reflected on some of the projects the place board has completed over the past two years. OT highlighted to the committee some of the changes that had occurred because of the projects, including improved working relationships, collaboration and problem solving across the system.</p> <p>Questions and comments from members of the committee:</p> <p>AD commented on the importance of engaging with smaller volunteer organisations and recognising their expertise and the intensive work they can do with people and communities. AD further commented that VCSE organisations should have a connection to Place in their own right through the VCSE Assembly. AD said the connection between the five Places and VCSE organisations wasn't quite working and there should be uniformity across Places and the Norfolk and Waveney system, to ensure people understand the connection between Place and the VCSE. Mark Hitchcock (MH) echoed AD comments and concerns.</p> <p>Mark Burgis (MB) was struck by a comment in OT presentation that Place partners are eager to be tasked with addressing bigger impactful challenges. MB said this was common across all five Places but how do we harness the power of place partnerships and relationships to help deliver system objectives. Getting the balance between local and system focus is key.</p> <p>Tricia D'Orsi (TD) added that she loved the potential of place and the collective power and experience of the various people, providers, organisations coming together to innovate and deliver outcomes. As Places mature there is great potential for doing something very different for the local population.</p> <p>OT gave an example of commissioning two community health and well-being workers in Watton in the Breckland area. The workers are employed by the district council but are fully integrated in primary care, and they work in the most deprived communities knocking on doors and engaging with the homeowners and supporting them with social needs (e.g. food vouchers, housing issues) and then discussing health and booking health checks. The workers discovered cases of modern slavery and a resident experiencing suicidal thoughts.</p> <p>The update was noted.</p>	
8.	<p>VCSE Assembly Update</p>	
	<p>Shelley Ames (SA) and Mark Hitchcock (MH) provided an update on the VCSE Assembly.</p>	

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	<p>MH explained the VCSE structure is now much clearer and several VCSE Assembly members are taking on portfolio roles. It is pleasing that SA has been recruited as the Head of Health Inequalities and VCSE Partnering. The challenge to do something different rather than worry about the governance is the key thing.</p> <p>SA added there is a new health inequalities and voluntary sector partnering team in the ICB. A new VCSE Assembly Chair is also being recruited as Emma Ratzer's term has concluded, and interviews for this role are being held imminently. SA had apprised the committee at the previous meeting regarding the review and refresh of the assembly model, including consideration of a portfolio holder approach to ensure clarity and transparency from the sector representatives who are representing the different joint forward plan priorities, as well as the wider priorities identified within the sector. SA gave an example of a comms lead position within the assembly who would help with the comms strategy and how the assembly engages with the wider sector.</p> <p>New terms of reference are being drafted for the Board and discussions are ongoing regarding Assembly Board representation on governance structures and communication flows back to the VCSE sector.</p> <p>Comments and questions from members of the committee:</p> <p>AD commented on the good progress that had been made since the last update, and it will be good to start having discussions about how the VCSE Assembly makes an impact and engages with the system.</p> <p>Tracy Williams (TW) was pleased with the VCSE refresh and road map and the positive join up with health inequalities and the voluntary sector partners. The voluntary sector are such essential partners in the system and are the closest contact with our communities. Health inequalities cannot be addressed without working closely with our volunteer sector and districts.</p> <p>The update was noted.</p>	
9.	<p>Healthwatch Suffolk Annual Report</p>	
	<p>Andy Yacoub, Chief Executive of Healthwatch Suffolk introduced Michael Ogden (MO) Communication, Information and Research Officer at Healthwatch Suffolk, who presented this item.</p> <p>MO highlighted some of the projects Healthwatch Suffolk had published including:</p> <ul style="list-style-type: none"> • Children and young people's asthma care and support • Smoking, vaping and using tobacco in Suffolk • Tackling Poverty Together in Suffolk • Living with COPD • Elective Care Proposals <p>In relation to the 'My Health, Our Future' project, 66,000 responses had been received from children or young people across the lifespan of that project and these insights are used across sectors to achieve impact and change for young people, particularly in schools and colleges.</p>	

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	<p>MO also highlighted the dementia project and POD service engagement which were good examples of how Healthwatch can influence strategic change to improve support. More than 1000 people were signposted last year by Suffolk teams and communities and by calling Healthwatch Suffolk.</p> <p>MO explained how Healthwatch's contribute insights to government committees, calls for evidence, and a whole range of insights and intelligence is shared to ultimately improve health and social care support for local people which is the end goal of every single project. Healthwatch Suffolk has been able to identify so many impacts and that comes from working with true system advocates and having close links within systems who take those insights and drive that change because ultimately change is done by organisations.</p> <p>AY added there are a range of reports on Healthwatch Suffolk website which may be of interest or will help colleagues and organisation their work at any one time.</p> <p>Comments and questions from members of the committee:</p> <p>AD commented it was an impressive portfolio of work and asked for reassurance now that the ICB restructure is settling that Healthwatch knew the channels by which to communicate with the ICB to share findings from reports. AY commented the channels were not clear. MO added that anyone who wants to receive insights from Healthwatch Suffolk can sign up for our Mailchimp or let MO know or get in touch. MO added he has a list of people that reports are shared with when they are published.</p> <p>MB encouraged AY and MO to link with him and his team if things come up that they feel cannot and we'll be happy to signpost to the appropriate area if it's not ourselves.</p> <p>The update was noted.</p>	
10.	<p>Healthwatch Norfolk Update</p>	
	<p>Alex Steward (AS) highlighted some current 'hot topics' from a Healthwatch Norfolk perspective.</p> <ul style="list-style-type: none"> • Views and concerns expressed by the LGBTQ+ Community at the two Pride events held in Norfolk recently. • Healthwatch attendance at two SEND Events in Wells, and Swaffham. <p>AS said the SEND events highlighted that health inequalities are increasing at a rapid rate. For example, those who can afford to pay can use private consultation, but this still left a huge barrier for those unable to pay. There is also an acute lack of appropriately trained staff within the system.</p> <p>In relation to the Pride report, AS thought that some very good points had been raised as follows which AS considered were issues that required addressing.</p> <ul style="list-style-type: none"> • In relation to transgender female to male who were not being offered various tests that should be offered, e.g. pregnancy tests. Or transsexual male to female who weren't being given prostate tests because the prostate 	

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	<p>is not removed during the operation, so that can have an impact later as well,</p> <ul style="list-style-type: none"> • GP practices not always knowing somebody's sexuality unless they're very explicit. • The use of personal pronouns. <p>Questions and comments from members of the committee</p> <p>In relation to the Pride report and the issues identified AD commented on the importance of raising awareness and improving the understanding of our health professionals and social care colleagues, and supporting people in whatever capacity to have the right conversations with their patients. AD added there is plenty of lived experience around us that we can draw from too, but it is important that we get a wider perspective too.</p> <p>TD commented that both reports made for very stark reading. From a SEND perspective, both our local authorities and ICBs in Norfolk and Waveney and in Suffolk are working to deliver an action plan to address the many gaps that we have in service provision for children in the SEND domain. In relation to the Pride report, TD reported she had been involved in discussions regarding a practice nurse conference to reinvigorate relationships with practitioner colleagues, and thinking about the same transgender issues that are raised in the Pride report, and how we make it easier for healthcare professionals to have the right conversation with their patients.</p> <p>It was noted that Dr Frankie Swords declared a professional interest during this discussion in relation to her work as an endocrinologist; a large number of the local trans community are under the care of FS and her team at NNUH.</p> <p>Tracy Williams (TW) commented there are opportunities in respect of all of our communities to protect the characteristics and those with health inequalities in respect of our quality and health impact assessments and some wider system work we can do in respect of that. TW is keen that work is taken forward. There is also working ongoing currently with the primary care workforce team around some health inequalities training for all our primary care staff, which will include elements of some of those protective characteristics as well as other elements of health inequalities.</p> <p>The reports were noted.</p>	
11.	<p>Population Health and Inequalities Board Update</p>	
<p>Parker Rachael 22/11/2024 15:17:52</p>	<p>Dr Frankie Swords presented the update for the Population Health and Inequalities Board. FS highlighted the following:</p> <ul style="list-style-type: none"> • The procurement of the PHM software was complete, and an announcement should be made shortly subject to contracting. • The Protect NoW team has been contacting patients who have been invited to a health check but haven't attended. This had been so successful the project had to pause it on the second day because the provider was overwhelmed with bookings (277 bookings in one day). The demonstrates how powerful PHM processes can be. • PHM projects: Priority Patient Review Evaluation has been completed and confirms that reversible risk can be identified, and defined interventions did 	

	<p>reduce acute care costs. However, the delivery of interventions is severely limited in primary care, despite incentivisation, due to lack of capacity. This should be considered during the design of any future projects.</p> <ul style="list-style-type: none"> • Equality and Health Impact Assessments (EHIA): The process has now been agreed and aligned with the Quality Impact Assessment (QIA) process. • A proposal for the Wellness on Wheels bus and the Community Voices programme to integrate into one outreach programme. • Population Health and Inequalities Terms of Reference (TOR): FS advised the TOR have been updated and there are two key changes. The first is that the PHI Board has passed the development stage of its strategies and is now overseeing their implementation. The second change is bringing in oversight and strategic leadership of VCSE working. <p>Comments and questions from members of the committee:</p> <p>AD commented on the Wellness on Wheels bus and Community Voices adding there are other resources within the community which may be able to support this programme, and some conversations may have to be restarted to ensure the programme is well supported and successful.</p> <p>Agreed: The Patients and Communities Committee:</p> <ul style="list-style-type: none"> • Received and approved the updated Population Health and Inequalities Board Terms of Reference. • Supported the integration of Community Voices and WoW bus into one outreach programme. 	
12.	<p>Ageing Well Programme Board Update</p>	
	<p>James Allen (JA) reminded the committee of the core aspects of the group and the workstreams which include prevention, dementia, frailty attuned acute care, and care homes and housing with care. JA highlighted the following:</p> <ul style="list-style-type: none"> • The appointment of the specialty advisors for dementia and frailty (Dr James Casson and Dr Katie Honney) is important to support the clinical expertise and the strategy going forwards. • The pilot of the Rockwood tool which is a clinical frailty scoring tool commenced at the Queen Elizabeth Hospital in early September. Currently working through the metrics to analyse the impact of that tool. • A prevention comms and engagement plan for winter is in development along with a comms and prevention plan for 2025/26. • Two programme managers have been recruited to the planned care team and one will be working across ageing well and palliative care. • The Carers Voice charity has developed the ICS Carers strategy which is being taken through the ageing well programme for review. • Two areas of focus before the end of this year include collecting the findings from the forthcoming dementia round table event and developing the blueprint of the operational plan for ageing well as a whole. <p>Comments and questions from members of the committee:</p> <p>AD asked which pieces of work the team is struggling with the most across all the workstreams. JA responded it was mostly funding as much of the work requires</p>	

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	<p>funding but there is no money attached to the projects. JA also mentioned primary care representation which could be developed in a number of groups, but GP leads have been identified across the five Places and JA is hopeful this will improve representation.</p> <p>AD further asked about engagement and traction from stakeholders and ensuring the N&W population’s voice is heard to inform thinking. JA responded that lived experience is important particularly from a carer perspective and the round table event will be part of interlinking this experience into the group. In terms of engagement, care markets are an area that need further exploration and engagement. Next financial year will focus more on the patient education pack, to advise patients who to go to and what the process is going to be.</p> <p>Tricia D’Orsi (TD) agreed with JA regarding care home markets and there is much more that can be done to influence delivery of care in care homes. TD added there is a lot more that needs to be done around patient empowerment and information and this is an opportunity to do something different to encourage people to either self-monitor or to get their blood pressure checked.</p> <p>AD sought reassurance in relation to process and how this is tested so that we don’t just develop and implement something and then a few months later we discover it’s not quite working. What is it that is going to help us validate if our thinking is going to work, and is that built into the process? JA responded that one of the programmes priorities is the development of a metrics dashboard which, along with performance metrics, will also look at the population health data and identify the impact of the programmes and projects. Secondly, lived experience representatives will be included in task and finish groups to understand what is or isn’t working and if things should be done differently.</p> <p>The update was noted.</p>	
13.	Any Other Business and Reflections on the Meeting	
	No AOB items were raised.	
Date, time, and venue of next meeting: Monday 25 November 2024, 14:30-16:30hrs via MS Teams		

Minutes agreed as accurate record of meeting:

Signed: Date:
 Chair

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



**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
25								
26								
27								

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Agenda item: 05

Subject:	Patients and Communities Committee Risk Register
Presented by:	Mark Burgis, Executive Director of Patients and Communities
Prepared by:	Rachael Parker, Executive Assistant
Submitted to:	N&W ICB Patients and Communities Committee
Date:	25 November 2024

Purpose of paper:

To update on the current risks held by the Patients and Communities Committee.

Executive Summary:

There are two risks which the committee is responsible for on the new board assurance framework, these are linked to our system ambitions in the joint forward plan:

BAF01 – Health Inequalities and Population Health Management: There is a risk that the ICB will not meet its statutory requirements to reduce HI or use PHM techniques to their full potential in line with the PHM strategy and HI strategic framework for action. If this happens, specific groups of people will experience poor outcomes which could have been prevented.

BAF05 – Increasing numbers and complexity of the ageing population in Norfolk and Waveney: Across Norfolk and Waveney life expectancy is longer than the average across England and is currently 80 years for males and 84 years for females. Furthermore, the *healthy* life expectancy across Norfolk is lower than the average for England at about 62.7 years for males and about 62.4 years for females and this figure has decreased over the last few years. This means that the period that older people spend in *ill* health in Norfolk is getting longer. Older people are already more likely to be living with multiple and complex health conditions. Common conditions that are more prevalent in older age include dementia, heart disease, hypertension (high blood pressure), respiratory disease, mental health conditions such as depression, cerebrovascular disease, joint problems, diabetes, and sensory impairment.

The risks are that:

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- a) services will be unable to continue to meet the increasing demand and needs of our ageing population.
 - b) costs associated with care of this population will increase significantly adding to financial pressures.
 - c) quality of care for older people may decline if a) and b) are not suitably mitigated.
- More detailed information regarding both risks can be found in Appendix 1.

Recommendation to the Committee:

The committee is asked to note the update.

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

Governance

Process/Committee approval with date(s) (as appropriate)	
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NHS Norfolk and Waveney ICB – Board Assurance Framework

Version V4 Date last updated:

Board Assurance Framework – Summary Page

Ref	Risk title	Executive lead	Committee	Date risk identified	Target delivery date	Risk appetite	Score at target delivery	2024/25 monthly risk rating											
								1	2	3	4	5	6	7	8	9	10	11	12
Ambition 1: Population Health Management, Reducing Inequalities and Supporting Prevention																			
BAF01	Health Inequalities and Population Management	Mark Burgis / Frankie Swords	Patients & Communities	01/07/22	31/03/25		4	12	12	12	12	12	12	12					
Ambition 5: Transforming Care in Later Life																			
BAF05	Increasing number of ageing population with complex health conditions	Frankie Swords	People and Communities	20/06/204	31/03/28		12			New 15	15	15	15	15					

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Ambition 1: Population Health Management, reducing inequalities and supporting prevention

BAF01 (Inphase ref 00000008)								
Risk Title	Health inequalities and Population Health Management							
Risk Description	There is a risk that the ICB will not meet its statutory requirements to reduce HI or use PHM techniques to their full potential in line with the PHM strategy and HI strategic framework for action. If this happens, specific groups of people will experience poor outcomes which could have been prevented.							
Please include any collaboration and partnership aspects of the risk.								
Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date				
Mark Burgis / Dr Frankie Swords	Patients and Communities	Suzanne Meredith/ Tracy Williams/ Shelley Ames	01/07/2022	31/03/2025				
Risk Scores								
Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	1	4	4
Risk appetite:			Risk tolerance:					
Controls				Assurances on controls				
<ul style="list-style-type: none"> The HI Strategic Framework for action and the PHM strategy have been published. Implementation plans under development. Specialty advisors are leading on HI, PHM and the Core20Plus5 clinical areas. ICP supported proposals for a strategic group and co-ordination group to formally oversee delivery of the Health Inequalities Framework for action. Co-ordinating multi-partner health inequalities group now in place. SROs established for Lifestyle factors and Healthcare Inequalities Health Inequalities & VCSE Partnering team appointed to lead health inequalities work programme development. The Health Improvement Transformation Group (HITG) focusses on Primary Prevention: smoking, physical activity and Healthy weight, report to ICP. Community Voices gathering insights into HI and connecting with local communities to help address. ICS groups set up for Inclusion health groups, vaccines inequalities, Core20plus5 programme group, NHS Anchors group, access and support programme group, reporting to HIOG Datahub Population Health dashboards in place to support reporting and health oversight. Health and wellbeing partnerships and place boards overseeing local work programmes. External factors that impact on "Plus groups" (such as the moving of hotels for asylum seekers which impacts on the services they receive) are raised by the HI team to be managed across the ICP. 				<p>Internal: PHM and addressing HI has been identified as a priority in our JFP. Progress against key national delivery timelines reported and led by appropriate governance structures: Health Inequalities Oversight Group (HIOG), PHM Oversight Group (PHMOG) and PH and Inequalities Board with assurance reporting to Patients and Communities Committee.</p> <p>NHSE reporting of NHS Inequalities Improvement Frameworks and annual reporting against NHS statement on Information for health Inequalities.</p> <p>Elective Recovery Board receive regular reporting on waiting lists per decile of deprivation index</p> <p>External: Integrated Care Partnership Board Health Inequalities governance structure including a strategic steering group and co-ordination group.</p>				

- Refresh of the VCSE Assembly and partnership working reporting into the PH&I Board

Gaps in controls or assurances

- Embedding resources at Place level to co-ordinate the mechanisms needed to address HI and deliver PHM.
- Further work required to develop the data hub and dashboards.
- NHSE HI funding not ring-fenced to support emerging work programmes and respond to system priorities.
- Agreed governance for Equality health impact assessments but uniform process not yet established.
- Dashboard of indicators to monitor progress for PHM and HI under development as part of ICB datahub

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
28/10/24	ICS Health Inequalities commitments launched at ICP conference on 16 th October. Working groups now established for NHS Anchors and Core20Plus5. The NHS Anchors Group will be overseeing completion of NHS Boards HI self-assessments. The ICBs own Board HI Self-assessment will be presented as part of the 12 November All-staff event. Re-procurement of specialist software to support PHM programme now completed.	G	30/11/24

Visual Risk Score Tracker – 2024/25

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12	12	12	12	12	12					
Change	→	→	→	→	→	→	→					

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BAF05 (Inphase re 00000031)

Risk Title	Increasing numbers of older people with complex health needs in Norfolk and Waveney							
Risk Description Please include any collaboration and partnership aspects of the risk.	The period that older people spend in <i>ill</i> health in Norfolk is getting longer. Older people are already more likely to be living with multiple and complex health conditions. Common conditions that are more prevalent in older age include dementia, heart disease, hypertension (high blood pressure), respiratory disease, mental health conditions such as depression, cerebrovascular disease, joint problems, diabetes, and sensory impairment. The risks are that: a) services will be unable to continue to meet the increasing demand and needs of our ageing population with complex health needs. b) costs associated with care of this population will increase significantly adding to financial pressures. c) quality of care for older people may decline if a) and b) are not suitably mitigated.							
Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date				
Dr Frankie Swords	People & Communities Committee	Olga Tsirogianni	20/06/24	31/03/28				
Risk Scores								
Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	5	3	15	4	3	12
Risk appetite:			Risk tolerance:					
Controls					Assurances on controls			
<ul style="list-style-type: none"> Ageing Well Programme Board with substantive programme manager and specialty advisors in post. Workstreams established across all programme areas: Dementia, Frailty Attuned Acute Care, Care Homes & Housing with Care and Prevention Increased focus upon early intervention (identify and intervene) Increased focus upon upstream prevention and remaining active 					<p>Internal: Transforming care in later life has been identified as a priority in our JFP. Progress against key national delivery timelines reported and led by appropriate governance structures: System Ageing Well Programme Board reporting to Patients and Communities Committee.</p> <p>External: Integrated Care Partnership Board</p>			
Gaps in controls or assurances								
<ul style="list-style-type: none"> Embedding resources at Place level to co-ordinate the mechanisms needed to deliver Ageing Well Strategic Framework Further work required to develop the data hub and dashboards to monitor medium / long term impacts. No specific budget allocated to the Ageing Well Programme to support emerging work and respond to system priorities. 								
Updates on actions and progress								
Date opened	Action / update						BRAG	Target completion
01/07/24	Frailty Attuned Acute Care workstream agreed unified frailty scoring for use across system.						G	19/07/24
01/07/24	Dementia Awareness education sessions delivered for Primary Care staff.						G	08/07/24
01/07/24	Population data analysis complete; social isolation and loneliness and falls prevention Joint Strategic Needs Assessment (JSNA) groups established.						G	19/07/24
01/07/24	Frailty Attuned Acute Care workstream agreed unified scoring tool for use across the ICS in July 24 with pilot of Clinical Frailty Scoring tool to start Sept 2024.						G	02/09/24
01/07/24	Joint Care home support group established including wider stakeholders.						G	06/09/24
01/07/24	Facilitating an ICS Dementia Round Table event with findings to be shared with stakeholders to identify priority areas.						G	25/09/24
04/11/24	Dementia Charter to be signed by all organisations and self-assessments completed by all providers to understand gaps in service delivery and what organisations must improve.						A	31/12/24
04/11/24	Winter Communications Plan for 2025 developed and finalised ahead of implementation.						A	30/09/24
04/11/24	Joint Strategic Needs Assessment for Social Isolation and Loneliness completed to inform systemwide work and NCC commissioning for 2025.						G	31/03/25

04/11/24	Ageing Well Programme Blueprint developed to establish priorities and align workstreams							A	31/01/25			
04/11/24	Develop appropriate system Dashboard with all core workstream metrics							A	31/03/25			
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score			15	15	15	15	15					
Change			NEW	→	→	→	→					

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Agenda item: 06iii

Subject:	Complaints, Feedback and Concerns – Mental Health Focus
Presented by:	Jon Punt, Patient Experience Senior Manager
Prepared by:	Jon Punt, Patient Experience Senior Manager, and Charlene Roberts, Senior Patient Experience Officer
Submitted to:	N&W ICB Patients and Communities Committee
Date:	25 November 2024

Purpose of paper:

This paper provides some level of detail on the feedback the ICB has received regarding mental health services during the financial year so far, as well as the local provider of mental health services complaints during 2023/24.

Executive Summary:

The ICB’s Patient Experience Team deals with many queries relating to mental health services, with some clear trends developing around areas of regular enquiry, These have predominantly included assessments for Autism Spectrum Disorder (ASD)/Attention Deficit Hyperactivity Disorder (ADHD) and feedback regarding Community Mental Health Teams (CMHTs).

Volumes

The ICB have received four formal complaints, eight enquiries from Members of Parliament and 75 informal concerns/enquiries.

For reference, this equates to around four percent of the total contacts the ICB has received in the financial year, at the time of writing.

Often it is more expedient for a patient/member of the public to raise their concerns directly with the provider of care, who typically in this instance would be the local commissioned provider of mental health services, Norfolk and Suffolk NHS Foundation Trust (NSFT). Therefore, we have reviewed NSFT’s annual complaints

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report for 2023/24 to consider whether there is commonality between what the ICB and NSFT are seeing.

For reference, NSFT received 428 new complaints in the year 2023/24.

Trends and themes

Individual Funding Requests

Two of the formal complaints the ICB received, along with several other queries, related to delays in individual fund requests being considered by the panel. Some of these cases also highlighted communication issues with the patient, which left them unclear around how their care would progress.

Right to Choose Queries

35 percent of all contacts regarding mental health services were in relation to delays experienced in patients waiting for ADHD or ASD diagnostic assessment. Often this included a request from the patient or their loved one around what options they had under Right to Choose and whether they could be seen by an alternative provider.

Community Mental Health Team Support

15 concerns received related to support received from CMHTs. Issues raised included patients feeling like there was a lack of defined treatment, or that they required more regular input. Other patients were unhappy they had been discharged from services while they felt they were still requiring support.

One particular case highlighted alleged significant delays between medication reviews and contact from professionals in the CMHT.

This is in line with NSFT's annual complaints report whereby 70 complaints were received with patients stating they had been discharged with an insufficient care package, while 130 raised that staff lacked empathy.

80% of NSFT's complaints relating to access to treatment, relate to complaints about service eligibility and delays in accessing services or treatment because of waiting times or identified gaps in service provision

Services under Section 117

One formal complaint and four informal concerns raised concerns that local health and social care services were not fulfilling their responsibilities to deliver aftercare under Section 117 of the Mental Health Act.

Perceived lack of commissioned services

Some more specific queries from patients have highlighted they believe there were no services commissioned to deal with their specific needs. These included

Parker Raine
22/11/2024 17:52

Avoidant/Restrictive Food Intake Disorder, some talking therapies and Obsessive Compulsive Disorder.

Recommendation to the Committee:

To note the contents of the report for further discussion

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

Governance

Process/Committee approval with date(s) (as appropriate)	
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Parker Rachael
22/11/2024 15:17:52

Agenda item: 06 iv

Subject:	Mental Health Coproduction Strategy
Presented by:	Mark Payne, Acting Associate Director Mental Health, N&W ICB
Prepared by:	William Snagge,
Submitted to:	N&W ICB Patients and Communities Committee
Date:	25 November 2024

Purpose of paper:

At the Committees request, when the draft version of the Mental Health Coproduction Strategy was presented in January 2024, the final Mental Health Coproduction Strategy is attached.

It is provided for information sharing and wider awareness raising purposes.

No committee actions or decision are required.

Executive Summary:

Please see attached document.

Report



NW Coproduction
Strategy final version

Recommendation to the Committee:

No committee actions or decision are required.

Key Risks

Parker Rachael
22/11/2024 15:41:52

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

Governance

Process/Committee approval with date(s) (as appropriate)	
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Parker Rachael
22/11/2024 15:17:52

Coproducing for better mental health
outcomes for the people of Norfolk and
Waveney

5 Year Coproduction Strategy

2025 - 2030

Parker Rachael
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Introduction

Better mental health outcomes for the people of Norfolk and Waveney of all ages, including children, will happen when services meet needs in the most effective ways possible. And if lived experience of care and support is valued equally to other expertise in the Integrated Care System.

Coproduction is when the feedback, views and ideas of people and communities flow into how care and support is offered and action is taken as a result. This includes carers and families. Collective lived experience priorities are effectively represented by people with lived experience in deciding what to do for better outcomes. Changes made as a result of coproduction are shared with the people often. There is an ongoing conversation so people and communities can respond about how experiences and outcomes are affected by changes. This way of working values power sharing between people and communities, and services and the system.

Coproducing mental health care and support in Norfolk and Waveney will help us reach our goals as an Integrated Care System. These goals are:

- To ensure people can live as healthy a life as possible.
- To ensure people only have to tell their story once.
- To make Norfolk and Waveney the best place to work in health & care.

All Integrated Care Systems in England have been asked to join up public engagement, participation, involvement and coproduction activities so people and communities are at the heart of the systems. In July 2022 statutory guidance was published with the new Health and Care Act to guide systems in their approach.

There are already some good examples of coproduction around mental ill health in Norfolk and Waveney, including 'I Statements' for adult outcomes and the Children and Young People's Mental Health Charter.

Rethink Mental Illness facilitated the coproduction of this strategy. Rethink is a national charity facilitating coproduction in a number of Integrated Care Systems across England.

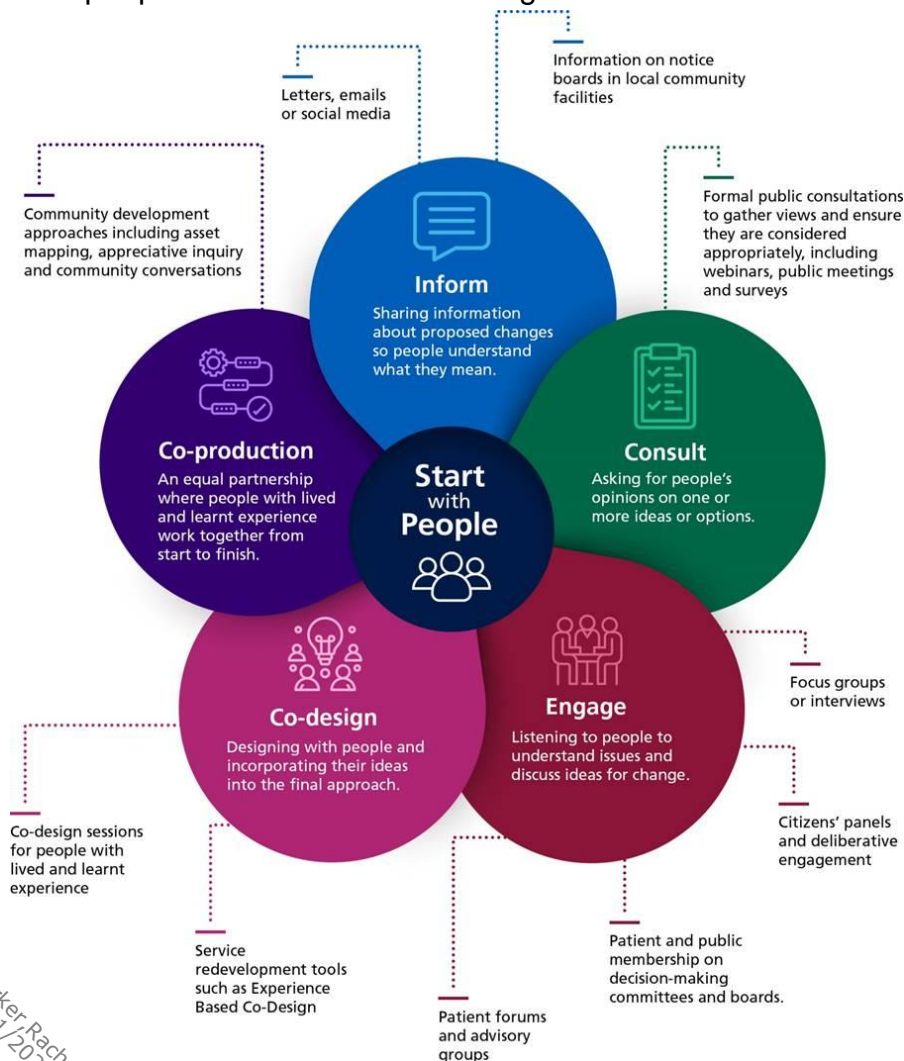
Parker Michael
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Vision and approach to coproduction

Our vision for coproduction in five years time is that the voices of people and communities are at the centre of decision-making and governance about mental health services, at every level of the Norfolk and Waveney Integrated Care System.

We believe this strategy will lead to a power shift from the system and services to the people and communities. We also believe this strategy will promote a culture shift towards de-stigmatising mental illness through greater awareness and understanding.

Our approach to coproduction is to follow the ten principles in the statutory guidance for coproduction, which you can read more about here: [Working in Partnership with People and Communities](#). It includes the ambition that partners in the integrated care system work together to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This guidance is summarised as:



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Norfolk and Waveney People and Communities Hub

A People and Communities Hub was developed by the Integrated Care System (ICS) to act as a focal point for ongoing work to deliver the national People and Communities guidance and to develop our approach over time. The first working draft of our approach aims to build on learning during the COVID-19 pandemic, and to develop our vision to improve our collective ability to listen to what people are saying across Norfolk and Waveney about what matters to them. We can do this by going out to the communities we serve, and by building on existing community engagement among our ICS partners including voluntary, charity and small community organisations

Feedback and insight can be joined up across ICS partners and channelled into decision making, so that insight shared in one part of the ICS is gathered and heard by other partners across the system.

All the partners in our ICS are talking and listening to people & communities every day. Our vision is that people tell their story of lived experience once and it's heard by everyone in the ICS. We want to build on the existing engagement and insight activity that all our system partners do. And to find ways of working together to share and learn from this insight. Working together will also mean we can share our resources and work more efficiently across the ICS.

Children and Young People

Our approach to coproducing with children and young people will use creative engagement strategies so both younger and older children can make substantial contributions towards the improvement and development of complex care systems. The Children and Young People's Mental Health Charter will provide a framework for services to self-assess, develop and improve their offer. It will also be in line with the Flourish work being led by Norfolk County Council to co-ordinate and promote engagement with children and young people across the system.

Parker Rachael
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Why create a coproduction strategy?

A strategy is helpful to plan what to focus on to achieve a vision or goal over time.

Our vision for five years time is ambitious. To achieve it we need everyone who is working closely with people with lived experience, including carers and families, to know what the plan is and what they can do to help achieve the vision.

We are creating this coproduction strategy so we have a better chance of achieving our vision and the benefits it will bring. Following the statutory guidance together means that mental health services will meet people's needs in the most effective ways possible.

The benefits of coproducing can be described as:



Parker Rachael
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How was this strategy developed?

In early 2023 the Mental Health Programme Oversight Board recognised the need for a whole Integrated Care System mental health coproduction strategy. It tasked a working group made up of people with experience of coproducing from different organisations and people with lived experience to coproduce the strategy.



This strategy builds on and brings together the lived experience involvement activity that is already strong across Norfolk and Waveney for better mental health outcomes.

A draft strategy was shared with a range of people who support others to have a voice to inform mental health and wellbeing services in Norfolk and Waveney. It was also published on the Norfolk and Waveney ICS website.

The feedback about the draft strategy was positive including that it outlined a commitment and way forward to bringing the wisdom of lived experience into the mental health system so that people have better outcomes. The feedback also identified the need for a Mental Health Coproduction Community of Practice across the ICS to support delivery of the vision.

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Equality, diversity and inclusion

By building connections with those who support people in communities, the strategy aims to improve the way mental health care and support is offered to more people who could benefit. So they feel it could be something for them, and they know how to give it a try.

Achieving the vision of the strategy will require:

- Working closely with community engagement and community listening projects in the Integrated Care System, such as Community Voices which is a Norfolk and Waveney information sharing, community listening, capacity building and action project.
- Sharing information about what is already there to help, and what is planned, in a way that is meaningful to communities of identity, including race, age, gender, neurodivergence including Autism, and other disabilities.
- Alignment with the Patient and Carer Race Equality Framework and the [Advancing Mental Health Equalities Strategy and the work of the ICB Health Inequalities team](#).
- Ensuring people who support people in communities are included in the conversation themselves. They know what matters, and need to be part of flowing lived experience into the Integrated Care System to make a difference. They can show the system the value of community help and action, and be part of the solution together with the people they support.
- Equality Impact Assessments to be an essential consideration for the Norfolk and Waveney ICS Mental Health Coproduction Community of Practice.
- Coproducing with people of all ages including children and young people, building on the strong activity that is already happening within this age group.

Parker Rachael
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What do we need to focus on to achieve the Vision?

Develop a Mental Health Coproduction Community of Practice with strong system links for lived experience to influence action.

Prioritise focus on addressing mental health inequalities in all activity.

Maintain space on the Integrated Care System website where people can find out ways of being involved and what lived experience has influenced.

Training and support for people involved, including people in lived experience roles, and staff.

Learn together by sharing coproduction resources, activities and outcomes, making the most of lived experience to make a difference.

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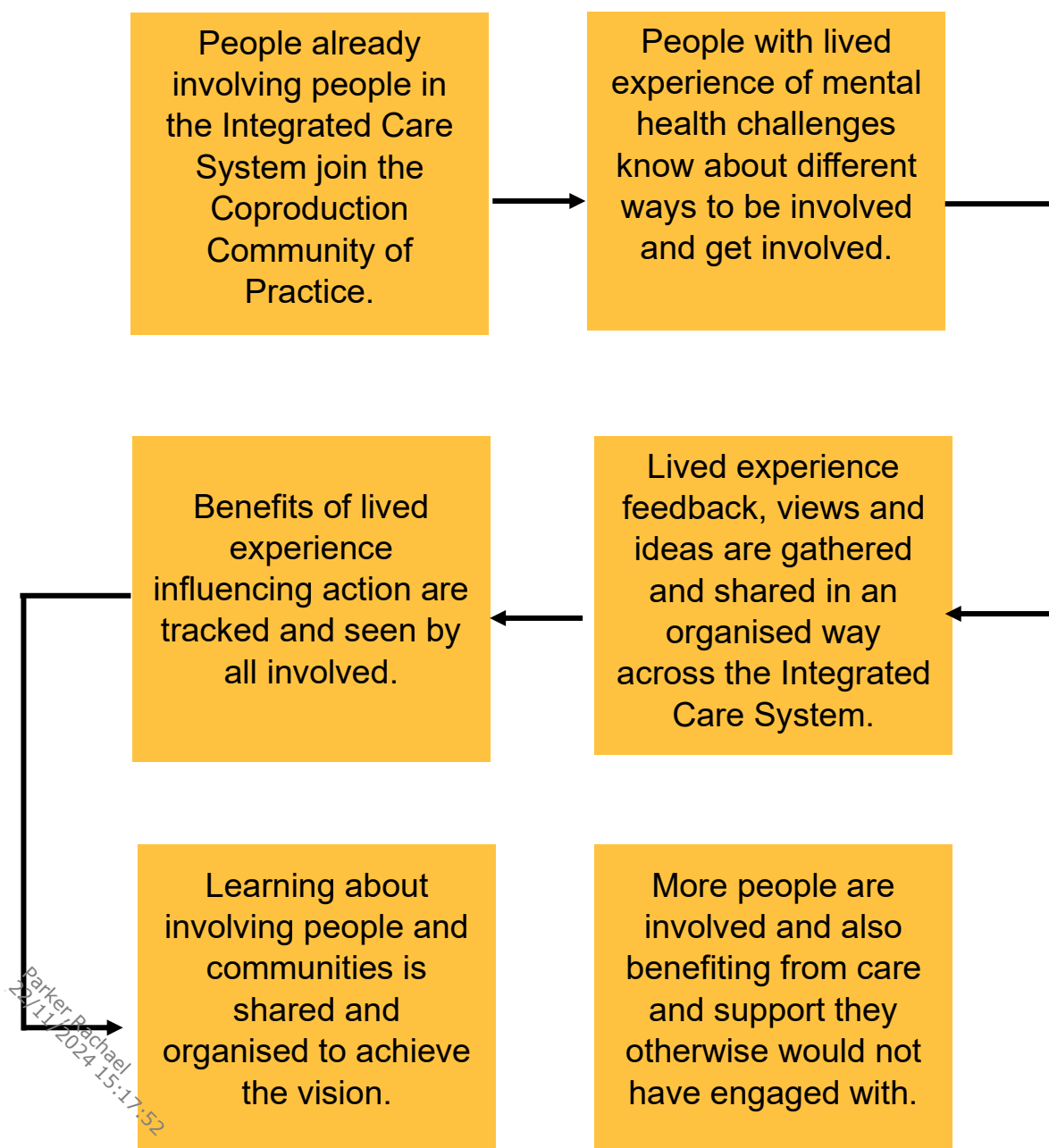
How will we know if the strategy is working?

We will use Principle 10 from the People and Communities Statutory Guidance to reflect and learn together each year by organising in person and online spaces to do this.

Learn from what works and build on the assets of all Integrated Care System partners – networks, relationships, activity in local places.

We will also provide a way for people to feed back using the website.

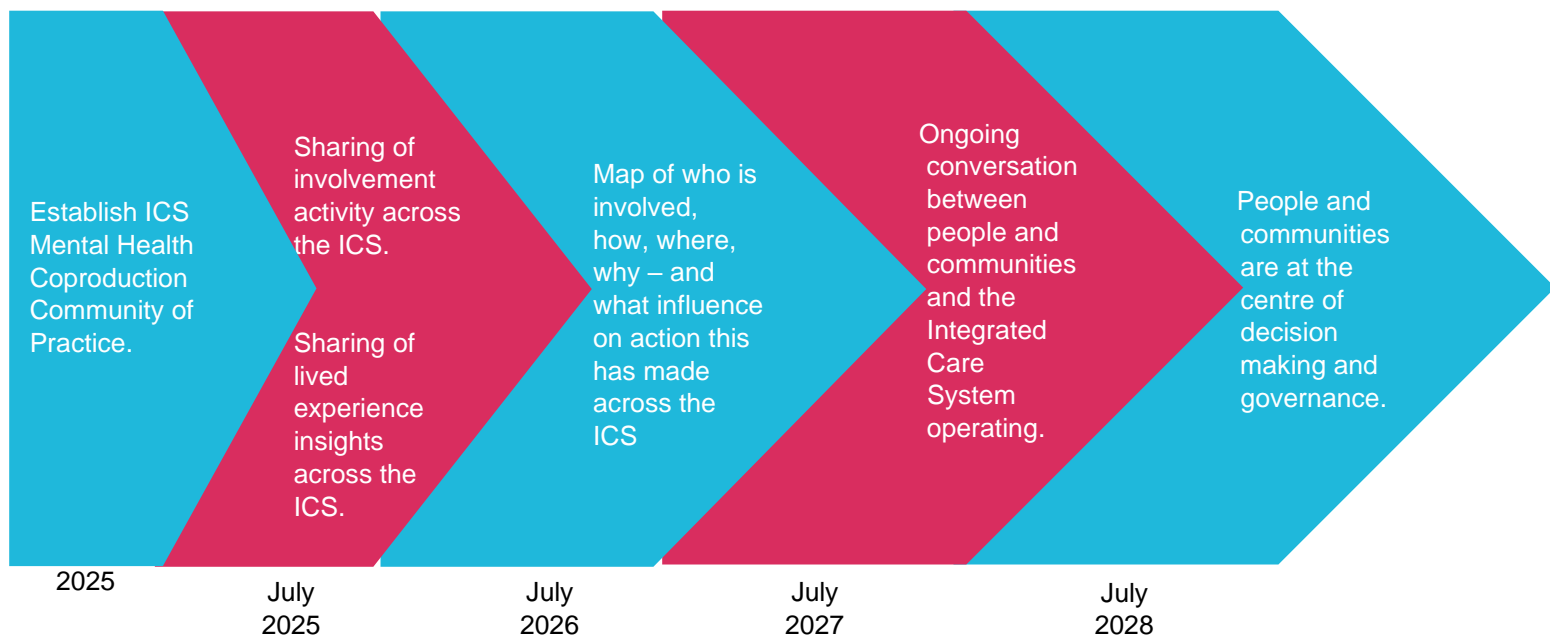
The Mental Health Programme Oversight Board will monitor and offer challenge where necessary.



What are the progress check-in points?

We expect to see progress towards our vision for coproduction in five years time as the following stages.

How much different organisations and groups are joining up to involve and coproduce across the Integrated Care System will be a key focus.



Parker Rachael
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Checklist and resources

Here is a helpful checklist for people who want to involve people with lived experience for better mental health outcomes in Norfolk and Waveney. There are some resources available on the ICS website [here](#)

Stage 1: Understanding your need for action

- Does your project need to understand what matters to people?
- Will your project be more successful if you bring in lived experience?
- Have you asked if the Integrated Care System already has lived experience information and insight about what matters relating to the focus of your project?
- Have you identified the focus for what you think you need to understand more about from people with a particular type of lived experience?
- Who can help you to identify the focus for lived experience involvement?
- Do you need/have lived experience partners working with you from start to finish?

Stage 2: Your knowledge and capacity to engage, involve and coproduce

- Have you looked at the ICS website to see what training and examples of good practice are available?
- Are you comfortable about hosting safe spaces for conversations about mental health topics and ways of sharing information, asking and listening to feedback, views and ideas?
- Are you able to support people in involvement activity and roles?
- Have you thought about equalities, inclusion and diversity factors in relation to your project? Have you connected with the Health Inclusion Group? Have you done an Equality Impact Assessment?
- Do you know about current lived experience priorities?

Stage 3: Doing your project

- Do you already have people trained, supported and appreciated in roles for your activity? Do they know what's in it for them – do they feel valued and supported?
- Are you involving people with lived experience from the beginning in the planning of your project? Are you agreeing with them what success looks like and the best ways of achieving this?
- Are you and people with lived experience involved asking the ICS what lived experience information (data) already exists that is relevant to your project?
- Do you have a plan to do further community engagement and listening?
- Are you tracking lived experience information into insight into influence into action?

Stage 4: Reflecting on your project and sharing

- Have you banked your lived experience insights with the ICS?
- Have you reflected on how much lived experience was involved in your project and the difference it made?
- Have you reflected on what went well, what could have gone better, and what to do differently next time?
- Have you shared your example and learning with colleagues and also the ICS?
- Will you look for further training, coaching or support with coproduction?

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Next step: Community of Practice

We shared a draft version of this strategy with a number of people and organisations who already involve and coproduce with people with lived experience across Norfolk and Waveney. From discussions, it became clear there is an opportunity to develop a Mental Health Coproduction Community of Practice to collectively achieve the vision of this strategy.

Membership of this Community of Practice could include a wide range of people and organisations from mental health service providers – to community voices and engagement projects – to libraries – to organisations that support people with co-occurring needs with mental health such as housing, substance misuse, neurodivergence and many other types of need – to organisations that support people of all ages such as children and young people, families and older people – to organisations that support people around challenging life circumstances and times.

Many mental health providers have a range of ways for people to be involved in and influence their services, through service feedback, quality improvement projects, working together projects, community engagement projects and much more. And organisations are investing in resources to help them to involve and coproduce.

This strategy aims to show the way to a whole system, joined up approach for lived experience to influence action in many different ways.

Ultimately coproducing with people and communities will make a positive difference to mental health outcomes for the people of Norfolk and Waveney.

As part of establishing the Community of Practice, it will be important to continue to have support from the ICS for the strategy. This includes being clear about who is responsible for its oversight and delivery, and resources needed.

Thank you for reading this strategy.

For further information please contact: nwicb.mentalhealthteam@nhs.net

Parker Rachael
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Improving lives **together**

Norfolk and Waveney Integrated Care System



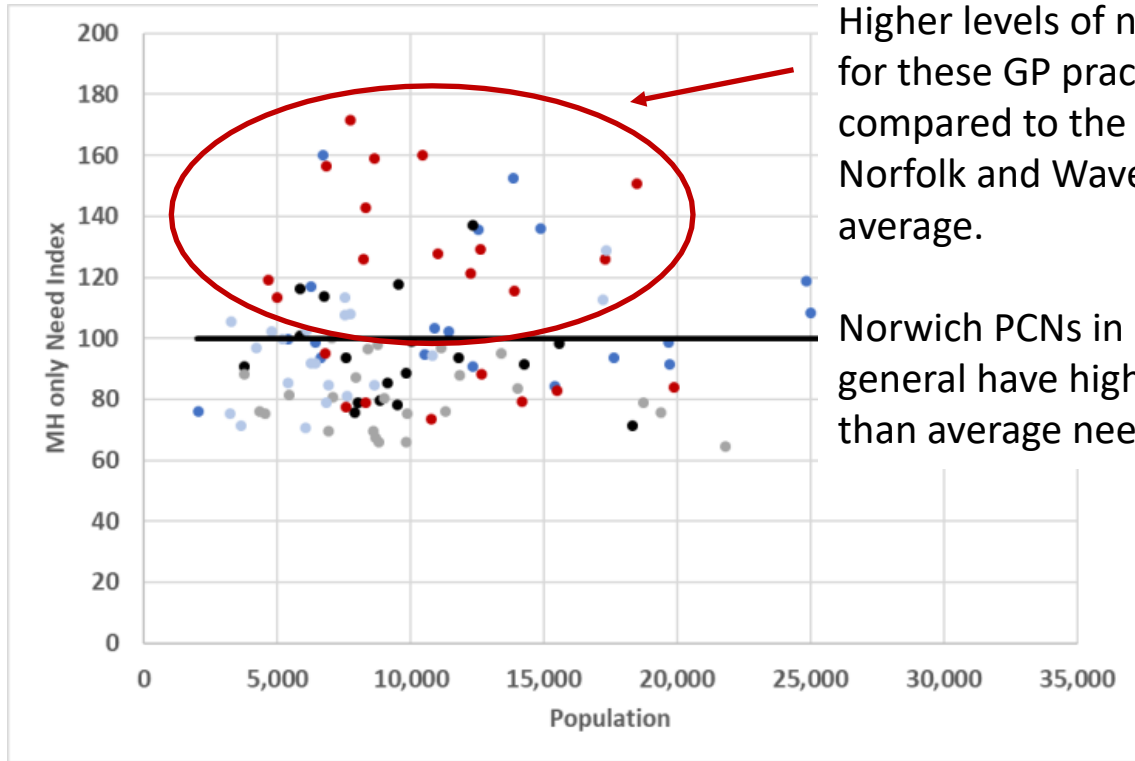
Mental Health - A view from Place

Claire Leborgne

Head of Place Development, Partnerships and Planning (Norwich)

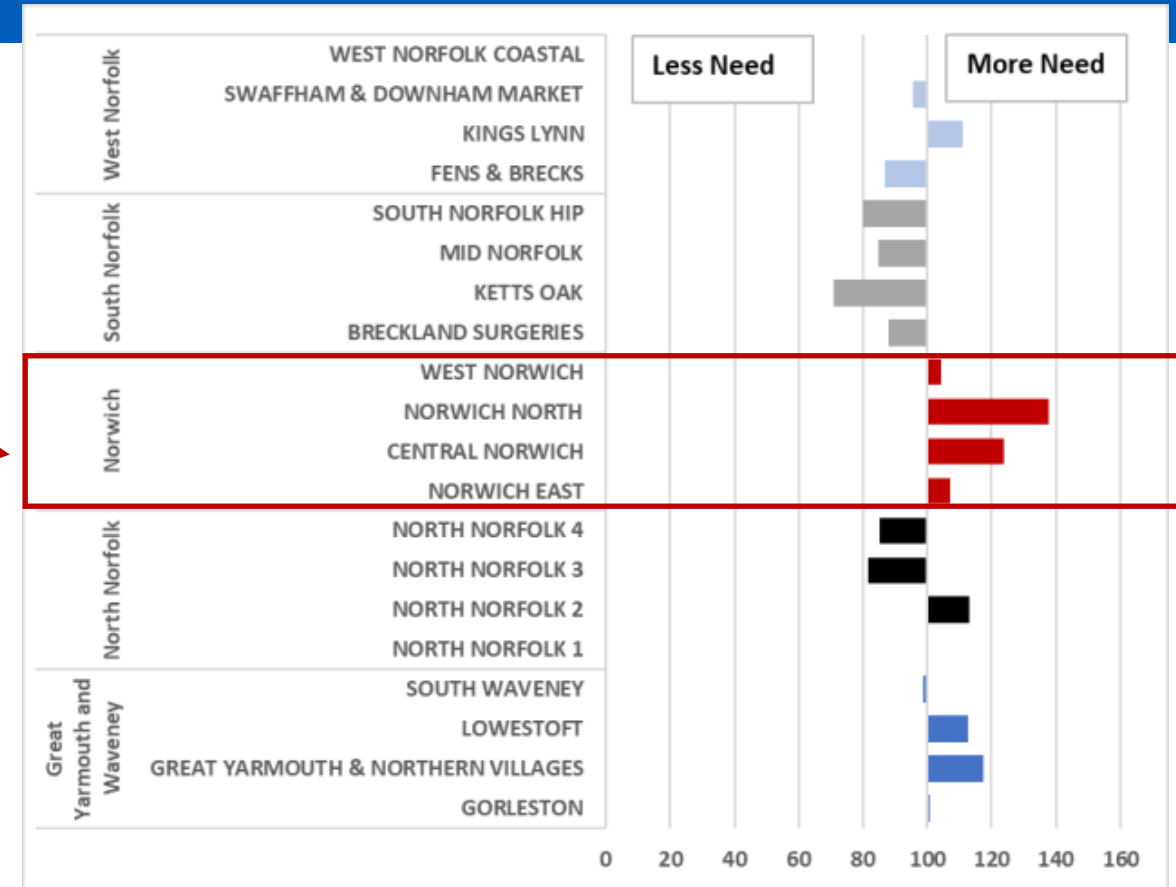
NHS Norfolk & Waveney ICB

Patient level data is one source of information. We can also estimate the level of mental health need from NHS resource allocation data. This also shows that there is variation in need across the system with three Norwich neighbourhoods having the highest level of need.



Higher levels of need for these GP practices compared to the Norfolk and Waveney average.

Norwich PCNs in general have higher than average need.



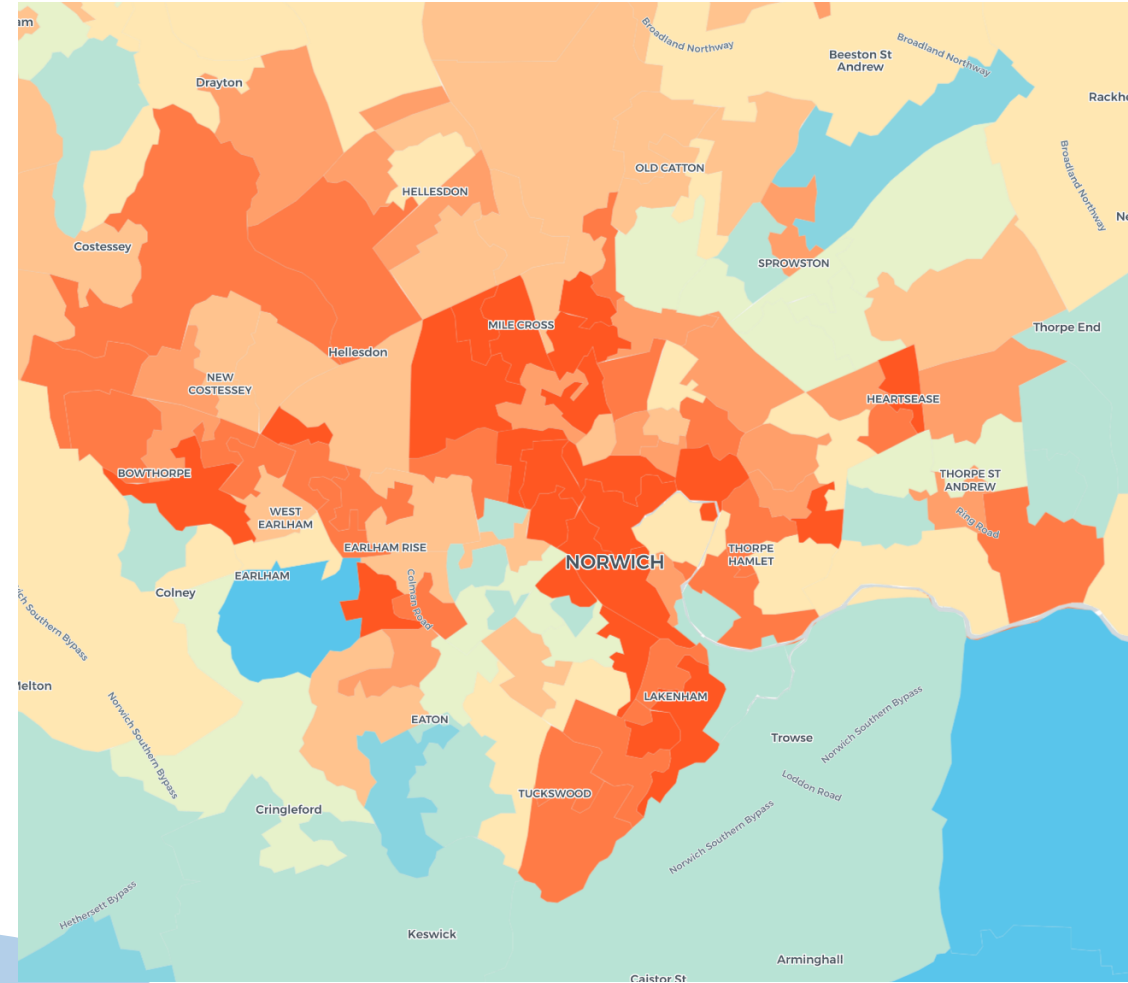
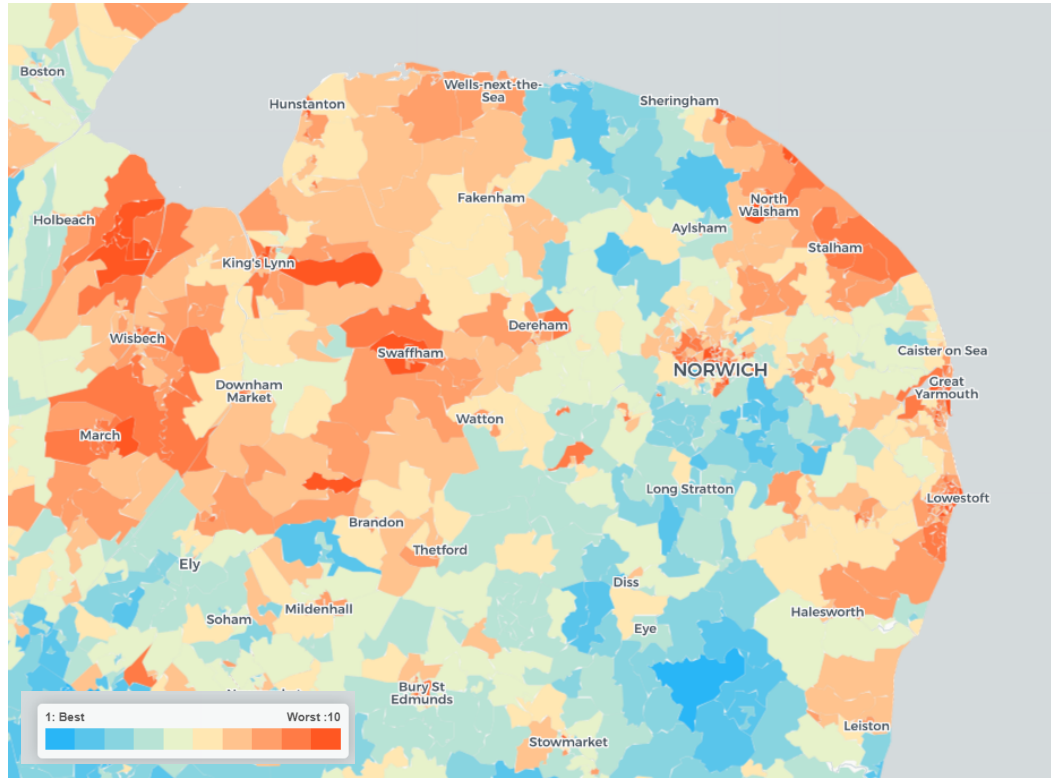
All ages, mental health only

Benchmarked to Norfolk and Waveney Average

<https://www.england.nhs.uk/allocations/>

<https://www.england.nhs.uk/wp-content/uploads/2023/01/d-mental-health-need-2023-24-v1.xlsx>

The 2022 small area mental health index is another useful tool to understand the communities that are likely to have more need for mental health support than others. This highlights several communities across Norfolk and Waveney in the deciles with most need. A number of these communities are in Norwich.



The SAMHI is a composite annual measure of population mental health for each Lower Super Output Area (LSOA) in England. The SAMHI combines data on mental health from multiple sources (NHS-Mental health-related hospital attendances, Prescribing data – Antidepressants, QOF - depression, and DWP - Incapacity benefit and Employment support allowance for mental illness) into a single index.

<https://pldr-uk.github.io/SAMHI/index.html>

<https://pldr.org/dataset/2noyv/small-area-mental-health-index-samhi>

The role of the Norwich Place

As a local system, we work together to drive the integration of health and care services with a focus on:

- Effective operational delivery
- Delivering care closer to home
- Improving health outcomes
- Reducing inequalities
- Optimising the use of finite resources
- Developing Primary Care Networks (PCNs)
- Supporting General Practice Resilience







A Brief Overview from Norwich Place

Parker Rachael
22/11/2024 15:17:52

Norwich Place All Age Mental Health Strategy Group

- We have a well-established and well-attended PCN strategy group that meets regularly and brings together CYP and Adult Mental Health commissioners, service providers and GPs
- This ensures that we take a “whole life approach” locally and that we collaborate to deliver the best possible outcomes with the finite resources available



Parker Rachael
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Norwich Health and Wellbeing Partnership Strategic Themes 2023-25

1. Mental health and social isolation – developing a long-term preventative approach to improved mental health and reduced social isolation across targeted populations: Men (16 years and over), C&YP, Older People, Inclusion Health Groups

2023-25 strategic priorities:

1. Hearing community voices
2. Improving community access to support and activities

Reducing health inequalities

Physical and mental health and wellbeing

2023-25 strategic priorities:

1. Mental health and social isolation in targeted populations
2. Physical Activity to improve health and wellbeing

Community resilience and voice

Social and economic wellbeing

2023-25 strategic priorities:

1. Food equity
2. Social mobility

- Place based collaboration using agreed frameworks such as RITA, Core20Plus
- Asset-based, community-led approach
- Focus on upstream primary prevention and tackling the wider social determinants of health
- Effective alignment with and reporting and communication routes between the HWP and each aspect of the ICS
- Make every contact count

Complex Health & Enhanced Social Support



CHES (Complex Health and Enhanced Social Support) is an initiative launched in Norwich in September 2022, aimed at reducing the need for residential care. Funded by Better Care Funding, CHES aims to support people on the Norwich Social Care holding list and those who have experienced a crisis and need additional support. The service is primarily provided by Age UK Norwich, but it collaborates with other organisations like Community Matrons, Case Managers, INTERACT, and ICCs/Community FICS to provide comprehensive care.



"Thank you for everything you have done. I did not leave the house for three years before I met you and now, I go to the weekly coffee morning. I feel like a new woman. Thank you!"



Norwich Health & Wellbeing Partnership



The Pitstop and INTERACT

Funded project April 2023 - 2025



The Menscraft PITSTOP programme has teamed up with the local agency INTERACT to match volunteers with clients who need help with their gardens to create spaces that will benefit their health and wellbeing. This project supports both volunteer and client and aims to have completed 12 referrals by April 25. The project has been funded by the Norwich health and wellbeing partnership with the following impacts reported based on data collected so far. 28 volunteers have engaged.

- 90% report improved wellbeing through a reduction in social isolation
- 80% report improvement in purpose and motivation
- 70% report feeling better connected and engaged with their community
- 60% will make an active ongoing contribution to their community

Testimonials from volunteers Jason and Sue.....

"We both thoroughly enjoyed working a team and it was great to chat with others"

"It was so good to see the end result and the achievement from start to finish"

"We loved being outdoors, felt the benefits of the outside and that definitely helped with our mental health"

53%

had improved mood



ALL TO PLAY FOR

APRIL 2023 - MARCH 2024



ALL TO PLAY FOR

Mental health football sessions for men



ALL TO PLAY FOR

APRIL 2023 - MARCH 2024

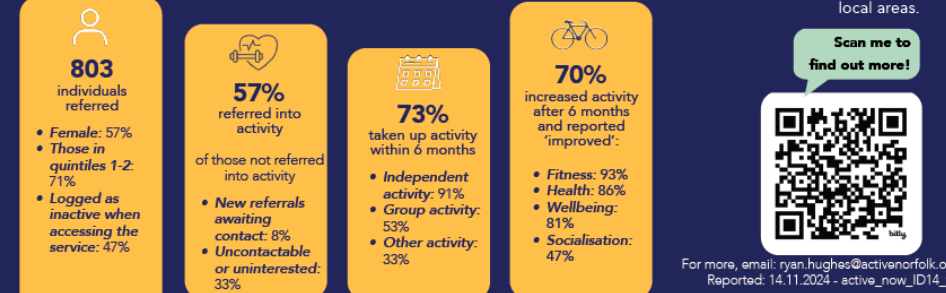
activeNoW

Supporting physical activity in Norfolk and Waveney

NORWICH: RESULTS AND KEY OBJECTIVES

In the future, Active NoW will:

- Support the movement to embed physical activity into the health and care system and preventative approaches.
- Act as the single point of referral into physical activity for adults within all frontline workforces across Norfolk and Waveney.
- Become embedded in all relevant health and social care pathways.
- Support the development of high quality physical activity opportunities for adults that reduce inequalities in local areas.



Scan me to find out more!



For more, email: ryan.hughes@activenorfolk.org
Reported: 14.11.2024 - active_now_ID14_v1



Primary Care Mental Health

- Establishment and facilitation of regular meetings between PCN Clinical Directors, GPs and NSFT Clinical Leaders
- Supports relationship building and provides an ongoing dialogue between Provider and Practices
- Opportunity to discuss operational issues, challenges and agree solutions
- Clinical collaboration to drive service development and quality improvement

Clinical Liaison



One Patient – One Team

Primary Care Mental Health

- **8/11/24** – Joint development session at the King's Centre in Norwich
- Attended by Mental Health Practitioners (NSFT) and Enhanced Recovery Workers (MIND) from across the 3 central Norfolk Places
- Focus on:
 - Clarity on roles and remits
 - Relationship Building
 - MDT working for better patient outcomes

Introducing...



Tea @ 3

Connect, Communicate, Collaborate

Parker Rachael
22/11/2024 15:17:52

- our local networking initiative for frontline staff started in March 2023
- encourages workforce integration and collaboration
- hosted in local community spaces to foster deeper connections with the populations we serve
- brief service overviews and speed updates with plenty of opportunity to meet and mingle
- thematic conversations around the specific health and wellbeing needs of our Norwich population
- Supporting staff wellbeing by helping to rebuild local relationships impacted by high levels of demand, remote working and COVID-19
- **Focus on Mental Health at our session on 17.7.24 with presentations from Menscraft, MIND and about Creative Health**

“The best reason to step out of the office this month”

Interested and want to know more?

Email us at nwicb.teaat3@nhs.net or scan the QR code

Parker Rachael
22/11/2024 15:17:52



Connecting for Healthier Communities

Local Authority, alongside Health and Social Care organisations uniting for better outcomes for people.



BUILDING CONNECTIONS
Dedicated time for networking, Bi-monthly in person sessions with meaningful interactions, leading to smoother transitions and better patient outcomes

SHARE BEST PRACTICES
By sharing successful approaches, partners can learn from each other, leading to continuous improvement

EMPOWERED COMMUNITIES
Broadening the scope of collaboration with partners, bringing diverse perspectives to the conversation

info : nwicb.teaat3@nhs.net



Addressing the wider determinants of Wellbeing



INTERACT - CTF funded multi-agency service providing support for people whose health and/or wellbeing is negatively impacted by their housing or home environment



Safe Habitable Homes – HWP CRF funded pilot to support people who are living with long-term **hoarding and/or self-neglect**

Find out more at the January Patient and Communities Committee...

Thank you
For listening

Any
questions...?

Parker Rachael
22/11/2024 15:17:52



Agenda item: 07

Subject:	Norfolk and Waveney Community Voices
Presented by:	Shelley Ames, Head of Health Inequalities & VCSE Partnering
Prepared by:	Amrita Kulkarni, Senior Programme Manager Community Voices
Submitted to:	Patients and Communities Committee
Date:	25 November 2024

Purpose of paper:

To update the Patients and Communities Committee on Community Voices programme progress, the successfully completed

- Lowestoft Healthy Hearts project and
- Children and Young People's Asthma project

Gain endorsement for the project priorities identified for 2025-26

Executive Summary:

Community Voices programme continues to develop and has successfully delivered 10 projects to date. The aim of the programme is listening to those communities who we know experience disparities and may not engage with the NHS, to better understand their experiences and opinions on a range of health topics.

Parker Rachael
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Projects- updated

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

CV has generated c.£800k external investment for Voices

2024-25 ➤➤➤	CV 11	CV 12	CV 13	CV 14
	Women's Health	Targeted Lung Health Checks	QEH- Migrant population	West Place Expansion
	Systemwide	GY&W	West Norfolk	West Norfolk

Key

- Area/Remit
- Completed
- Underway
- Potential

PMO-020 ICS Power Point TEMPLATE v2.1 August 2022

Table above:
 Top row- CV pilot number
 Middle row- CV project title and topic
 Bottom row- Area of focus

The ICB has recently completed CV6 and CV10 projects utilising trusted communicators equipped with training and resources to support conversations regarding asthma in children and young people (CV6) and healthy hearts (CV10). The insights gained were recorded on the Community Voices Insight bank.

CV6 Children and Young People’s Asthma Project Update

This project had 10 organisations involved in its delivery, VCSE groups and physical activity providers, to conduct asthma conversations with children, young people, and their families in Norwich and Great Yarmouth. The project aimed to raise awareness of asthma signs and symptoms, enhance asthma management, and inform children and young people where to seek support. A total of 229 conversations were recorded and analysed in the Community Voices insight bank.

Key themes from Insights:

The project demonstrated the value of trusted communicators in connecting children, young people, and families to relevant resources and support through:

- Signposting to GP surgeries for medical and relevant guidance related to asthma.
- Providing information on asthma management plans and facilitating their implementation.
- Offering access to asthma-related training and education.
- Sharing information and support on wider determinants of health such housing concerns like damp and mould, which can exacerbate asthma.

Parker Rachael
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Evaluation Findings and Recommendations

The evaluation and case studies from the project, available [here](#), highlighted the following key recommendations:

- **Address Environmental and Housing Conditions:** Emphasise the influence of poor housing and environmental factors on asthma management and target interventions that address these wider determinants of health.
- **Awareness on Asthma Prevalence:** Tackle the gap between perceived and actual asthma prevalence by enhancing awareness, leading to improved diagnosis and management.
- **Empower Families and C&YP:** Foster confidence among children, young people, and their families to seek timely support and better manage their asthma.
- **Leverage Trusted Communicators:** Continue to use trusted communicators to guide children and families to relevant resources, while helping organisations gain deeper insight into available local support services.

The ICB Children and Young People's team is currently reviewing the outcomes of this initiative in the context of the national asthma bundle (plan from NHS England to improve asthma care for children and young people), using the gathered insights to shape future work.

On 8th November 2024, a facilitated session brought together the CYP team and participating organisations to discuss findings and next steps.

CV10 Lowestoft Healthy Hearts Project (to be presented at the Committee)

The two-year Healthy Hearts programme in Lowestoft is focused on addressing health inequalities, specifically targeting cardiovascular disease (CVD) risk factors, with a primary emphasis on hypertension.

With a budget of £140k plus additional system partner contributions, the initiative aims to:

- Reduce CVD-related morbidity and mortality in disadvantaged communities.
- Improve hypertension diagnosis and management.
- Reduce healthcare access barriers.
- Empower residents to adopt healthier behaviours.

The programme followed a phased approach:

- Community Voices (Engagement)
- Lowestoft Healthy Hearts (Implementation)
- Lowestoft Healthy Hearts (Maintenance and Evaluation)

Community Voices: Trusted communicators from 5 VCSE groups were trained to have healthy hearts conversations. A total of 98 (reaching a total of 219 people) group and individual conversations were recorded in the insight bank.

The insights gathered were analysed using a theoretical model (COM-B) that explains how behaviour is influenced by 3 factors- Capability Opportunity Motivation.

Parker, Richard
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Key themes

The analysis highlighted some key barriers and enablers

- Physical barriers such as limited mobility, chronic pain, perceived age-related limitations, lack of access to GPs, and expensive healthy foods.
- Psychological barriers like lack of awareness about diet's role in heart health, disbelief in lifestyle impacts, family history leading to fatalistic attitudes, and reluctance to change habits (e.g. smoking).
- Social barriers such as dislike of GP visits and past experiences of feeling judged about weight.
- Automatic barriers like low motivation, feeling overwhelmed by other responsibilities (e.g. family or home conditions).
- Reflective barriers of influence of peer behaviour, other priorities like cost of living, and overcoming inertia to exercise.

The enablers to maintaining a healthy lifestyle included personal health concerns, being in a caregiving role for a family member, access to physical activity such as walks, social support and family influence, outlook and motivation and reflective behaviours and habits 'some wanted to be healthy so they could be around longer for their grandchildren'.

Implementation using insights

The insights gathered and its thematic analysis led to Community Voices influencing the next steps of the programme including the planning and implementing interventions, showcasing the importance of community feedback in shaping health initiatives.

As part of the programme's Prevent-Detect-Protect framework, several interventions influenced directly by Community Voices were planned. These include a hypertension media campaign, the Feel Good Suffolk Advisor, and health check stations, all aimed at detecting and protecting against cardiovascular risks.

Ripple Effect Mapping of Community Voices

The Evidence and Evaluation hub conducted a ripple effect mapping and analysis of the impacts of the programme which demonstrates the success of the programme.



CV evaluation
report (final version)

Full report

Mutual Learning and Enhanced Knowledge: The programme facilitated two-way learning between trusted communicators and marginalised communities on topics such as health screening, smoking cessation, and research engagement, boosting understanding on both sides.

Building Trust and Community Relationships: By establishing trust, the programme enabled deeper engagement, empowering individuals to take responsibility for their health and helping VCSE organisations to strengthen relationships and adopt a more holistic view of health and wellbeing.

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Sustained Collaboration and System Impact: The programme fostered stronger collaborations across the integrated care system and highlighted the need for continuous funding to maintain engagement, refine the trusted communicator model, and drive long-term health outcomes for our core20plus populations.

Future Projects

A review of the Community Voices business case has been carried out and a reduced financial ask has been re-submitted through the ICB prioritisation process.

For 2025-26 three priorities have been identified to proactively engage with our core20plus population groups on (with further scoping required for each project area)

- primary care transformation linked with the national NHS engagement
- CVD-R project
- Children and Young people’s project (neurodevelopmental disorders)

and continue building on the Women’s Health project (through internal income generation)

Report

Please refer to the presentation included below.

Recommendation to the Committee:

To note the progress and successful delivery of the Children and Young People’s asthma project and the Lowestoft Healthy Hearts projects.

Support the Community Voices project priorities identified for 2025-26.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	N/A
Legal:	N/A
Information Governance:	N/A

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Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	Audit Committee for information.
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Improving lives **together**

Norfolk and Waveney Integrated Care System

Community Voices update

Shelley Ames, Head of Health Inequalities & VCSE Partnering

Healthy Hearts (Lowestoft) project

Steve Gray, Place Programme Lead (Suffolk County Council)

Alison Matthews, Senior JSNA Researcher (Suffolk County Council)

Children and Young People's Asthma (Great Yarmouth and Norwich) project

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Informed by “Community Voices”

Parker Rachael
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Programme overview

- A two-year programme working with partners across the system aiming to address health inequalities in Lowestoft.
- Focus: cardiovascular disease (CVD) risk factors – hypertension
- Funding: £140k plus system partner contributions (funding and in-kind)
- Anticipated outcomes
 - Reduce morbidity and mortality from cardiovascular disease in our most deprived communities.
 - Increase the diagnosis of hypertension
 - Optimise hypertension management.
 - Reduce barriers to accessing healthcare
 - Empower Lowestoft residents to make healthy behaviour choices which have an impact on heart health
- Phased approach
 - Community Voices (engagement)
 - Lowestoft Healthy Hearts (implementation)
 - Lowestoft Healthy Hearts (maintenance and evaluation)

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Community Voices



Using your feedback to improve care



SUFFOLK
Community
Foundation

**Disability
Advice**
North East Suffolk
Free, Impartial & Confidential



The Local Conversation In
Kirkley



Here for young people
Here for communities
Here for you



**HOME
START**
In Suffolk

Aim of Community Voices



Listen: hold conversations with communities that experience significantly health inequalities about their experiences and what matters to them



Respond: in cases where conversations result in specific queries about health and wellbeing support, provide high quality advice, guidance and information that promotes health and wellbeing



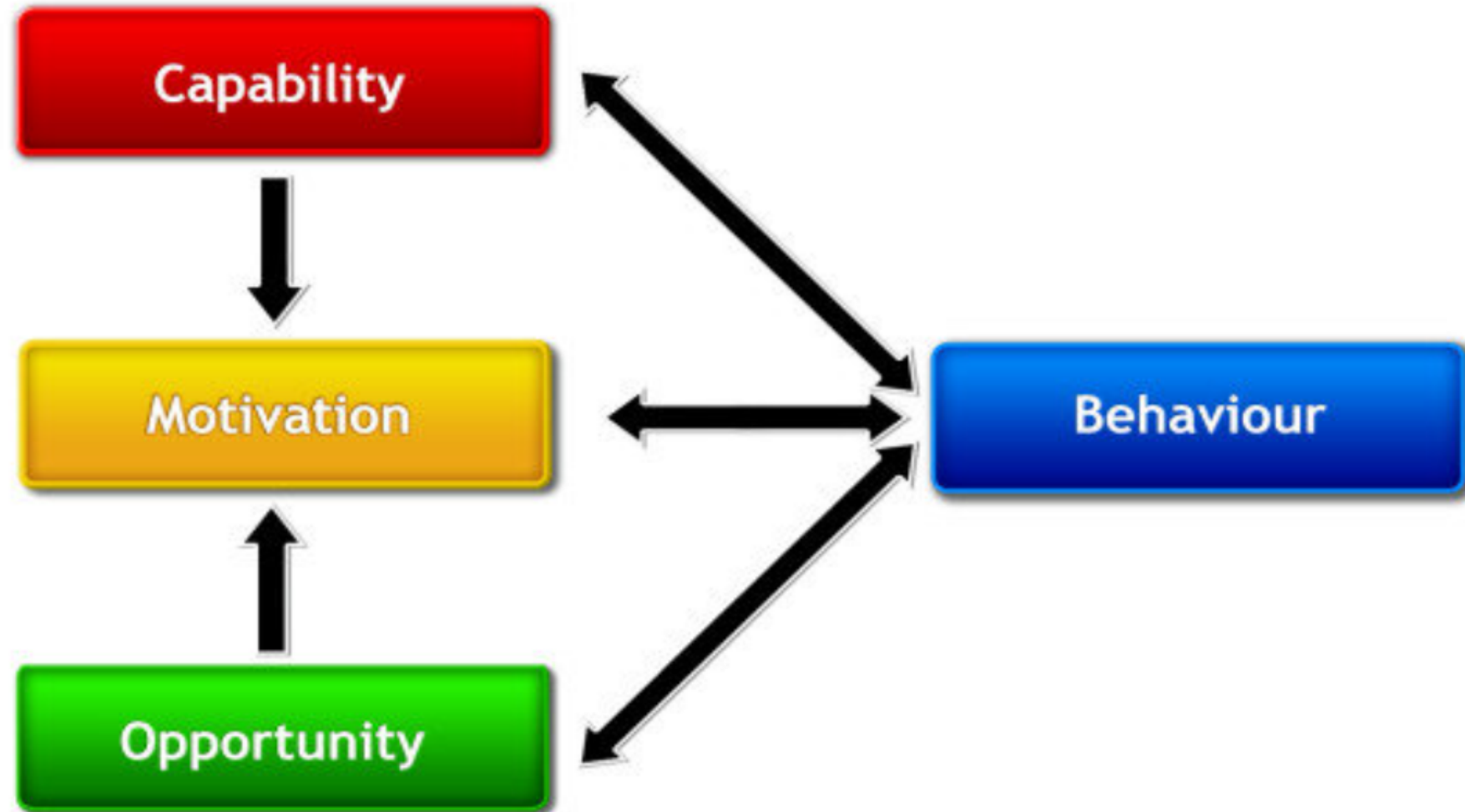
Capture: record insights from the conversations that help build a picture about health and wellbeing within a place or community



Amplify: utilise the data captured to identify key themes / issues / opportunities that can be shared across the Integrated Care System to help shape service delivery and decision making

- Face to face engagement with residents in a range of community hubs across the town, working with VCFSE organisations.
- Understand what is important to Lowestoft residents
- Gauge understanding of CVD and its risk factors
- Understand “health(y) behaviours”
- Gain insight to inform the design of a LHH programme

Community Voices analysis using the COM-B Behaviour Change model



Parker Rachael
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Capability - summary

Capability	Physical (physical skill, strength, stamina)	Do they have the physical capacity and skills needed for the behaviour? Are they able to overcome any physical limitations they might have?
	Psychological (knowledge, interpersonal skills, cognition)	Do they know that the behaviour needs to change? Do they know what achieving this requires? Do they fully understand why it is important? Are they likely to remember to do the behaviour? Can they focus?

Barriers

Physical

- limited mobility or wheelchair user, long-term conditions such as back or joint pain
- Perceived – “felt her age was a big issue”, “ unable to walk any distance without stopping for rest”

Psychological

- Some people didn't know diet was important for heart health
- Not believing the link between heart health and lifestyle
- History of heart disease in the family and a feeling that if it happens it happens and that there isn't much they can do about it
- The person is aware of her heart health, but in conversation kept saying "but I'm still here" as a reason for not taking action such as giving up smoking
- He said that as he has no problems he doesn't need to do anything
- None specific other than he feels that at his age (84) he doesn't need to take special measures to improve his heart health

Enablers

Psychological:

- Many people knew the importance of heart health, and the need for exercise and good diet
- Some older people had started think more about heart heath and their health in general. They had cut down on fatty food and were thinking more around their drinking. The younger members hadn't thought about it and seemed to indicate a stoke was more of a worry for them
- Anxiety about own health after seeing serious deterioration in sister's health.
- “He is very mindful of his own health and well-being as he is at times her carer.”
- Wants to live life to the full
- **“Being overweight for most their life prevented them from being active or confident to go to new places, or speak to strangers about how to lose weight. But one day they just knew they had to do something as nobody else could do it for them.”**

Updated with data up to 14 August 2024

Opportunity - summary

Barriers

Physical

- Not being able to get appointments at GP
- “Healthy” food is (too) expensive and foodbanks have long-life / less healthy food
- Some would only use monitors in a private space or at GP practice
- Some saw rural areas as “isolated from services”
- Concerned that as resources have been withdrawn he may have difficulty accessing services - was not able to be specific
- Difficulty is accessing GP appointments and perceived GP attitude that older people don't need the level of health support as younger folk do

Social

- She does not like visiting the GP
- **“Before losing the weight they hadn't given any information a second thought (only how annoying medical staff are when talking to people that are over weight - always just felt judged). Since losing the weight they feel much healthier and determined to keep up with eating healthier so they can enjoy life more.”**
(same interview as previous page)

Opportunity	Physical (location, space, time)	Do they have the time to do the behaviour? Do they have the financial resources? Do they have the material support required? Do they have easy access? Are there competing tasks and time constraints?
	Social (peer-pressure, social norms, culture, credible models)	Are social influences likely to facilitate or hinder the behaviour (e.g. peers, social/group norms, managers, other professional groups, service users, carers, relatives)? Do they have the social support required Do they have people around them doing it?

Enablers

Physical

- Most respondents (where recorded) would use blood pressure monitors / health checks in community spaces
- Some saw rural areas as offering “easy access for walks”
- He has been able to find a gym (in Gt. Yarmouth) where he can exercise and swim

Social

- A very caring and supportive family / Support from family who are very vigilant to her health and well-being
- Felt it would be a good idea to offer free Gym membership to retirees
- To improve their heart health. Joining walking groups and seated exercise classes they felt would be a social event as well. Some don't get out much
- Having good family and social relationships and the sharing of roles within the family e.g. in terms of cooking and housework, therefore removing stress
- She and her husband both enjoy exercise and good diet to keep their hearts healthy
- Supporting his wife

Updated with data up to 14 August 2024

Motivation - summary

Motivation	Automatic (emotions, habits, urges)	<p>Is doing the behaviour likely to evoke an emotional response?</p> <p>Can they be led to develop a habit of doing it ?</p> <p>Do they need to find a way of avoiding or coping with cravings and urges?</p> <p>Are they likely to feel bad or good if they do or don't do the behaviour?</p>
	Reflective (beliefs, identity, plans, cost & benefit analysis)	<p>Do they feel that they want or need it enough?</p> <p>Are there other things they want to do or achieve that might interfere with the behaviour?</p> <p>Do they see the behaviour as normal and commonplace?</p> <p>Do they have effective plans for doing it?</p> <p>Is doing the behaviour compatible or in conflict with the person's identity?</p>

Barriers

Automatic

- Lack of motivation / getting out of the house / low mood
- None specific other than he feels that at his age (84) he doesn't need to take special measures to improve his heart health
- Mum didn't engage in the topic and said she felt she would be healthier once she had managed to get on top of her home conditions and in a better routine with the children
- Often wondered about participating in the Saturday morning Lowestoft 'park run' but has not been sufficiently motivated yet

Reflective

- Peer pressure, examples of family/friends who lived longer despite smoking / weight / heart problems, "more important issues" (such as cost of living or housing)
- He didn't do anything to cause the heart attack and therefore can't prevent a further one
- "Overcoming inertia" is the biggest barrier to taking up swimming and cycling again, but he has other distractions at present

Enablers

Automatic

- Having a positive outlook, well-motivated, doing the best for yourself
- Although she is advised to rest for much of the day because of the leg ulcer, she chooses to be up - either sitting in the lounge talking to other residents or walking around the garden. She said she likes to be as active as possible, within the limitations of her disabilities

Reflective

- Peer pressure, group activities, thinking of family (setting a good example, or wanting to have quality time with them)
- This person used to snack loads in the evenings but has now cut that out as he knows it's bad for him
- Very proud to have given up smoking for good
- Some wanted to be healthy so they could be around longer for their grandchildren
- He has close relationship with teenage sons and wants to be there for them

Updated with data up to 14 August 2024

The Interventions..



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High level overview

Underpinned by Community Voices

PREVENT

- Hypertension media campaign and resources
- **Feel Good Suffolk Advisors (behaviour change support & signposting)**
- Self help resources
- Health check screening in the community

DETECT

- Public health detection campaigns
- **SiSU health check machine**
- NHS Health Checks
- *@Home blood pressure monitors*
- *Community Pharmacy Hypertension Case Finding Scheme*
- *Primary care system code cleansing (Interface Clinical Services)*
- Primary care hypertension training/education on protocol/pathway (wider workforce included)

PROTECT

- Lowestoft PCN patient texts for @home BP monitoring
- **ExpertCare medicine optimisation reviews**



Patient pathway

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Blue writing = core LHH interventions

Community Voices Influence - SiSU Health Check Station

- Most respondents (where recorded) would use blood pressure monitors / health checks in community spaces
 - Allows people to monitor changes
- Addresses perceived barriers
- No appointment needed – don't have to go to GP
 - People can choose when to use the station to fit into their routine
 - Visible resource showing investment
 - Not necessary to engage with health professionals (addresses fear of judgment)



Lowestoft Library



First six weeks of SiSU Health Checks



1 health station location(s)

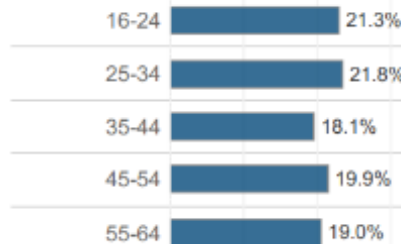
302 health checks

245
participants



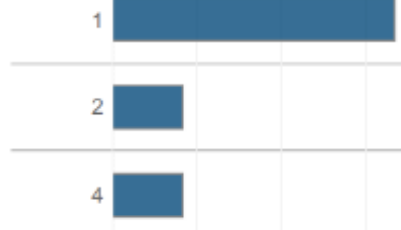
Median Age

42



Median Socio Economic Index (quintile)

2



10.4% of participants recorded high blood pressure ($\geq 140/90$ mmHg).



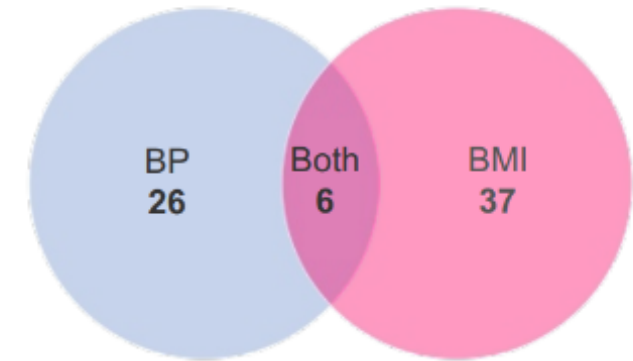
64.5% of participants were overweight or obese (BMI ≥ 25).



17.8% of participants stated that they are smokers



69 health checks triggered a **GP call-to-action** for high BP ($\geq 140/90$ mmHg) and/or high BMI (≥ 35).



137 participants had not received a blood pressure check in the previous 12 months.

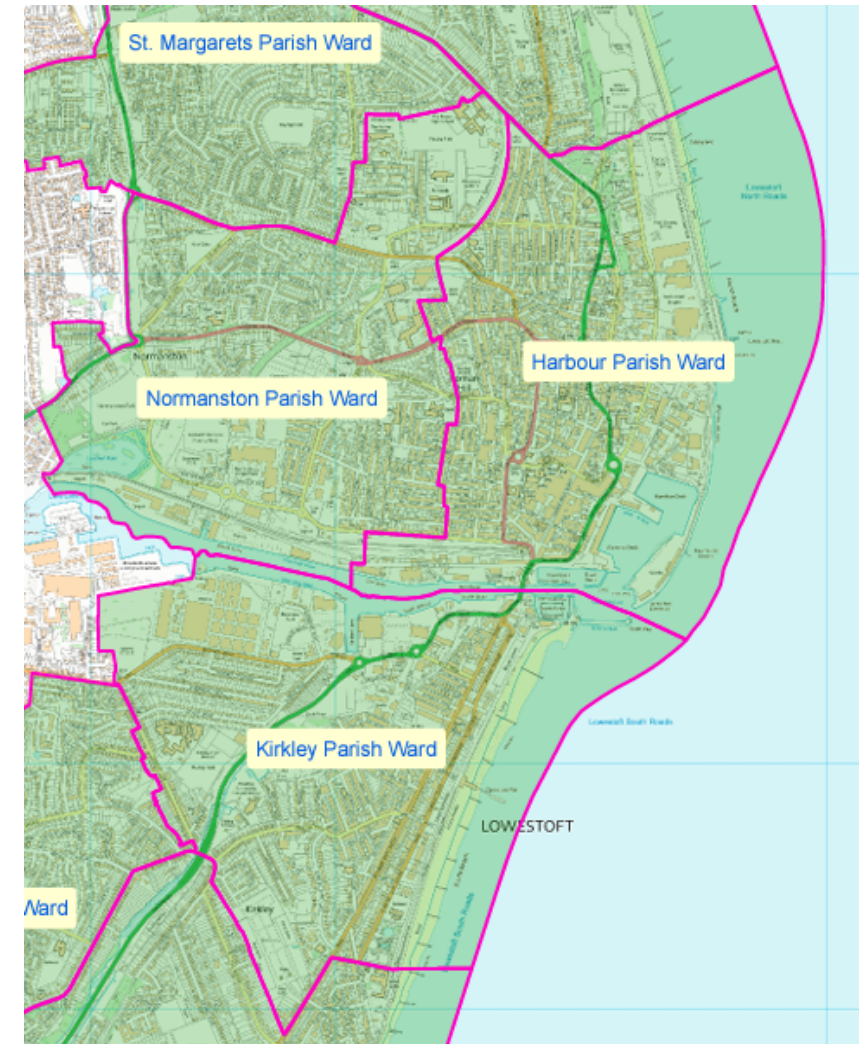
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Community Voices Influence – Feel Good Suffolk Advisor (Healthy Hearts)

FGS (Behaviour Change) Advisor with a Heart Health remit working across the Normanston, Harbour and Kirkley wards in Lowestoft.

- New FGS Advisor will link back to CV feedback to work with individuals and communities. At the same time expanding on the CV insight.
- Community Heart Health Hubs
- BP Checks - **supporting those who prefer to speak to a professional**
- Onward referrals - Including local community groups – **value of the social side of improving their health**
- Health Coaching
- Link into the **Feel Good Suffolk** services offer – Stop Smoking, Be Active, and Healthy Weight

<https://feelgoodsuffolk.co.uk/>

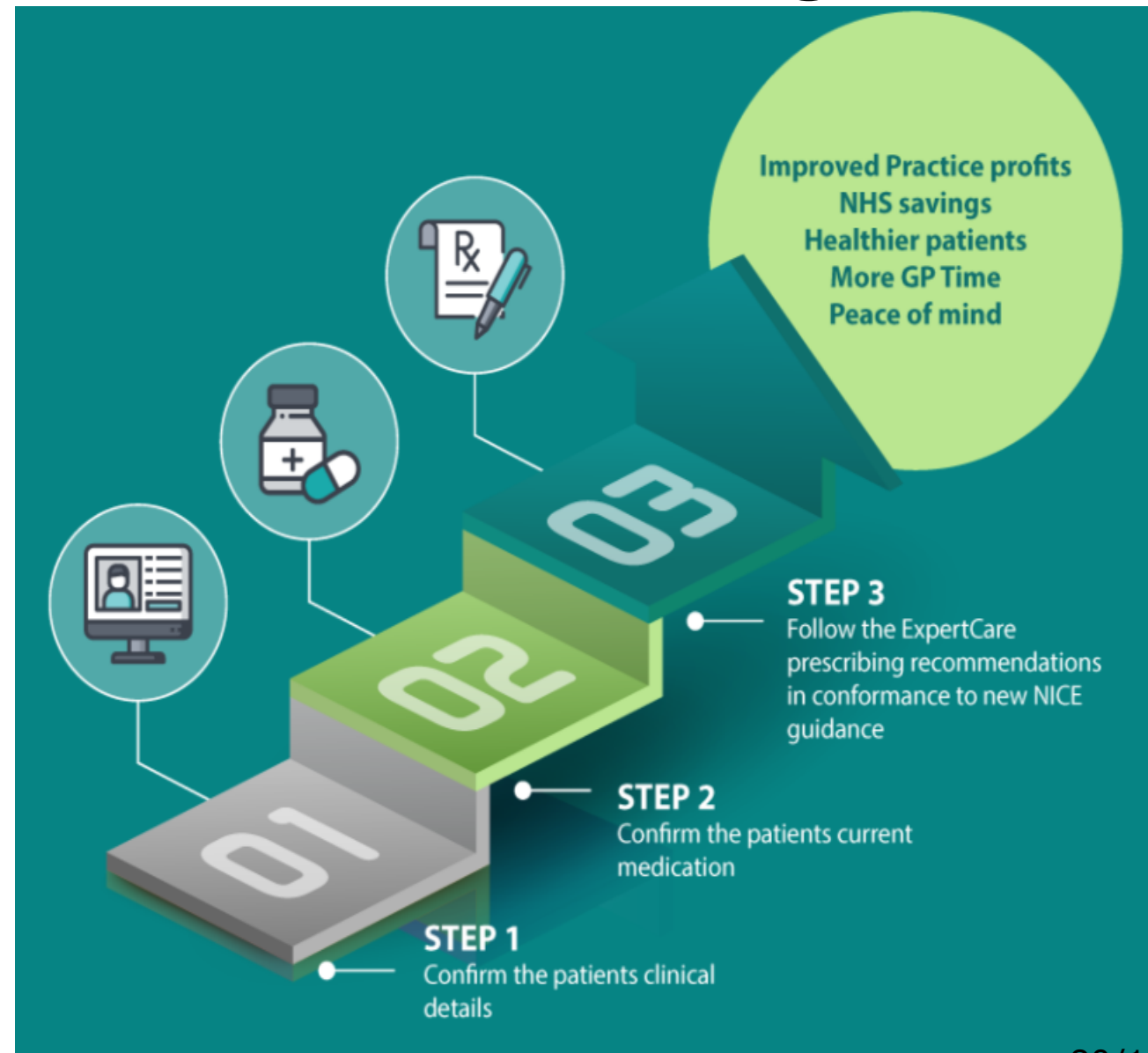


ExpertCare: The Hypertension Prescribing Solution

ExpertCare is a medicines optimisation tool which promotes adherence with NICE guidelines on the management of Hypertension and its comorbidities.

Using coded patient data from clinical systems, ExpertCare requires 3 simple steps to achieve NICE compliance for every hypertensive patient.

- Reduces GP time spent on hypertension consultations
- Contributes to a significant reduction in heart attacks and strokes



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Community Voices Influence – Communications

Wrap around communications campaign reflecting Community Voices feedback:

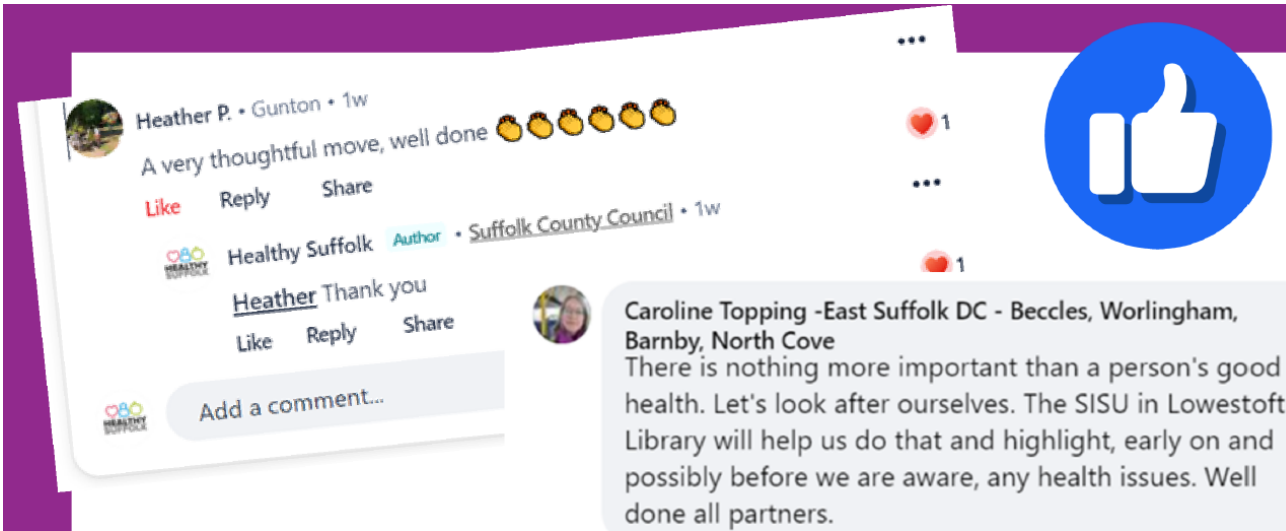
- Educate/ inform
- Encourage/ motivate
- Raise awareness
- Local knowledge = Health Checks/ BP Check
- Briefings

What we did first

1. Creating a distinct campaign identity
2. Understanding the audience and tailoring the approach



Campaign hub and paid vs organic promotion



Visit the dedicated Healthy Hearts campaign page at www.healthysuffolk.org.uk/healthyhearts



BBC

Lowestoft library machine offers free blood pressure checks

New machine set up as part of a drive to treat more people with undiagnosed high blood pressure.



East Anglian Daily Times

New healthy hearts campaign 'could ultimately save your life'

People in Lowestoft are being urged to get their blood pressure checked as part of a new campaign.



[Healthy Hearts - Healthy Suffolk](http://www.healthysuffolk.org.uk/healthyhearts)

Thank you!

If you would like more information on Lowestoft Healthy Hearts, please contact me:

steve.gray@suffolk.gov.uk

Or you could visit our Healthy Suffolk Website for more information on Heart Health



Parker Rachael
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Children and Young People's Asthma- Core20Connectors Project

Aim: to engage children and young people and their families in conversations about their awareness, knowledge and experience of asthma.

Ten organisations were commissioned

through Norfolk Community Foundation



- Community Sports Foundation
- Action Community Enterprises CIC
- Shrublands
- Great Yarmouth and Gorleston Young Carers
- Norwich Puppet Theatre

through Active Norfolk



- Premier Education
- East Norfolk Sixth Form
- ESKA (Eastern Shotokan Karate Association)
- Hoopstars
- Pav Funball Academy

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Insights

Conversations between trusted communicators and children, young people and their families were recorded on the Community Voices Insight Bank.



229 conversations recorded

39 group + 190 individual

Age groups of C&YP spoken to:

61% → 0-15 yrs

16% → 16-24 yrs

23% → 25+ yrs

Actions taken by trusted communicators as a result of the conversation

21.3% signposted to information about housing issues such as damp and mould



30.6% signposted to information about asthma management and how to get a plan in place



21.3% accessing asthma training



40% other, included signposting to GP surgery



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Key findings

General Awareness and Symptom Recognition

Children, young people, and families generally showed awareness of asthma, but their ability to identify symptoms or recognize their severity was inconsistent.

Confidence and Strategy for Management

There was a general confidence in managing asthma, with the main strategy being seeking medical support.

Barriers and Solutions

Key barriers included lack of support in schools, insufficient information, attitudinal challenges, and limited medical support.

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Process evaluation

- Positive experience of the application and onboarding process for Community Voices
- The importance of establishing rapport in **setting up a conversation** was noted.
- Conversations, resources, and methods were **adapted** according to children and young people's ages
- Different approaches to **selecting** children and young people (and their families)
- Trusted communicators found **conducting** the conversations a positive experience.
- Every organisation said they felt **supported** during and after training.
- The **learning** identified by organisations involved increased knowledge about asthma, and better understanding of the children and young people they support including how to engage them in meaningful conversations. Positive impacts on organisational practice were also mentioned.
- **Recording and submitting** conversations to the Insight Bank was straightforward for most people.

Every organisation said they would like to be involved in future projects

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Recommendations and next steps

- **Address Wider Determinants of Health:** The impact of factors like poor housing on health outcomes. The role of the trusted communicators in directing families to housing support based on their discussions.
- **Improve Asthma Diagnosis Awareness:** Clarifying the difference between perceived and actual asthma prevalence to address issues around diagnosis.
- **Enhance Confidence and Knowledge:** Focus on improving both confidence and knowledge among children and young people and their families to encourage seeking support, addressing ongoing challenges in this area.
- **Strengthen Signposting and Resource Mapping:** The key role trusted communicators play in signposting, with the added benefit of helping organisations better understand local resources available for support.

Full evaluation report and case studies- <https://improvinglivesnw.org.uk/get-involved/community-voices/>

For further details contact Amrita Kulkarni, Community Voices- amrita.kulkarni@nhs.net



Norfolk and Waveney ICB

H2 planning and winter preparation 2024/25

Parker Rachael
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Introduction

The NHS remains in a period of pressure around urgent and emergency care (UEC) and planned care provision. Alongside continued delivery of existing priorities, such as elective care including for those who have experienced a longer wait for treatment, the NHS is focussed on delivering year two of the UEC Care Recovery Plan (part of a submitted annual operating planning). As we enter the second half of the year the focus remains on:

- Delivering a 30min response for category 2 ambulance patients.
- Delivering an emergency department standard of 78% of patients being admitted, transferred or discharged within 4hrs of arrival, with a stretch to 80%.

Although H2 and winter is not an emergency or considered an unusual event, it is recognised as a period of increased pressure due to demand both in the complexity of people's needs and the capacity demands it places on resources within health, social care, and the wider Integrated Care System (ICS). Collaborative preparation and sharing of learning between partners is key to ensuring our population are best supported when pressures arise.

NHS England (NHSE) have also set national expectations for the winter period (16th September 2024) that will have ramifications for NHS organisations and wider ICS partners, in both the planning and delivery of support. These cover:

- Providing safe care over winter.
- Supporting people to stay well.
- Maintaining safety and patient experience.
- Using evidence based practice.

Social Care – Winter Overview

Publication of national expectations on social care during winter, by the Department of Health and Social Care (DHSC), was received on 17th September 2024. The letter outlines short-term priorities for the winter period, including:

- A 'home first' approach to support independence for as long as possible.
- A focus on ensuring high-quality care.
- Involvement of people receiving care and their families and carers.

The Association of Directors of Adult Social Services (ADASS) have emphasised the importance of care at home, intermediate care and information and advice this winter – with a focus on prevention of admission to hospital or residential care as a means of reducing pressures across health and social.

ASSD has developed a winter framework, building on previous years successful approaches. This framework reflects the following increasing priorities:

- Additional focus on intermediate care – given its vital importance to supporting people to remain at home, and return home after crisis, during winter.
- Managing demand and capacity within limited resource.
- Prioritising proactive intervention to support people to remain independent in winter.

With these refinements, the key strategic priorities for ASSD winter framework are:

- Meeting people's needs (to remain at, or return to, home).
- Resilient communities.
- Supporting our workforce, and
- Working together in winter conditions.

NWICB Context

For the NHS, and wider ICS partners involved in urgent and emergency care, delivery plans over the last 12 months have been developed to support this winter, leading to alternative access to healthcare, and alternatives to the emergency department if hospital care is required. Planning has also looked to increase capacity for patients on discharge pathways.

Three key areas of winter planning are in place

- 9 winter focus areas
- UEC Board Priorities
- 10 high impact interventions

For the NHS, the strategic focus is on responding to demand for UEC. Actions are designed to support safety and quality of patient care, with aim to get the right care, to the right patient at the right time, through various access points.

UEC Board priorities - Across Norfolk and Waveney, system partners have worked to meet national standards, to support patient care. The focus has enabled an improvement within our ambulance response times and our emergency department performance. It is recognised that these interim targets are still subject to variation with the focus on medium- and longer-term transformation to support sustainable change. The experience within 2024/25 to date has been one of fluctuation demand patterns on urgent and emergency care, especially at our emergency departments.

The areas of focus for the delivery of winter cover build upon existing workstreams and direction set by the Urgent and Emergency Care Board, across three domains:

- Deterioration/accident
- In-hospital
- Recovery and rehabilitation

Operational Delivery

- Focus on annual operating planning – what we said we would do and has anything changed.
- Continue with the UECRP (urgent and emergency care recovery plan) year 2;
 - ED 4hr performance
 - C2 performance including response to respond at 45mins
- Continue with the High Impact Interventions (Top 10) and the maturity matrices
- Support admissions avoidance and discharge activities being key
- SURGE and Demand approaches to support –revised OPEL
- Vaccination, Vaccination and Vaccination
- Wide system engagement, awareness and involvement
- Risk identification and mitigations
- Focus on building and enhancing rather than plan to utilise new monies.

Demand and Capacity - overview

- From annual operating plan submission our providers submitted data returns covering activity, capacity and assumptions. There was a submission linked to mental health.

Assumptions	Acute LOS	G&A Beds	Occupancy	Escalation Beds	NCTR
JPUH	7.1	470	95.10%	16	80
NNUH	6.9	973	99.30%	12	62
QEH	8.4	460	99.40%	0	73

- The annual planning guidance did not require triangulation with primary care.
- These were triangulated with workforce and finance returns.
- In reviewing half 2 compared to the submitted plan the following is noted:
 - The financial position of the system has deteriorated requiring further actions.
 - Workforce plans and triangulation require continued monitoring for delivery.
 - Activity is subject to variation in type (presentation of UEC) in minors.
 - The patients with NCTR is higher at this point than originally planned
 - The physical bed base has reduced in line with improvement programmes
 - Occupancy is higher than the operating plan

Winter Plan

Enhancing
care

Developing
Services

Connecting
Care

Prevention

Reducing
Length of Stay

Continuous
Improvement

Identifying
Capacity

System
Oversight and
Resilience

UEC alliance
workstreams

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Winter Plan – Outline Workstreams

- Enhancing Care
 - GP streaming
 - Pharmacy First
 - WIC
 - 111/OOH
- Developing Services
 - SDEC
 - UCCH
- UEC Alliance Workstream
 - D2A
 - Models of care
- Connecting Care
 - Care Homes
 - Older People and VW
 - Process improvement
- Reducing LOS
 - Increasing capacity
 - Process review
 - Improved outcomes
 - Pathway movement
- Prevention
 - Vaccinations – staff and community
- Improvement
 - Tier 2 regional support
 - Rapid Improvement Offer at JPUH
- Capacity
 - Waterfall chart linked to beds
 - Are there things we could stop doing to create capacity.
 - MH
- System oversight and escalation
 - Provider plans
 - System Control Centre
 - OPEL escalation
 - Ambulance 45min handover
 - Discharge focus event
 - Interprofessional standards
 - Temporary Escalation Space Oversight
- Risks
- Communication – public and professional

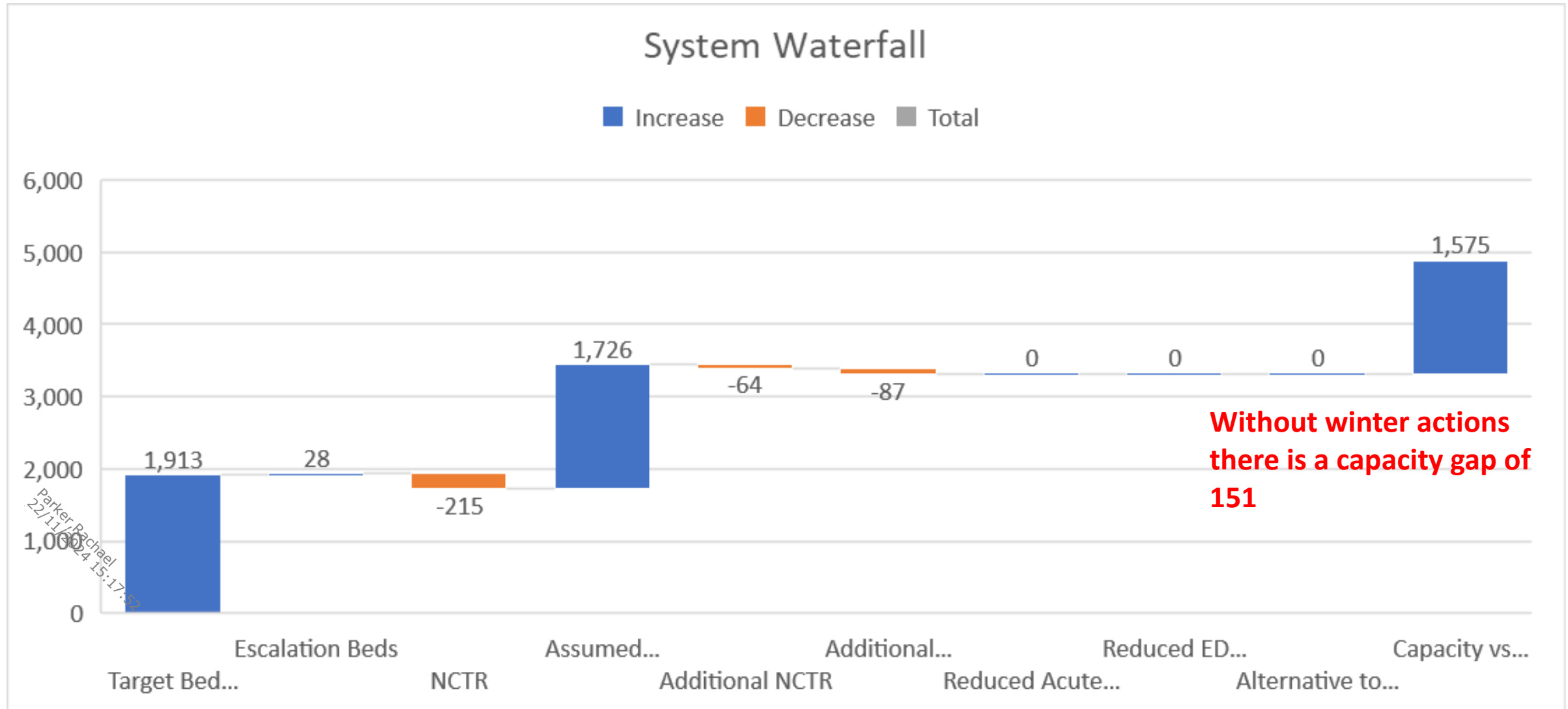
Key winter deliverables to support flow

The following areas are designed to support capacity:

- Internal provider actions aimed at front door, processes and discharge,
- Developing the frailty offer through integrating VW and care homes and 999 through the UCCH,
- Delivery of UCCH against MVP and enhancing further for winter with support of EEAST of extending hours and rapid triage,
- Maximise the opportunity within GP streaming across acute sites.
- Further development of Medical SDEC and frailty across our three acutes
- Reducing LOS in Acute across medical wards and where possible surgery,
- Reducing LOS in Community Intermediate care and delivery of the bed plan

System Capacity – 'Waterfall'

Awaiting Mitigation Action Inclusion and Provider Validation



System Actions

- Reducing length of stay across community and acute providers to support increased flow.
- Increase capacity through mobilisation of bed plan across community and mental health care Trusts.
- Focus support and care for people within care/residential homes using UCCH and VW to provide care closer to their home.
- Work with EEAST to effectively support alternative care to patients triaged as category two (segmentation).
- Expand UCCH hours of operation and facility to hold patients until services are available
- Support process and capacity improvement across D2A pathway 1 and 3

High Levels Risks

- In addition to system and provider strategic UEC risk the following have emerged:
 - There is no mobilisation of separate acute respiratory infection hub for this period, patients may present through existing care, increasing demand.
 - Occupancy levels remains high, resulting in over 96% occupancy through this period, resulting in further escalation mitigations being deployed.
 - Elements of the annual operating planning assumptions are not being met contributing to higher occupancy level and process challenges impacting flow.
 - Risk of impact through collective action remains during this period.
 - Operational pressure impacts sustainable improvement programmes across all providers, this increases further for providers who have additional support.

Patricia Rachael
22/11/2024 13:52

Leading Winter

- System Control Centre – supporting operational delivery daily across the system.
- Meeting cascade established at tactical level with ability to increase to gold.
- Senior Operational Delivery Group – weekly meeting with providers across the system to focus on learning and operational delivery.
- Infection Prevention and Control – meetings held three times per week across the system with ICS team.
- The revised OPEL framework is being implemented with associated actions.

Parker Rachael
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Escalation Space

- Throughout periods of pressure a range of actions, aligned to OPEL actions are considered for enactment based around risk balance.
- One of the immediate actions (within 60mins) to support patient flow and community risk is the use of full capacity or escalation policies.
- To create continued capacity full capacity principles are utilised.
- Under extremis, and within the guidance of NHSE, the use of temporary escalation space may be considered against the level of risk in the community and Urgent/Emergency Care Pathway.

Parker, Michael
22/09/2024 15:17:52

Festive Period

- Between the 20th December to the 6th January - remains a pressurised period due to holidays, annual leave and demand variation.
- There is a lived experience of other services not being available or fully functioning creating additional/risk pressure with regards to patient flow.
- Provider planning will look at appropriate services and associated staffing for this period.
- Focus on UEC throughout this period covering:
 - 111/OOH and UCCH
 - EEAST ambulance cover
 - ED flow
 - Discharge activity
 - EPPR – cold and adverse weather
 - IP&C

Agenda item: 10

Subject:	Population Health & Inequalities (PH&I) Board – 15/10/2024 – Assurance & Escalation Report
Presented by:	Dr Frankie Swords, Executive Medical Director
Prepared by:	Dr Frankie Swords, Executive Medical Director
Submitted to:	N&W ICB Patients and Communities Committee
Date:	25 November 2024

Purpose of paper:

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

Executive Summary:

The Population Health & Inequalities Board (PH&I) Board meets bi monthly and was last held on Tuesday 15 October 2024. The report details points of assurance and escalation as well as a high-level risk overview summary.

Report

Please find attached document.

Recommendation to the Committee:

To note the contents of the report.

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

Parker Rachael
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	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:	<ol style="list-style-type: none"> 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 01 (Previously BAF 06)

Governance

Process/Committee approval with date(s) (as appropriate)	
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Parker Rachael
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Population Health & Inequalities (PH&I) Board - Points of Assurance / Escalation [15/10/2024]

Item No.	Meeting Name	Date of meeting where item was first 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
34.	PH&I Board	20/08/2024	ICS PHM Strategy & HI Framework for Action Implementation Plans	Update: Implementation plans agreed. Ongoing oversight , governance & reporting of PHM HI & VCSE programmes agreed.	N/A	N/A	For assurance	
19.	PH&I Board	20/02/2024	PHM software procurement	Update: Provider selected subject to contract signing. To be announced via Regional Procurement Hub once signed.	N/A	PHMI09	For assurance	
33.	PH&I Board	18/06/2024	Equality Health Impact Assessments	Update: The ICB EHIA process now launched.	N/A	HI06	For assurance	
43.	PH&I Board	15/10/2024	New chair of the Norfolk & Waveney VCSE Health & Social Care Assembly	Tim Gardiner (TG) appointed as the new chair. External announcement made. Will join this group	N/A	N/A	For assurance	
44.	PH&I Board	15/10/2024	HI training developed, cohort 3 NHSE CORE20 ambassadors applications received	HI and inclusion health training event for Primary Care (including POD) planned. Strong interest in next cohort NHSE Core 20 Ambassadors awaiting regional decision	N/A	N/A	For assurance	
45.	PH&I Board	15/10/2024	Volunteering for Health - £540k successful bid	Aimed at embedding volunteering to improve health & well-being & supporting health & care work opportunities for Core 20 population.	N/A	N/A	For assurance	
46.	PH&I Board	15/10/2024	ICS Conference 16/10/2024	Health Inequalities Strategic Framework for action agenda item, launch of HI commitments as well as the launch of the Advocate Network & self-assessment programme.	N/A	N/A	For assurance	
47.	PH&I Board	15/10/2024	'ICS – Population Insights' - 'Norfolk & Waveney Registered Population Explorer'	PHM reporting & infrastructure noted. Actions taken to promote usage and raise awareness during commissioning As well as collaboration with the research & innovation team to ensure alignment with their evidence-based commissioning paper	N/A	N/A	For escalation to raise awareness	

Part 1 Rachael
24/11/2024 15:17:52

Programme Risks as of 15/10/2024 – PH&I Board

The PHM & HI September 2024 risk registers were reviewed at this meeting.

The overarching BAF01 (previously BAG06) PHM & HI risk, was updated and continues to score at 12.

The PHM team reported 1 risks (as the previous 'PHMI09 Procurement of PHM System – Lack of ICB Resource' risk was closed due to the procurement exercise being finalised) , no new risks were added, no risks scored above 15.

- 'PHMI18 Lack of allocated PHM Budget. Impacting PHM projects and Protect NoW VST team' increased from a risk score of 8 to 10. After further review , and recommendation by the PHMOG, it was agreed to increase the risk scoring as it was felt that the income generation from Cambridgeshire & Peterborough VST support project was not enough of a risk mitigation

The HI team reported 7 risks, no new risks were added.

1 risk scored above 15:

- 'HI05 No HI ring fencing of NHSE funding allocations' remains at a risk score of 16. This was previously escalated to the Patient & Communities Committee and continues to be an escalation.

2 risks reduced:

- 'HI04 Risk of not delivering against NHSE directives e.g. Core20plus5 health inequalities improvement framework for adults and CYP, anchor institutions' reduced from a risk score of 9 to 6. Reduced due to governance/structure developments and establishment of HIOG working groups.
- 'HI06 No PMO process for Equality Impact Assessments (EIAs)' reduced from a risk score of 6 to 4. Reduced due to implementation of process.

4 risk scores remain the same:

- 'HI01 Not completing HI Strategy as per JFP ambition/objective' risk score 1 (risk will be archived following risk register update)
- 'HI02 Incomplete data picture for health inequalities' risk score 6.
- HI03 Lack of coordination of HI workstreams' reduced risk score 6.
- 'HI07 Lack of Place resources to support HI strategy development & implementation' risk score 12.

The PHM & HI team met with the ICB's governance team to complete a full review of the PHM & HI Risk register and to ensure alignment with new groups terms of reference & governance. A meeting is scheduled with Dr Frankie Swords & Mark Burgis to progress this.

2024/10/15 15:17:52
Rachael

Agenda item: 11

Subject:	VCSE Assembly Update
Presented by:	Tim Gardiner, VCSE Assembly Chair Shelley Ames, Head of Health Inequalities & VCSE Partnering
Prepared by:	Shelley Ames, Head of Health Inequalities & VCSE Partnering
Submitted to:	N&W ICB Patients and Communities Committee
Date:	25 November 2024

Purpose of paper:

Assurance, information and updates

Executive Summary:

A new Chair of the VCSE Assembly was appointed in September 2024, Tim Gardiner. Tim will lead the VCSE Assembly into the implementation of a new model for delivery, including the development of a robust communications strategy to further the engagement with the wider VCSE sector and Integrated Care System.

A work programme for the Assembly is in development, working alongside the new Health Inequalities & VCSE Partnering team in the ICB, as well as colleagues in Norfolk County Council and the wider ICS. This work programme will complement and align with the VCSE integration work programme for the ICB, which is overseen by the Patient & Communities Committee.

VCSE Assembly Board members have met informally, with a full relaunch planned in January 2025 following a thorough induction of the new Chair.

Further discussions that support the continued integration of the VCSE sector into our ICS have been held, including a Forging Integration Roundtable event hosted by members of the VCSE Assembly Board. This useful space for discussion supported identification of the key challenges and generated commitment to a system approach to supporting integration that methodology used to create the Health Inequalities Strategic Framework for Action.

Parkers
 22/11/2024 17:52

Report

The VCSE Assembly model has been extensively reviewed during 2024, with a new model developed and agreed by the ICB and current Assembly Board in summer 2024.

A work programme for the VCSE Assembly has been in development since the inception of the Health Inequalities & VCSE Partnering team in July 2024, with key deliverables determined.

The attached highlight report (appendix 1) provides a summary of progress for each of the key identified actions. Highlights include:

- The appointment of a new VCSE Assembly Chair, Tim Gardiner, as the previous Chair, Emma Ratzer, had reached the end of her term.
- Tim was appointed via a multi-agency panel chaired by Patricia Hewitt and commenced his appointment in October 2024.
- The Health Inequalities & VCSE team have been working with Tim to review the current arrangements for the Assembly – how the model works, communications with the wider sector, and how statutory partners can request support within governance structures. A clear understanding of finances, portfolio holder role descriptions, vacancies and future comms requirements has been developed.

The Integrated Care Board, working alongside partners across the Integrated Care System, are developing a VCSE Integration work programme, which the Assembly will support to develop and implement. A copy of this and the developing actions is attached (appendix 2).

The VCSE Assembly Board has met informally to discuss the emerging approach, notes of which are attached (appendix 3).

In addition, members of the VCSE Assembly hosted a VCSE Roundtable: Forging Integration event in October 2024 which was attended by senior leaders from across the ICS. This event discussed the barriers, challenges and potential solutions to support further integration of the VCSE sector into the ICS. A summary of the Roundtable discussions is included (appendix 4) and a number of next step actions were identified:

- To gain a better understanding of ourselves (VCSE and Statutory) to enable us to explore how both parties work better together
- To establish a task group to drive this piece of work forwards
- A commitment to develop a shared plan
- Identify a shared challenge to focus on - to enact some change to create some momentum
- To develop a values charter/MOU and embed across the system - learning from best practice
- A commitment to utilising existing structures e.g. driving forward the Assembly
- To create more spaces for future gazing/horizon scanning

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Recommendation to the Committee:

For information only

Parker Rachael
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Appendix 1:

VCSE Assembly Progress Report As at November 2024

Parker Rachael
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Programme	VCSE Assembly	SRO	Mark Burgis, Exec Director Patient & Communities	Overall Prog RAG
		Programme Lead/s	Philippa Gregory, Senior Programme Manager HI & VCSE Partnering Shelley Ames, Head of HI & VCSE Partnering	
		VCSE Assembly Chair	Tim Gardiner	

What have we achieved since last report (time period)	Key Programme Milestones (for this time period)
<ul style="list-style-type: none"> Agreed Assembly road map and action plan for next 3 years Appointment of new VCSE Assembly Chair – consensus across agencies Informal Assembly Board meeting Sector Roundtable event with system leaders 	<ul style="list-style-type: none"> Appointment of VCSE Assembly Chair
Activities planned for next reporting period	
<ul style="list-style-type: none"> Induction of new Assembly Chair Agree TOR for Assembly and promote to partners to build understanding Relaunch of Assembly – Jan 2024 Development of Assembly work programme 	

Key Programme Risks (Description)	Mitigation Action	Issues to be escalated	RAG
Assembly progress – pace of change	Dedicated capacity from HI & VCSE Partnering team – needs to align with new Chair appointment.		AMBER
Sector instability – impact on ability to engage	State of the sector reports to build understanding of sector landscape.		AMBER

Decisions to be made/ escalated to board

Project Ref	Project Title	Key project milestones (with dates)	Progress / Comments / Escalation	Key project risks (with mitigation actions / support requested)	Project Lead	Planned Comp	Current RAG
VCSE11	Chair recruitment	<ul style="list-style-type: none"> Appointment of new Chair from Oct 24 Induction plan - Oct 24 	<ul style="list-style-type: none"> Appointment process concluded and position offered and accepted Previous Chair vacated position on 30/9/24 	<ul style="list-style-type: none"> Induction plan for Chair – key introductions and governance support 	SA	Oct 24	GREEN
VCSE12	Terms of Reference	<ul style="list-style-type: none"> Review TOR with new Chair & Assembly Board – Nov 24 Agreed TOR – Jan 2025 	<ul style="list-style-type: none"> TOR have been scoped via agreed Road Map, need to be formalised and accepted by board. 	<ul style="list-style-type: none"> Communication of TOR – understanding of Assembly role and function across system. 	SA/PG	Nov 24	GREEN
VCSE13	Portfolio vacancies and EOIs	<ul style="list-style-type: none"> Develop JDs and EOI process for current vacancies - Comms lead, Creative Health, Research & Innovation – Nov 24 Appointment of new leads – Mar 2025 			SA	Jan 25	AMBER
VCSE14	Governance request process	<ul style="list-style-type: none"> Develop Assembly governance representation process – Nov 24 Agree with Board - Dec 24 Promotion of process – Jan 25 		<ul style="list-style-type: none"> 'Asks' of Assembly Chair time (only 3-4 days per month appointment, requests need to be shared across Assembly). Resource/capacity limitations 	SA		GREEN
VCSE15	Finance & remuneration policy	<ul style="list-style-type: none"> Review remuneration policy for meeting attendance and annual budget – Jan 2025 Explore integrated approach with Empowering Communities (Norfolk County Council) 			SA		GREEN
VCSE16	Action plan	<ul style="list-style-type: none"> Agree Assembly outcomes/areas of focus for 2025/26 – Jan 2025 Include MOU refresh & comms plan development 	<ul style="list-style-type: none"> Action plans to include MOU refresh 		SA		GREEN

Parker Remuneration
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VCSE Assembly Programme Summary Headline Scope & Exception Reporting DD Mon Year

Project Ref	Project Title	Key project milestones (with dates)	Progress / Comments / Escalation	Key project risks (with mitigation actions / support requested)	Project Lead	Planned Comp	Current RAG
VCSE17	Comms plan	<ul style="list-style-type: none"> Development of communications plan – Dec 2024 Formal relaunch of Assembly – Feb 2025 			SA		AMBER
VCSE18	Sector events	<ul style="list-style-type: none"> Sector and statutory leader round table planning (prescribing prevention) – Oct 24 Prescribing prevention round table – Oct 24 Discussions with Empowering Communities around alignment of VCSE Leaders events with Assembly – Nov 24 		<ul style="list-style-type: none"> Statutory partner engagement 	SA		AMBER

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Appendix 2

VCSE Integration Work Programme Progress Report As at November 2024

Parker Rachael
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Programme	VCSE Integration	SRO	Mark Burgis, Exec Director Patient & Communities	Overall Prog RAG
		Programme Lead/s	Philippa Gregory, Senior Programme Manager HI & VCSE Partnering Shelley Ames, Head of HI & VCSE Partnering	
		VCSE Assembly Chair	Tim Gardiner	

What have we achieved since last report (time period)	Key Programme Milestones (for this time period)
<ul style="list-style-type: none"> Ongoing discussions with ICB teams around VCSE partnering practices and experiences Ongoing State of the Sector report mapping – building understanding of existing activity Attended a recent VCSE Roundtable: Forging Integration First VCSE Assembly meeting with new Chair 	<ul style="list-style-type: none"> Re-launch of the VCSE Assembly with new Chair
Activities planned for next reporting period	
<ul style="list-style-type: none"> State of the sector report communication Ongoing VCSE strategy groups to provide oversight and assurance Scoping of VCSE commissioning piece with NCC 	

Key Programme Risks (Description)	Mitigation Action	Issues to be escalated	RAG
Organisational and system buy in			AMBER
Sector stability and ability to collaborate			AMBER

Decisions to be made/ escalated to board

Project Ref	Project Title	Key project milestones (with dates)	Progress / Comments / Escalation	Key project risks (with mitigation actions / support requested)	Project Lead	Planned Comp	Current RAG
VCSE21	Governance arrangements	<ul style="list-style-type: none"> ICB VCSE Strategy Group scoping meeting – Sep 24 Development of work programmes – Oct 24 Agree TOR and establish regular meetings to provide oversight to work programmes – Nov 24 	<ul style="list-style-type: none"> Since the kick off session, individual conversations have been taking place with ICB teams to explore how they partner with the VCSE sector Outputs to be discussed at follow up meeting, as well as discussions at a recent VCSE Roundtable and VCSE Assembly meeting. 	<ul style="list-style-type: none"> Organisational buy in – this is mitigated to a certain extent by alignment with the Health Inequalities Framework. 	PG/SA	Nov 24	GREEN
VCSE22	VCSE State of the Sector	<ul style="list-style-type: none"> Working with Place teams support development of VCSE 'State of the Sector' reports – tbc Consolidate local findings with system work undertaken via Empowering Communities - TBC 	<ul style="list-style-type: none"> Empowering Communities are in the process of producing a report from their recent 'State of the Sector' survey A similar, but more Place focussed, piece of work is being commissioned by North and West Norfolk – CAN are to deliver this. Outputs from both pieces of work will be brought together. Discussions taking place around how we align all sources of insights in the system. 	<ul style="list-style-type: none"> Ensuring we reach all parts of the VCSE Sector – support has been offered by both the VCSE Assembly and Empowering Communities to utilise their networks. Similar asks have been made of Place colleagues. 	PG	Feb 25	GREEN
VCSE23	VCSE Commissioning Strategy	<ul style="list-style-type: none"> Revisit initial ASC work for VCSE Commissioning Strategy – Nov 25 Codesign phase with sector – Jan 25 Commissioning principles to ICP – Jun 25 			TBC		N/S
VCSE 24	VCSE Partnering MOU	<ul style="list-style-type: none"> Refresh and relaunch of VCSE Partnering MOU with VCSE Assembly – Apr 2025 	<ul style="list-style-type: none"> Discussed at Roundtable event, appetite to develop a system MOU and integration action plan 		TBC		N/S

Parker Rachael
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Improving lives **together**

Norfolk and Waveney Integrated Care System

VCSE Roundtable: Forging Integration

Parker Rachael
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Setting the Scene: Forging Integration

This Roundtable event, organised by Age UK Norwich and Citizens Advice Norfolk (CAB) and supported by the Norfolk and Waveney VCSE Assembly, was an opportunity to explore how we work collaboratively to '*realise prevention through sustainable investment and partnerships*'. The event was attended by a range of statutory partners (including Norfolk County Council, the Integrated Care Board and acute and community colleagues), as well as representation from the VCSE sector. The aim for the session was to agree a set of resolutions that will drive VCSE integration and enable the *Joint Health & Wellbeing Strategy* - specifically tackling the following objectives:

1. Embed the VCSE sector as an equal partner within our ICS, through our VCSE Assembly
2. Work together to drive change, support prevention and tackle health inequalities
3. Support and enable a thriving VCSE sector to play its part
4. Build strong, inclusive and empowering relationships through our partnership.

Vision, Values and Principles

To set the scene, colleagues talked through the vision, values and principles that have been collaboratively developed over the past couple of years.

Vision



Our ICS VCSE Integration Programme Vision

Our vision is a vibrant and thriving VCSE sector, embedded within the Integrated Care System and collaborating on strategic ambitions, that drives health and wellbeing in our communities in a way that is inclusive and empowering.

Parker Rachael
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Values and Principles

This work will be driven by some core values and principles:



Values and Principles

- The VCSE sector is **a part of our Integrated Care System**
- We will all work together with mutual respect, recognising that we have shared values and principles to improve the health and wellbeing of our communities.
- We will all work to promote open and honest communication, using common language, recognising that transparency builds stronger, trusted relationships
- We will all work collaboratively ensuring that strategic planning and genuine co-design is prioritised



A Perspective from the Integrated Care Board (ICB)

Statutory partners were asked to talk through some of their ambitions for working with the VCSE sector, as well as identifying the challenges and what we need to overcome these. ICB colleagues set out a series of key areas where they would like to influence change:

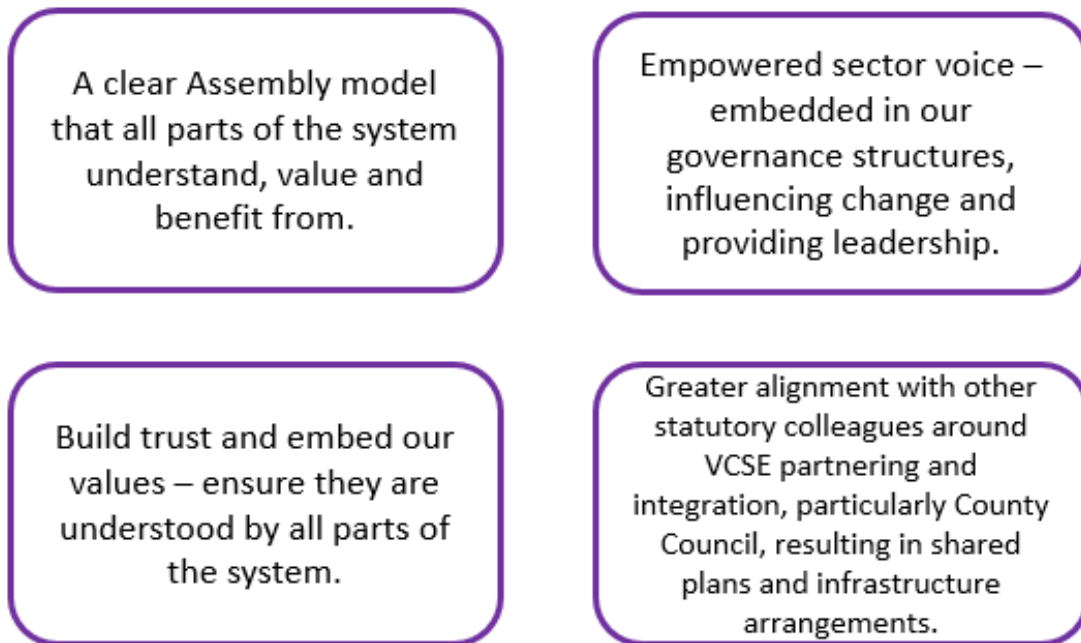
What do we want to change?

- **Ambition:** We want to develop a shared ambition for VCSE partnering in the future, alongside our other statutory colleagues.
- **Voice:** The lack of representation, equality, power and voice of the VCSE sector in our Integrated Care System.
- **Culture:** Understanding the role and importance of the VCSE sector, as well as the challenges they face, to support stronger partnering in the future (and vice-versa).
- **Processes:** We recognise our current ways of working impact on our ability to be good partners with the sector - we need to improve these where we can.
- **Resource alignment:** We need to get better at using our existing assets and resources, particularly when it comes to VCSE commissioning.
- **Capacity:** We are building capacity in our organisation to support better partnering in the future.
- **Alignment:** With other parts of the system, particularly other statutory colleagues
- **Whole system working:** The ICB can act as a convenor to the system, but we need the whole system to recognise its role and work together.

Vision

Colleagues emphasised that the ICB's vision for VCSE Integration is very much in line with the co-designed ICS VCSE Integration vision as noted on page 3.

In terms of immediate goals, 4 key areas were set out as achievable by **2026**:



Norfolk & Waveney ICB - VCSE Integration

To enable the ICB to partner with the VCSE sector to the best of our ability, an internal *VCSE & Volunteering Work Programme* is underway to better understand the breadth of the work taking place within the ICB, identify challenges and barriers as well as opportunities to develop practices, as well as opportunities to collaborate with other statutory partners. Moreover, it will inform the work of the *Health Inequalities & VCSE Partnering Team*.

Longer term, the intention is to work across both our organisation and the wider system to drive change to processes, culture and ways of working. To maximise our resources and impact, we will align work programmes with statutory partners and identify some key areas that we can collaborate around.

Parker Rachael
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ICB Scoping - Current Challenges

Following an initial scoping session of the Internal ICB VCSE& Volunteering Strategy Group, some key themes were identified:

Commissioning

- ICB processes can be overwhelming and resource heavy
- Procurement legislation can hinder collaboration
- Lack of flexibility and grant giving
- Do we understand what works best for the sector? Can we meet those needs currently?

Understanding the Sector

- Awareness and understanding of how the sector operates is limited across the whole organisation → leads to poor engagement with the sector
- Recognising and evidencing sector impact
- Understanding the sector isn't 'free'

System Complexity

- Complex commissioning landscape and pathways can be alienating → VCSE organisations from being competitive/excludes them entirely
- Language barriers – both ways

Sector Representation and Engagement

- Knowing how to engage with sector colleagues (communication routes, forums, ways of working)
- Understanding the role and function of the VCSE Assembly – are we using it to the best of our advantage?
- Cross VCSE sector competition and lack of homogeneity

NHS Expectations/ Requirements

- Data sharing requirements (DPST)
- Contracting
- KPI's and reporting
- Capacity

Alignment of Priorities

- Are we working closely with the sector to identify shared priorities and how we might address them?
- Understanding why our priorities differ and how we might support one another

Finances and Resources

Our financial position is meaning we are having to make tough decisions daily.
Lack of resources is a shared issue.

What do we need from the sector:

Some key 'asks' of the sector were put forwards for further exploration:

- Clear mechanisms to engage and communicate with the sector
- Greater collaboration between the sector - 'sector collaboratives'
- Nominated people that can support us with strategic planning and support/influence change (i.e. Assembly Portfolio Holders)
- Strong communications *to us* (the statutory sector) - social value, 'state of the sector', return on investment
- Collaboration *with us*
- Support in reviewing the infrastructure arrangements to reflect the challenges of health integration
- The values and behaviours piece of work both ways
- Help to identify where improvements have been made and the development of the business case for change

A useful case study of where we, as statutory partners, have been working differently with the VCSE sector can be found in the *Children and Young People's Professional Therapeutic Pathway* (see appendix 1a).

A Perspective from Norfolk County Council.

Norfolk County Council colleagues set the scene for some of the challenges afoot, noting that whilst demand will continue to grow and short term VCSE investment, such as the COMF (covid) monies have now gone, we need to consider how we do differently with less money. Colleagues from Norfolk County Council provided a summary of their thoughts, outlining some of the key opportunities:

An opportunity to change the operating model

Exploring what VCSE Infrastructure arrangements look like moving forwards

Norfolk County Council have the Communities Team in place now – how can we work closer together?

Longer-term view and to create space for innovative conversations

A change in culture – better recognising one another's pressures and opportunities

How do we better arrange ourselves moving forwards?

Case Studies.

Colleagues from Age UK Norwich and CAB presented a series of case studies demonstrating some decisions from recent years which have had an impact on the VCSE sector. Some of the key themes have been summarised below :

Commissioning

→ Closing the gap between the commissioner, provider and client e.g. shared responsibility in the mobilisation of services, stronger involvement in integration of services and decision making

Evaluation

→ Consistent approach to evaluating the success or value of a tool/service

Governance

→ How decisions are made at a Health & Wellbeing Partnership level – are we posing enough challenge?
→ Navigation of system governance

Impact of contracting/commissioning decisions on the sector

→ Short and long-term e.g. staff redundancies and knock on impact elsewhere in the system
→ Impact no inflationary uplifts has on the sector, including reputational damage for the NHS

Impact on Population

→ Loss of services
→ Reduction in capacity
→ Increasing need

Equity of Relationship – System and Sector

→ Examples where VCSE sector are not treated as equal partners
→ Role of the Assembly?

For details of each example, please see appendix 1b.

Wider discussion picked up on some additional themes and experiences from partners around the table:

- When engaging with the sector, we need to consider who we are engaging with - not all parts of the VCSE sector want to engage
- There needs to be an emphasis on understanding one another's perspectives
- Experiences of engaging with commissioners varies dependant on who you work with - this creates inconsistency in how partnerships evolve
- How can we influence jointly?
- How can VCSE organise themselves better?
 - How can we better engage with the sector?
 - An emphasis on internal work before we can work better together
- Statutory partners need to increase transparency
- The Assembly needs to be open to wider VCSE engagement - increase visibility
- We need to share power better with VCSE colleagues and increase trust
- We need to maximise on learning from elsewhere
- We need to explore how we make decisions as a system
 - Does it start within individual organisations before it is brought to the system for a system solution? or vice versa?
- The focus needs to be brought back to the needs of the population and the voices of our communities
- The role of Population Health Management and evidence-based decision making

Group Discussion.

The group split to explore the following questions:

1. **What would you recommend to accelerate integration?**
2. **What conditions or principles would enable this?**

The table below sets out a summary of the discussion:

What would you recommend to accelerate integration?

- Ensuring strong alignment with strategy and ambitions
- Longer term models/approaches
- Keeping the population at the heart of everything we do
- Do we back one thing and see how we can address it? - would require a commitment from all
- Ensuring we are looking across VCSE of all sizes
- Exploring all models/mechanisms - looking for best practice elsewhere
- A better understanding of one another at all levels (including providers)
- Looking to how we operated during covid - we are no longer in the same crisis, but we are facing significant challenges

- Amplifying existing opportunities
- Identifying which 'part' each partner can focus on so we can collectively tackle the big issues
- Exploring the social value of decisions which are made
- Parity of approach to support sustainability (equity)
- Expand the view of VCSE delivery opportunities (based on historic commissioning arrangements)
- Sector has expertise and skills
 - Need to ensure clear visibility of this
- Planning should be robust and in place
 - Underpinned by data
- Evolution of delivery at Place
 - Do we understand what Place is?
- Timescales - we need to commit to longer-term contracts and move away from short-term and extensions

What conditions or principles would enable this?

- Better join up amongst the Public sector
- A two way conversation between the VCSE and ICS
- Opening up the VCSE Assembly
- Allowing and enabling maturity of delivery
- Addressing the failure to make decisions
- Addressing double funding
- Clarity regarding governance - ICP, ICS, ICB
 - What is the framework which we're delivering in?
 - How are risks owned and managed?
 - Utilisation of ICP - are we clear about this?
 - How are things taken to the ICP? Delivery vs assurance.
- Understanding needs of VCSE partners
 - Including independent bodies with own governance
- Values - Trust, be curious, learning from others and ourselves
 - We need to trust that organisations can change as required
- Culture - the focus on transactional requirements needs to change to facilitate transformation.

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Summary and Next Steps.

As demonstrated above, both honesty and enthusiasm for change came through in the discussions. There was also a clear need for commitment to drive this change, something that was supported by all members around the table. With this in mind, the following steps were identified to enable a new way of working and change:

- To gain a better understanding of ourselves (VCSE and Statutory) to enable us to explore how both parties work better together
- To establish a task group to drive this piece of work forwards
 - A commitment to develop a shared plan
 - Identify a shared challenge to focus on - to enact some change to create some momentum
- To develop a values charter/MOU and embed across the system - learning from best practice
- A commitment to utilising existing structures
 - e.g. driving forward the Assembly
- To create more spaces for future gazing/horizon scanning

The ICB Health Inequalities & VCSE Partnering Team will support taking this work forwards, with a discussion taken to the VCSE Assembly by the Chair in due course.

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Appendix 1a.

An example of best practice: *Professional Therapeutic Pathway (Children & Young People's Team, ICB)*

Professional Therapeutic Pathway (PTP)?



- PTP is the coming together of different, quality assured therapists across Norfolk and Waveney who offer creative and talking therapies that can support people with MH & Emotional wellbeing needs.
- We identified an opportunity to 'tap into' underutilised system capacity without requiring several small contracts and commissioning arrangements.
- Organisations/Therapists sit under a 'lead provider' – currently YMCA Norfolk, who hold a spot-purchasing pot to pay for bespoke packages of care, as well as the infrastructure to support the delivery of the model – this includes, a pathway manager, a clinical lead, administrators and a small number of 'engagement practitioners' who support with identifying needs and preparing young people for therapy.
- To become a member of the PTP organisations need to sign up to the provider agreement including proof of appropriately trained/qualified therapists, adherence to the co-developed 'payment per session' framework and capturing of routine outcome measures for every child supported. Organisations only invoice the PTP for sessions completed – resulting in a cost-efficient model.
- There are over 30 PTP member organisations; sometimes these specialise in key areas that can offer us better access to support for particular needs when required.
- To date the PTP has supported over 400 CYP, many of whom have additional/complex needs meaning they have historically struggled with accessing or engaging in mainstream mental health services, and benefit from an adapted or creative approach. Outcomes for this group are incredibly positive.
- The PTP has also supported many CYP on system waiting lists – our larger commissioned providers are now flowing the PTP underspend to support with waits ensuring the finite spot purchasing pot is self-sustaining.



Appendix 1b.

Ex1: Working Well Norfolk



Prior to decision

- Four VCSE Norfolk-based consortium delivery of Chances employability support to Sep 23; NCC funded and managed
- Tender out for 18 months employability support funding; multiple bids including existing VCSE consortium and others such as MIND as well as national primes

Decision-making

- Service tendered publicly

Result

- Contract awarded
- NCC grew their management team based on this project alone

Outcome for clients

- Uncertain – service took some time to draw sufficient referrals despite the low bar to entry
- Referral from existing services delayed significantly due to change and implementation period, and due to the frustration this caused

Outcome for VCSE providers

- Most Chances providers laid off a number of advisors
- A number of Chances staff, including the former project lead, left to join the new provider
- Chances consortium organisations capability in this area almost totally degraded
- Overheads lost out of county
- VCSE provider of complementary service overlooked

Reflection / Learning:

- Tendering for an 18-month service when there are multiple Norfolk-based charities capable of delivering it seems counter-productive to place-approach
- Not linking into existing community providers, with strong links to health, suggests no consideration to system impact
- Awarding to a national provider at the loss of capacity and capability locally belies a lack of support to Norfolk charities and businesses – every commissioning, procurement and funding decision has the opportunity to strengthen or weaken the ICS, whilst NCC staffing increased

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Ex2: Commissioning

Prior to decision

Tender A opened covering two lots. Invitation opened 22/06 with deadlines for 28/07. Timelines - preferred bidder announced 22/10 with award of November – start date for lot 1 – 01/03 and Lot 2, 01/04.

Tender B opened for Provider Framework in Feb 2024 with deadline of 08/03. Services to start 24/04. Award received, with instruction of provider workshops to be scheduled.

Decision-making

- No announcement was made in October.
- Queries raised via the procurement portal, but no reply. No announcement in Nov. Commissioners contracted but instruction was given to use the portal.
- Commissioners chased in July, August for workshops. No dates given, told these were to be scheduled in due course.

Result

- January – decision was made to change the bid process and the procurement closed.
- No client referrals have been made to date. Reasons given by commissioning team was the “adjustment” needed by the team responsible for referrals.

Outcome for clients

- Clients continue to wait for statutory support, whilst community based services are likely to be beneficial in parallel or in replacement.
- Missed opportunities for early intervention or care and support closer to home. i.e. delaying strategic intent.
- Lack of trust by clients of some statutory bodies, impacting reach and impact, particularly those in HI areas and Core20+5 groups.

Outcome for VCSE providers

- Significant resources invested in tenders, with budgetary assumptions made in income/cost profiles.
- Lack of certainty around service demands/scale.
- Recruitment challenges/ loss of staff and skills in preparedness for contracts. Often we “front-load” to hit the ground running.
- Continued referrals from system by other routes, without investment.

Reflection / Learning: There is minimal large scale tender opportunities in N&W, so when they arise, these provide significant opportunity around improved models of care and support, integration, and long-term funding (which is rare). Various examples show a misalignment between statutory teams “on the ground” and commissioned services from the VCSE, with key elements lost in translation. With our population profile and challenges, we should never struggle for referrals. There is also an imbalance of VCSE being responsible for driving the cultural changes for referrals, rather than wards/practices/service teams. System commissioning is often fragmented, with duplication of existing services in VCSE and clinical leaning, at higher costs.

Ex3: Prevention / Health Coaching / GaitSmart

Prior to decision

- ICB funded Health Coaching 22/23 from “Winter Slippage”, within UEC.
- Transformational Strategy of ICB Published with Health Coaching as case study.
- Active NoW platform launched to refer into PA providers, including Coaching.
- November 23. CMO Publishes ‘Health in an Ageing Society, citing Health Coaching.
- December 23. ICB confirm funding will not be renewed.

Decision-making

- Budgetary decision related to winter-slippage only. Not clear on whether any interdependent budgets were reviewed and impact to Active NoW.
- ICB PA Steering Group administered place-funding, but very small scale. Overhead of governance was disproportionate.
- Norfolk CC extended arrangement by three months (April-June). Norfolk CC extended arrangement by 9 months (July – March 25)

Result

- No support from system partners in growing a preventative service, cited by CMO, or within own strategy.
- Various parts of the system are aware of GaitSmart and Coaching. VCSE remains the sole investor in this NICE Approved Hardware/software.
- Oct 24 – Presentation of GaitSmart at Allied Health Professionals Conference, with no reference to Age UK Norwich role.

Outcome for clients

- Reduced capacity of health coaching, vs rising demand. Increased waiting times for advice. 2-3 months+.
- Reduced capacity for Active NoW, deemed a strategic platform.
- Continued poor health and wellbeing whilst residents wait for support. Commissioners prioritising hospitals, vs community.
- Frail clients getting referred to services they can’t enact due to mobility.

Outcome for VCSE providers

- Loss of staffing, due to the uncertainty over contracts. Redundancy costs due to gaps in funding.
- Reduced economies putting whole provision at risk.
- Conflicting messages – prevention priority / lack of physios for PA.
- Leaning towards hospital model – Willow Ward et al rather than investing into community models where wider support delivered.

Reflection / Learning: Norfolk has a significant frailty and falls issue. Health Coaching/Falls Prevention/Activity Classes are recommended by NICE, the BGS Frailty Hub. The endorsement of Coaching in the N&W Strategy and then the CMO Report was a positive intention, and recently at the N&W 2024 Conference Prevention was headlined. This has not transpired into any relative investment for either the Active NoW pathway, and/or existing commissioned services i.e. Age UK Norwich. GaitSmart, Broadly Active, EPIC etc. There is a significant opportunity for falls/frailty support, and utilisation of technology to improve resident outcomes / lifestyle changes. The ownership/exploration of how this tool could improve health outcomes has been null.

Ex4: Advocacy & Specialist Support

Prior to decision

- Consortium of VCSE organisations offering advocacy and specialist support to people with protected characteristics
- Tender awarded for 3+3+3, jointly funded by - local authority and the NHS.

Decision-making

- Contract entirely managed by County Council with no representation/ feedback with NHS representatives at any time despite funding up to 28% of the contract. This prompted “late challenges”.
- County Council provided inflation increases on the Councils part of the contract, but the NHS did not match the same level.

Result

- Reporting requirements lean towards Council aims rather than ICS aims
- Real terms cut in service provision over the course of the contract
- Denies NHS valuable data on service improvement
- NHS is viewed less favourably as a commissioner than the local authority due to the disconnected relationship
- Lack of joint communication. ICS confirmed a 0.6% increase.

Outcome for clients

- Clients with Social Care related outcomes are prioritised over clients with NHS related outcomes.
- Less support due to the real terms cut; increased waiting times for advocacy. 4 – 6 months +
- Less support for Core20+5 groups, the major clients of this contract.
- Lack of NHS service improvement.

Outcome for VCSE providers

- Under-representation of the impact of VCSE on the NHS, reducing influence on services provided by the NHS, especially from user led organisations.
- The public sector expecting more for less over the course of the contract, resulting in increased services pressures, including financial and morale.

Reflection / Learning: The skills and experience of user led organisations are felt to be valued by the NHS. Preference is to lean on VCSE for steps in decision making, rather than any integration of services. This raises scepticism of ICS due to the lack of joined up working across the contract. 8 organisations now believe that the NHS does not give inflation increases in its contracts, giving rise to reputational damage to the NHS. This is heightened by health/care services that refer into VCSE without the following investment. Limited understanding of the commissioned service, advice, advocacy and support models put quality services at risk due. Many grant contracts have below inflation/ no uplifts meaning VCSE capacity reduces overall and real risk of collapse.

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Ex5: Social Prescribing in Secondary Care

Prior to decision

- Social prescribing based in primary care around the county
- Discussion regarding extending SP provision to a range of locations, without any consideration of existing provision or impact – discussion included inclusion of SP on ambulances
- Project planned without relation to any strategy
- No business case seen ahead of drive to secure funding to prescribe from NNUH

Decision-making

- Funding sought from HWPs around Norwich but unclear which committee or individual approved the project
- Project clearly agreed prior to all SP providers being engaged; at least two were not aware until late on, including Norwich
- Funding for evaluation sought from multiple funders well after the project had started.

Result

- Project started but delayed several months for data governance and process planning as this had not been factored in
- Unclear on scale and cost – not detailed in the evaluation report - but figures of £365k cost and £30k evaluation suggest a cost of £1,200pp

Outcome for clients

- Some good outcomes noted in the evaluation service, although in one case this included a £9,000 spend on taxis for one client over 34 days.

Outcome for VCSE providers

- Omitted from project decision-making and Norwich SP service seemingly forgotten about – no funding available and this was then sought from the ICB; Living Well Team provided with 6% of project budget despite servicing 24% of the referrals.
- Vast majority of funding given to new provision in councils despite existing VCSE services in place to provide service at a lower cost; VCSE sidelined and degraded
- Funded services still making onward referrals to unfunded VCSE organisations

Reflection / Learning:

- It is too easy to create projects with no business case that draw extensive funding for unsustainable practice away from strategic models.
- This service already existed in Norwich and could have been expanded, probably at no additional cost; ignorance of the existing provision is degrading us
- Many of these projects are justified by a sense of group enthusiasm that does not recognise or value challenge or criticism; they also lack rigour in management or review; evaluation presented an exceptionally narrow view of the impacts and costs, and is not recognised by VCSE partners.

Ex6: Living Well Partnership

Prior to decision

- Three years of full contract followed two years of successful short projects and pilots supporting over 5,000 clients with casework
- High performing service with excellent client outcomes and satisfaction levels
- ICB-award winning provision for individual, team and innovation in social prescribing, shortlisted for HSJ Award
- Offer of innovation and no-cost expansion
- 8 months of presentations and meetings with PCN, HWP and Place Board, including a written offer of a 12-month extension

Decision-making

- Decisions made in final fortnight of contract
- Bulk given to councils who were unprepared for delivery and unaware of staff transfer requirements
- PCN asks for 12-week extension
- 94% of contract moves to unaccredited district council outside Norwich

Result

- Award-winning casework partnership replaced by signposting provision
- PCN refused to pay the amount required by the contract
- PCN disputed invoices for reduced amount for six months
- Compounded by procurement of the JOY system believed to be expensive and lacking in a business case
- PCNs continue to make referrals LWP

Outcome for clients

- Casework provision capable of seeing 1,400 people is lost and clients only able to access signposting service from a council district in which they are not residents.
- Increased complexity for support from wider services VCSE provided "in house" with case-work i.e. befriending, coaching
- No assessment of models/ client needs/ client impact.

Outcome for VCSE providers

- 13 experienced caseworkers lost from the service
- Lead organisation lost 25% of its income and ran at risk of £250k loss – an amount capable of closing the charity
- Two partners put advisors on contract notice because of the PCN decision-making
- SP providers expecting VCSE to accept SP referrals for free; providers considering barring referrals to their services

Reflection / Learning:

- Social prescribing represents a major resource for addressing health inequalities but is not managed in a systematic or informed way, to the point it represents a barrier to community working and is degrading the capacity and value of the VCSE sector.
- Further episode in replacement of accredited, community-based VCSE services with unaccredited provision by local government and NHS services.
- VCSE organisations do not have the access to funds or the guarantee of long-term funding to be able to survive this type of decision-making.

Ex7: Responding to Health Inequalities Risk

Prior to decision

- Public Tender of NCC Advice/Advoc. awarded 04/22 for 3+3+3 years.
- Cost of living emergency declared by NCAN partners Nov. 22 due to significant jumps in demand (Post Covid & Ukraine Col).
- Risk raised via VCSE Assembly of risks to residents/health inequalities.
- ICB requested VCSE Assembly Chair for paper outlining risks and options for decision. Drafted with NCAN & sent Jan 2023.

Decision-making

- No outcome/response from ICB paper.
- Not clear on governance ownership or whether assessment was conducted to understand risks or residents or impact to Health Inequalities Programme or other ICB priorities.
- Latterly informed the paper should have gone to HWP as it was deemed their responsibility.

Result:

- Growing waiting lists.
- Connected events: Proposed reduction to advice/advocacy of £453K over two years in NCC budget (ASS007 Oct 24 Cabinet Papers) & end of 75-year core grant for Comm. advice.
- Multiple other contracts/grants at risk impacting 45,000+ clients with WDH.
- Ongoing strategic focus on Health Inequalities and Prevention, requesting VCSE input.
- WC 30/10/24 providers contacted by NCC to discuss Pension Credit Campaign.

Outcome for clients

- Reduced capacity of accredited info/advice/advocacy.
- Increased waiting times for advice. 2-3 months+
- Continued poor health and wellbeing whilst residents wait for support.
- Underutilisation of statutory support i.e. benefits, hardship funds etc
- Continued referrals to trusted VCSE brands as a trusted "front door", but with reduced ability to support.

Outcome for VCSE providers

- Proposed reduction in contract value. Loss of staffing.
- Erosion of skilled workforce. Takes 2-3 years to train an advisor.
- Increased service pressures and waiting lists for support. Referral levels continue to increase, despite this change/other reductions.
- Loss of flexibility in place-based support/models due to reduced capacity and HI.

- Reflection / Learning:** Original risk was raised ahead of the ICS Health Inequalities Strategy. As this was in the Transformational Strategy, there was an opportunity to understand the interdependency of accredited advice, advocacy and HIs. Data on system demand from the VCSE could have been used to explore the county/place demand and help influence place-based priorities for funding, and an early narrative towards the Core20+5. Lack of reply to Assembly did not embody 'equity' of relationship. Recent disclosures around cuts to funding seem regressive to a system focused on both health inequalities, prevention, and ageing well. They also have the potential to impact place-based approaches. No apparent equality impact assessment

Norfolk and Waveney VCSE Assembly

Meeting of the Norfolk and Waveney VCSE Assembly

7th November 2024, 12:00pm
Meeting to be held via Teams

Item	Agenda Item	Lead
1.	Tim's Introduction to the Assembly	TG
2.	Roundtable Event How do we keep this moving/task group	TG
3.	Keep It Local	TG
4.	Health Inequalities Self-Assessment Tool Soft launch with the Assembly	PG
5.	Governance Moving Forward	TG
6.	Any Other Business	ALL
<p>The next meeting will be held: 21st January 2025, 2pm Via Teams</p>		
<p>For any queries or agenda items, please contact: nwicb.vcseassembly@nhs.net</p>		

Summary Notes

In Attendance: Tim Gardiner (TG), Daniel Williams (DW), Mark Hitcock (MH), Dan Mobbs (DM), Amanda Garbielsen (AG), Emma Ratzer (ER), Philippa Gregory (PG)

Apologies: Ashley Bunn, Mark Burgis, Shelley Ames, Dan Skipper

1.	<ul style="list-style-type: none"> TG provided an introduction to himself in his new role as Chair. TG will look to meet with all Assembly members and statutory partners in due course. TG noted that there were no actions from the previous meeting minutes and will share the minutes for review - ACTION.
2.	<ul style="list-style-type: none"> TG gave a summary of the Roundtable event that took place on the 28th October which focussed on 'Forging Integration'. TG felt there was general support from partners in attendance (both VCSE and statutory). MH noted that the focus of the discussion was around system decision making and the wider impact this has on the sector, providing some specific examples for consideration. The aim of the session was to break new ground and to cut through

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	<p>organisational silos.</p> <ul style="list-style-type: none"> • PG is producing a write up of the session. • DM noted that we need to move to more honest conversations. • MH stated that the VCSE sector need to identify their challenges and issues and address these (as well as statutory colleagues doing the same), as well as there being a lack of understanding of the impact the sector has in the system. • TG outlined a proposal for a group to sit beneath the VCSE Assembly to drive this work forwards – to continue the conversations that took place at the Roundtable. • DM stated that we need to know where this is going, what the outcomes are as well as agreement amongst statutory colleagues as to where this work will sit and how decisions will be made i.e. how can we influence change? • PG noted that the ICB's Health Inequalities & VCSE Partnering team will be here to support this programme of work. • ACTION – share session write up for the Assembly with key points to review and discuss what the task group might look like and who might be in it. • TG noted that the portfolio model will help us structure this work, as well as the Health Inequalities governance and lens.
3.	<ul style="list-style-type: none"> • TG talked through the <i>Keep it Local</i> principles and a recent webinar which TG and PG attended. • TG asked whether this was something the group wanted to take forwards. • The Assembly would like to review the documentation and consider this – ACTION. • There was interest in what impact the framework and principles have had elsewhere and how this will fit in with our work - there is an option for someone from another ICB who has engaged with this model to come and speak to the Assembly.
4.	<ul style="list-style-type: none"> • PG presented the launch of the <i>Health Inequalities Commitments</i> and the <i>Self-Assessment</i>. There was an ask of the Assembly to support with a soft-launch of the assessment to test it out and feedback. • AG was in support as it met her organisation's priorities. • MH was also supportive and asked how we will get other organisations to complete this. The group discussed different forums and networks, as well as utilising Empowering Communities. PG also talked through the use of workshops and 1:1's to ensure a range of engagement methods. • DM was supportive but not 100% sure on the impact. PG explained that the impact won't be instant for organisations as it will feed into system planning around resources and support but organisations will be able to receive their report and maturity scoring. • ACTION – PG to share the <i>Self-Assessment</i> and associated communications for the Assembly to complete. Assembly members to also share details of any networks they have access to.
5.	<ul style="list-style-type: none"> • TG talked through governance moving forwards, including a Terms of Reference, profiles for Assembly members/ Portfolio holders as well as how colleagues across the system can request support from the Assembly. • TG also noted that we need to collate which engagement networks and forums we all have access to so we can broaden how we communicate with the system. • ACTION – PG to share link of draft support request form for review. • ACTION – TG to draft a ToR for circulation and review.

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6.	<ul style="list-style-type: none">• DW noted that of the upcoming Assembly Board dates, he cannot attend any on a Monday or Tuesday – ACTION – PG to review meeting dates.• ER noted that the ICB Board has changed the name of her role on the Board to 'Assembly Lead' – this doesn't effect the nature of the role.
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APPENDIX D

Norfolk and Waveney Integrated Care Board Patients and Communities Committee Terms of Reference

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
10 March 2023	Tweaks to the Terms of Reference following the meeting held on 23 January 2023	Paul Hemingway	1.1
13 April 2023	Tweaks to the Terms of Reference following the meeting held on 27 March 2023	Paul Hemingway	1.2
28 April 2023	Update to membership	Mark Burgis	1.3
10 May 2023	Changes made to quoracy	Mark Burgis	1.4
16 May 2023	Update to membership	Mark Burgis	1.5
19 July 2024	Tweaks to Terms of Reference following a committee development session	Mark Burgis	1.6

Approvals

This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1
30 May 2023	ICB Board		2
25 Sept 2024	ICB Board		3

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1. CONSTITUTION

The Patients and Communities Committee (“the Committee”) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

2. PURPOSE OF THE COMMITTEE

The Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that meets the needs of patients and communities, that is based on engagement and feedback from local people and groups, and that takes account of and reduces the health inequalities experienced by individuals and communities.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care.

The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

3. DELEGATED AUTHORITY

The Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

The Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

4. MEMBERSHIP AND ATTENDANCE

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than four members of the Committee, including one who is a Non-Executive Member of the Board (from the ICB). Other attendees of the Committee need not be members of the Board, but they may be.

When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Conflicts of Interest

The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

Chair and Deputy chair

If a Chair has a conflict of interest then the Deputy Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

In the event that the Chair is unable to attend a meeting, then the deputy Chair will chair the meeting or if unavailable the members will choose a Chair from amongst themselves.

Members

The Members attending Part 1 and Part 2 meetings of the Committee are as follows

- Non-Executive Member of the ICB Board (Chair)
- Non- Executive Member of the ICB Board (Deputy Chair)
- VCSE Board Member on the ICB Board
- Executive Director Patients and Communities, NHS Norfolk and Waveney ICB or nominated deputy
- Executive Medical Director, Norfolk and Waveney ICB or nominated deputy
- Executive Nursing Director, Norfolk and Waveney ICB or nominated deputy

The following are invited to attend meetings of the Committee:

- A representative from Commissioning (ICB/NCC)
- A primary care representative
- Senior Public Health Officer Norfolk County Council
- A representative from the Place Boards
- A representative from the Health and Wellbeing Partnerships
- A representative from Healthwatch Norfolk
- A representative from HealthWatch Suffolk
- Lived Experience Representatives
- Health Inequalities advisor

5 MEETING QUORACY AND DECISIONS

The Committee shall meet at least on a bi-monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

The quorum for the meeting will be a minimum of eight members including at least the Chair or Deputy Chair, and one ICB Executive Director.

Where members are unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf. For the avoidance of doubt the deputy will be counted as part of the quorum.

If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. If an urgent decision is required, the process set out below may be followed.

Decision making and voting

Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee or their nominated deputy may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

Urgent decisions

In the event that an urgent decision is required, if it is not possible for the Committee to meet virtually an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum one other member).

The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification and noted in the minutes.

6. RESPONSIBILITIES OF THE COMMITTEE

The Committee will hold a Part 1 meeting to cover system-wide issues and a Part 2 meeting to consider issues internal to the ICB or that are of a nature where it is not appropriate to discuss in a public forum e.g. sensitive patient specific detail, or contractual issues.

The responsibilities of the Committee will be authorised by the ICB Board. It is expected that the Committee will:

Complaints

- Approve the ICB's arrangements for handling complaints
- Receive regular reports about complaints received by the ICB and performance against the organisation's Complaints Policy.
- Oversee the sharing of lessons learnt from complaints received by the ICB across the organisation and the Integrated Care System.
- Provide assurance to the ICB Board regarding the organisation's performance against its Complaints Policy and processes.

Listening to, engaging and working with people and communities

- Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote the involvement of patients, their carers and representatives in decisions about their healthcare.
- Approve annual changes to the Norfolk and Waveney People and Communities Approach that sets out how the ICB and wider ICS will deliver on the system wide approach to working with people and communities in Norfolk and Waveney.
- Receive regular reports setting-out the ICB's implementation of its annual communications and engagement plan and the organisation's contribution to delivering the Integrated Care System's approach to working with people and communities in Norfolk and Waveney.
- Consider how the ICB and the Integrated Care System could improve how we listen to, engage and work with people and communities.
- Oversee the sharing of insight gained from engagement with people and communities across the ICB and the Integrated Care System.
- Provide assurance to the ICB Board regarding the effectiveness of the organisation's approach to listening to, engaging and working with people and communities.

The Patients and Communities Committee will receive and approve any substantial departure from the Norfolk and Waveney People and Communities Approach and national guidance for working with People and Communities, published by NHS England.

Using Population Health Management Approaches and addressing health inequalities

- Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to have regard to the need to reduce inequalities and use population health management approaches to help achieve this.
- The Committee will receive regular reports from the Norfolk and Waveney Health Inequalities Oversight Group about the Integrated Care System's work to reduce health inequalities.
- Consider how the ICB and the Integrated Care System could improve its work to address health inequalities.
- Provide assurance to the ICB Board regarding the effectiveness of the organisation's work to address health inequalities.

Integration with the voluntary, community and social enterprise sector

- Receive regular reports about the work of the ICB and the Integrated Care System to improve integration between the statutory and voluntary, community and social enterprise sectors.
- Consider how the ICB and the Integrated Care System could improve integration between the statutory and voluntary, community and social enterprise sectors.

Development funding

- Agree how the ICB should use development funding received from NHS England.
- Agree how the ICB should use any funding received by the ICB as a result of bids to external bodies with regard to health inequalities or patient engagement.

Place

- Review and approve arrangements as to the delegations to place boards or place Directors.

7. ACCOUNTABILITY and REPORTING ARRANGEMENTS

The Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board (public session) after each meeting and provide a written report on assurances received, escalating any concerns where necessary.

The Committee will receive scheduled assurance reports from any delegated groups. Any delegated groups would need to be agreed by the ICB Board.

8. BEHAVIOURS AND CONDUCT

ICB values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

9. DECLARATIONS OF INTEREST

All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

10. SECRETARIAT AND ADMINISTRATION

The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

11. REVIEW

The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board.

These terms of reference will be reviewed at least annually from the date the latest version was approved and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval: 25 Sept 2024

Date of review: Annually

Parker Rachael
22/11/2024 15:17:52

Agenda item: 13ii

Subject:	Patient and Communities Committee policies
Prepared by:	Nikki Bartrum, Corporate Governance Senior Manager
Submitted to:	Patient and Communities Committee
Date:	25 November 2024

Purpose of paper:

For information.

Executive Summary:

The Corporate Governance team maintains a database of all the ICB's policies. Each policy is assigned to a committee for oversight and formal approval.

[Appendix A](#) sets out the current status of the policies that the Patient and Communities Committee is responsible for.

Recommendation to the Patient and Communities Committee:

The Committee is asked to note the contents of this paper and ensure all policies are maintained in line with their review date timeline.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	There is a risk to the ICB's reputation if policies are not in place, implemented and regularly reviewed.
Legal:	There may be a risk of legal challenge where the implementation of a policy does not reflect current legislation/statutory guidance
Information Governance:	N/A
Resource Required:	Policy owners
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Appendix A: Patient and Communities Committee policies

Category	Policy Name	Current version	Date of this version	Team	Date Approved	Review Date	Comments
Comms & Engagement	People and Communities Approach	V11	Apr-24	Communications & Engagement	01/07/2022 V11: 20/05/2024	May-25	
Comms & Engagement	Media Policy	V2	Jun-23	Comms	01/07/22	Jun-25	
Corporate	Complaints Handling Policy and Procedure	V3	Jul-23	Corporate Affairs – Patient experience	01/07/2022	Jul-25	Constitution requires this to be published annually.

Parker Rachael
22/11/2024 15:17:52