Patients and Communities Committee
Part One

Mon 27 January 2025, 14:30 - 16:30

Virtual via MS Teams

Agenda

14:30 - 14:30
0 min

Meeting Agenda

00. P&C Committee - Agenda 27.1.25 - FINAL.pdf (2 pages)

14:30 - 14:30
0 min

1. Chair's Welcome and Apologies for Absence

Aliona Derrett

14:30 - 14:30
0 min

2. Declarations of Interest

Aliona Derrett

02 ICB Master Register PCC.pdf (3 pages)

14:30 - 14:30
0 min

3. Minutes from Previous Meeting and Matters Arising

Aliona Derrett

03 NW ICB PC Committee Minutes 25.11.24 Part One - DRAFT.pdf (14 pages)

14:30 - 14:30
0 min

4. Action Log

Aliona Derrett

04PATI~2.pdf (1 pages)

14:30 - 14:30
0 min

5. Risk Register

Mark Burgis

05i Risk Register cover sheet Januay 2025.pdf (2 pages)
05ii Appendix 1 - P&CC Risks - January 2025.pdf (5 pages)

14:30 - 14:30
0 min

6. Spotlight on: Waiting Times

6.1. Feedback Received in Relation to Patient Experience – Elective and Non-Elective Care Waiting Times

Alex Stewart

06i Patient_Healtwatch perspective.pdf (5 pages)

6.2. Complaints, Feedback and Concerns – Acute Hospital Waits

06ii P & C Committee report - Acute Waits One Pager.pdf (3 pages)

6.3. Long Waits Data

Matt Dooley

06iii PPPOG Long Waits Data Slides - Jan-25.pdf (4 pages)

6.4. Waiting Well Project - Place Example

Heather Farley

06iv NN Waiting Well PCC - 27 Jan 2025.pdf (4 pages)
06iv NN Waiting Well Presentation.pdf (11 pages)

14:30 - 14:30
0 min

7. Place Board Report: Norwich

Claire Leborgne, Sarah Young, Tracy Williams

07 Norwich Place Update FINAL P&CC 27.1.25.pdf (39 pages)

14:30 - 14:30
0 min

8. VCSE Assembly Update

Tim Gardiner

08i VCSE Assembly P&CC report 23.01.25.pdf (3 pages)
08ii 21.01.25 VCSE Assembly Notes v2.pdf (2 pages)

14:30 - 14:30
0 min

9. Population Health and Inequalities Board Update

Dr Frankie Swords

09a 2024.12.17_PHI Board Report Cover Sheetv1.pdf (2 pages)
09b 2024.12.17_PHI Board Assurance-Escalations- v3.pdf (3 pages)

14:30 - 14:30
0 min

10. Ageing Well Programme Board Update including Frailty Attuned Acute Care Workstream Update

Janice Shirley

10i Ageing Well Board Report Cover Sheet v1.0.pdf (2 pages)
10ii Escalation Assurance Template - Ageing Well.pdf (2 pages)
2025.01.24_Ageing Well_Highlight Report_Patients and Communities Committee.pdf (4 pages)
10iii Frailty Attuned Acute Care Workstream Report.pdf (4 pages)
10iv Frailty Attuned Acute Care Workstream Presentation.pdf (9 pages)

14:30 - 14:30
0 min

11. Healthwatch Suffolk Update

Andy Yacoub

14:30 - 14:30
0 min

12. Healthwatch Norfolk Update

Alex Stewart

14:30 - 14:30

13. Items for Escalation to ICB Board

0 min

Aliona Derrett

14:30 - 14:30
0 min

14. Any Other Business and Reflections on todays meeting

Aliona Derrett

14.1. Patients and Communities Committee Revised Terms of Reference

Aliona Derrett

14i NW ICB PCC TOR v3 Sept 24 FS.pdf (9 pages)

14:30 - 14:30
0 min

For Information - Patients and Communities Committee Forward Plan

Patients and Communities Committee Forward Planner 24-25.pdf (1 pages)

NHS
Norfolk and Waveney
Integrated Care Board

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

Monday 27 January 2025, 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: Waiting Times** 1. Feedback Received in Relation to Patient Experience 2. Complaints, Feedback and Concerns – Acute Hospital Waits 3. Long Waits Data - Strategic Planned Care Team 4. Waiting Well Project – Place Example	Pr	Alex Stewart Mark Burgis Matt Dooley Heather Farley
7	15:30	Place Board Report: Norwich	Pr	Claire Leborgne Sarah Young Tracy Williams
		Standing Items		
8	15:45	VCSE Assembly Update	P	Tim Gardiner
9	15:55	Population Health and Inequalities Board Update	P	Dr Frankie Swords
10	16:05	Ageing Well Programme Board Update including Frailty Attuned Acute Care Workstream Update	P	Janice Shirley
11	16:15	Healthwatch Suffolk Update	V	Andy Yacoub

12	16:20	Healthwatch Norfolk Update	V	Alex Stewart
13	16:25	Items for Escalation to ICB Board	V	Chair
14	16:28	Any Other Business and Reflections on the Meeting i. Revised Committee Terms of Reference - **for approval**	 P	Chair
15	16:30	Close		
		Shared For Information *– Patients and Communities Committee Forward Plan*		
Date, time and venue of next meeting: Monday 24 March 2025, 14:30-16:30hrs via MS Teams				
Any queries or items for the next agenda please contact: rachael.parker9@nhs.net				

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

Declared interests of the Patients and Communities Committee

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Aliona DerrettA8:J13A8:J19A8:H40	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 discipline that relates to the declared conflict.
		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
		Lakers Games Ltd	X			indirect	I am the Director of Lakers Games Ltd	Nov-24	To date	Very low risk. In the unlikely event that a risk arises I will discuss the mitigation actions with the Chair of the ICB Board.
		St Stephens Gate 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
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 Arts			X		Deputy Chair of Council, Norwich University of the Arts	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	Dec-23	
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		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
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	
		Public Health and professional registration on UKPHR			X	Direct	Statutory registration as a Public Health Consultant- Fellow of the Faculty of Public Health and professional registration on UKPHR	*2014	Present	
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			Inidrect	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
		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 personal interest		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

Norfolk and Waveney
Integrated Care Board

NHS Norfolk and Waveney Integrated Care Board

DRAFT Minutes of the Patients and Communities Committee meeting

Held on Monday 25 November 2024

Meeting in Public

Committee members in attendance:

- 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
- Tim Gardner (TG), VCSE Assembly Chair
- Mark Burgis (MB), Executive Director of Patients and Communities, NHS Norfolk and Waveney Integrated Care Board
- Dr Frankie Swords (FS), Executive Medical Director, NHS Norfolk and Waveney Integrated Care Board
- Karen Watts (KW), Director of Nursing and Quality, NHS Norfolk and Waveney Integrated Care Board *representing Tricia D'Orsi, Executive Nursing Director, NHS Norfolk and Waveney Integrated Care Board*

In attendance:

- 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
- Alex Stewart, (AS), Chief Executive, Healthwatch Norfolk
- 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

- Claire Leborgne (CL), Head of Place Development, Partnerships & Planning (Norwich), NHS Norfolk and Waveney Integrated Care Board for item 6
- Chris Williams (CW), Head of Communications and Engagement, NHS Norfolk and Waveney Integrated Care Board for item 8
- Steve Gray (SG), Place Programme Lead (Suffolk County Council) for item 7
- Amrita Kulkarni (AK), Senior Programme Manager Community Voices, Norfolk and Waveney Integrated Care Board for item 7
- Emma Ratzer (ER), Chief Executive Officer, Access Community Trust for item 6
- Alison Matthews (AM), Senior JSNA Researcher (Suffolk County Council)
- Emma Bugg (EB), Acting Associate Director of North, Norwich & South Norfolk Place, NHS Norfolk and Waveney Integrated Care Board for item 6
- Mark Payne (MP), Interim Associate Director of Mental Health, Adult Mental Health Strategic Commissioning Team, Norfolk and Waveney Integrated Care Board for item 6
- Shelley Ames (SA), Head of Health Inequalities & VCSE Partnering, NHS Norfolk and Waveney Integrated Care Board for item 7
- Jon Punt (JP), Complaints and Enquiries Manager, NHS Norfolk and Waveney Integrated Care Board for item 6

Attending to support the meeting:

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

1.	**Chairs welcome and apologies for absence**	
	Aliona Derrett (AD) began by welcoming everyone to the Patients and Communities Committee. Apologies for absence had been received from: • Tricia D'Orsi, Executive Director of Nursing • Matt Dooley, Executive Director of Commissioning and Performance • Stuart Lines, Director Public Health	
2.	**Declarations of Interest**	
	None declared.	
3.	**Agree Minutes from the Previous meeting and Matters Arising**	
	The minutes of the previous meeting were approved as an accurate record.	
4.	**Action Log**	
	As there were no outstanding actions the action log was not reviewed.	
5.	**Risk Register**	
	Mark Burgis (MB) introduced the item, noting the two BAF risks relating to: BAF01 – Health Inequalities and Population Health Management and the ICB meeting its statutory duty. The score had not changed since the last committee in September. BAF05 – around the increasing number and complexity of the ageing population in Norfolk and Waveney. MB said it was an important risk for the ICB to consider, but the scoring hadn't changed. In terms of operational risks, none had been raised specifically for the Patients and Communities Committee, however MB expected that to change for the next meeting following conversations with some place-based colleagues who had expressed a wish to highlight to the committee some concerns at an operational level. MB added there were some operational risks proposed that are already being picked up by other committees e.g. the Primary Care Commissioning Committee. Questions and comments from members of the committee: Aliona Derrett (AD) asked in relation to BAF01 how is the ICB ensuring providers are working towards reducing those health inequalities. MB responded there is much interest in the work in this area and engagement is key around this, making sure every project that we do has at least considered the impact on health inequalities. Tracy Williams (TW) added there is a strategic group within the ICS which includes NHS trust colleagues. This year has been about laying foundations and getting	

	everything right, and the aim is to be able to report progress moving forward as a health inequalities framework. Progress is reported to the Integrated Care Partnership AD added that whilst some progress is being made within the health part of the system, it is important to ensure it is being extended across the whole ICS. We have a wide range of providers, and we need reassurance that we're trying to move the agenda across the ICS as much as possible and at the same time. Karin Bryant (KB) reflected on the messaging around frailty and trying to move to an all-age focus. Frankie Swords (FS) said we are moving to a non-age specific definition of frailty across the system and bringing in the Rockwood Clinical Frailty Score. However, the BAF risks are in line with the BAF wording so that is what our board assurance framework wording says. The update was noted.	
6.	**Spotlight on: Mental Health**	
	i. Patient Experience Emma Ratzer (ER) shared two patient experience videos (see links below) with the committee to highlight the importance of community-based intervention and multidisciplinary working. The first was made by Age UK Norwich and was a customer experience of Community Health Enhanced Social Support. The second was a multi-agency customer experience of a project embedding employment support in community mental health settings. Age UK Norwich – customer experience of Community Health Enhanced Social Support Multi Agency – customer experience of project embedding employment support in community mental health settings Comments and questions from members of the committee: In relation to the second video and accessing the programme and ongoing support, AD asked how easy was it for people to access support as and when they needed it. ER responded that people can access the programme at any time during their journey and there is a zero-exclusion approach to a lot of the work that goes on in the hubs. In relation to the Age UK Norwich service, ER added it's a social prescribing type service but the additional support by Age UK and all the agencies Age UK are linked with mean that an individual receives services from many support services rather than just one. AD asked, where a more specialist mental health intervention was required, how easy was it for organisations to make referrals to specialist services. ER responded that it was not that easy. Often people present in crisis at a variety of community place-based services. People will arrive in crisis and then really, it's down to the referral process into NSFT, but staff report that there are times that actually they feel their only option is to phone an	

ambulance because it's late at night and someone's presenting in crisis and you haven't had a reply to your referral four hours ago.

AD commented that she was sorry to hear this and asked ER for her thoughts on what the committee should be taking forwards in terms of ER experience on behalf of service users.

ii. Healthwatch Perspective

Alex Stewart (AS) advised that Healthwatch Norfolk had been working with carers of people with serious mental illness (SMI) and the group also included some Suffolk carers. AS said the group don't feel valued or recognised and they must fight for the person they are trying to represent. Other key areas highlighted by the group include:

- Inadequate support which was not specialised enough
- The challenge of caring would often have a negative impact on their own physical and mental health
- Finances and personal relationships were frequently affected.

AS felt these concerns were set against a backdrop of need for better mental health care in in Norfolk generally adding from the Learning From Deaths report historically there's been poor communication within the mental health trust and although it has improved there is still a long way to go, and there is still a decided lack of trust in very specific services.

AS added the SMI carers group had made some recommendations to NSFT which are hopefully being actioned including:

- More staff training to ensure there's more involvement and support for carers and that they feel involved.
- Increased communication and information for carers of adults with SMI and that they explore the possibility of care groups or forums in each part of the Norfolk and Suffolk Foundation Trust which works with adults with SMI to see if care champions could also be employed.

AS also commented from an ICB perspective, Healthwatch must voice its disappointment that when its report was issued, Healthwatch didn't receive a response from the ICB. Healthwatch has been asking for the ICB to be actively involved in the SMI group because Healthwatch feel the commissioners of services should be involved, and Healthwatch is still pushing for that to happen.

AS advised that NSFT had responded to the report and advised it was putting in several measures to ensure carers feel involved and at a recent Health Overview and Scrutiny Committee (HOSC) meeting, one of the carers spoke quite vocally about the fact that they did feel they were finally being listened to, however AS felt this particular carer was very good at advocating on their son's behalf, and AS expressed fears that for those who haven't the ability to articulate the problems they're experiencing.

Comments and questions from members of the committee:

AD commented it was very sad to hear what AS had to say and AD was under the impression the SMI project was well connected within the system. AD asked MB and FS to ensure that whoever is responsible in the ICB for mental health transformation connects with AS to see what we need to learn from the project and what is needed to take it forward.

AD asked AS whether there had been any improvement at all from the perspective of carers of people with SMI. AS felt the carers involved in the project would all agree there had been improvement, however this is just a select few and as previously alluded to, the concern was for those who are unable to articulate the challenges they are facing.

AS also felt another concern was that mental health is not part of a GPs core training and is still a voluntary module so AS felt there was a feeling in primary care that there's a lack of knowledge and perhaps the desire to deflect.

FS advised in the meeting chat that GPs do undertake training across a very broad curriculum and must now pass an applied knowledge test. Most also complete at least 3-6 months of a dedicated mental health placement though that was not compulsory previously. GPs do work much more as a multidisciplinary team now as well though, so while every GP is not an expert on everything, they should have access to someone to help, including via their mental health support workers.

AS added in relation to co-production that he still felt we haven't defined what we mean by co-production, and it was confusing for those working in that sphere and even more confusing for those that want to help co-produce. AD agreed with AS comments asked AS to think of a few points which they would like the committee to take forward and ensure it is supporting progress.

iii. Patient Feedback

Jon Punt (JP) provided an overview of patient feedback and queries received in the Patient Engagement Team. As commissioners the ICB only sees a small number of queries and most go directly to NSFT and although the number of formal complaints that NSFT receives is significant, there has been a decrease in recent years which is positive. However, the issues seen within the patient engagement team are twofold and some relate to what AS had already reported. Firstly, around ADHD and ASD assessments and the waits that patient experience to be seen for diagnostic assessments, which is subsequently having an impact on their mental health. The second is the number of patients which community mental health or secondary care teams don't deem them ill enough to be seen. However, they are being managed in primary care. JP perception is that patients may be falling through the cracks in services and that is something that has been ongoing for some time and something JPs team see with regularity. JP felt that sometimes there are patients that might be labelled as too difficult to deal with and that's why they then get pushed around services rather than actually someone getting hold of their presenting issues and then pushing them forward.

Comments and questions from members of the committee.

AD asked in relation to the complaints received by NSFT and the ICB how are we joining together to address issues. JP advised that if it's a complaint about the services that NSFT provide, the ICB will always gain consent from the complainant and then go to NSFT to work together on a joint response. However, there is more work that needs to happen at system level around identifying themes and working out if the same picture is presenting at both the ICB and NSFT and if there is what action is required to address. JP added that on the individual cases, there are a lot of wins in that regard, but it's the system working better more broadly e.g. not just for mental health services but for the acutes, primary care, and secondary care to look at systemic issues.

TW asked for clarification in respect of the complaints that NSFT received directly and those that come to the ICB, and whether there is any analysis of the trends e.g are they going down generally. In relation to complex services users, it can be a real challenge navigating through different services so the more we can do to support people navigating and helping people through is going to be really key. JP responded that from NSFTs perspective, the formal complaint numbers are going down and in terms of ICB numbers, the volumes are quite low across the board, so it's quite difficult correlate that and work out whether there are any huge trends in numbers. JP added in relation to complex patients there's very often a real distrust of services which is built up over a length of time, which is really sad but that sometimes is the blocker as well. If a complainant ends up at the ICB making their complaint or inquiry, they've probably been through a broad range of services already by which point they can be quite jaded so to try and resolve those ones is becoming increasingly difficult.

CA asked whether there were any strict turnaround times in relation to responding to the complaints which come through to either NSFT or the ICB about Individual Funding Requests (IFR) delays. FS responded that there is work ongoing to bring the mental health IFR panel in line with how the drugs and non-drug panels work as it has run quite differently. MP added the work will define exactly what should be going through the IFR and the turnaround times. It is important to be clear about where these actually sit to avoid confusion as there is a tendency to just push them into one pot and class them all as IFR when actually it may not be truly an IFR in terms of what their real classification is once they come through the process.

FS reflected on the fact that JP's paper summarises the specific complaints with the title 'mental health' or 'NSFT', but there are of course other complaints that might be addressed to primary care, which relate to MH. There is also ongoing discussion between primary care and mental health providers to what additional support they want and that doesn't show through in JP complaints paper, but it is a very regular theme at the monthly interface meetings where we have a concern about more support being available for both patients and for referrers into that service. AD asked if that relates back to communication and how well people are informed of what is available. FS agreed and said it was also about, as AS had previously mentioned, referrals being rejected and a request for advice, and not necessarily getting it.

iv. Strategic Mental Health Team

Mark Payne presented the strategic perspective and highlighted the following key areas.

- A co production strategy has been developed between the ICB and Rethink following the work undertaken over the past three years linked to community transformation. Some positive results came out of that work and there was a strong feeling to continue on some kind of co-production going into the future, which is where the strategy has come from.

The strategy outlines the next steps about how co production in the system can be improved further and seeking views of people across a wider spectrum. There is also national NHSE co-production guidance National NHSE Co-production guidance.

MP said co-production had played out in multiple conversations and service developments over time within the mental health world. A small example of that is the mental health joint response car that was commissioned between the ambulance trust (EEAST) and NSFT. Co-production was used to determine whether a liveried vehicle with blue lights that was used or if it should be an unmarked vehicle with blue lights that were concealed. What came back was they wanted a liveried vehicle with blue lights because they felt safer. They knew it was the right professionals turning up to help and support them. That patient cohort group got what they needed to feel safe, it reflected an appropriate response but equally, it didn't make them feel within the community that everyone knew what was going on around them. This is a very small example of what has been achieved with Co production, a really poignant conversation and a really important part to the individuals using that service.

Comments and questions from members of the committee.

AD thanked MP for providing an example and helping the committee to understand how co-production had been applied. AD asked members of the committee for their views of the strategy and what experience had they had in being part of its development,

TW commented it was a good strategy but felt it could have been more ambitious and think about co production in a wider strategy across the ICS, and using opportunities to co-produce with all those who have lived experience.

AD asked MB about the co-production strategy that the NCC engagement team worked on and the need to rethink what people have spent lots of time already developing. MB agreed and felt it would be good to bring this topic back to a future meeting to revisit it.

ER added the VCSE assembly and colleagues were involved in the development and it's a good piece of work.

In response to AD question earlier in the meeting about what is missing ER felt it would be helpful to have some co-production around service specifications and giving providers an opportunity to feed into what services look like.

Emma Bugg (EB) felt we ought to be a little bit more ambitious and creative, now that we're operating as one system, with regards the opportunities that

integrated neighbourhood teams present in relation to personalised care plans and coproduction.

AS felt we still need to get some of the basics right and referred to those people that are slipping through the net because if we fail, then they're going to be requiring very intensive services moving forward. AS said Healthwatch had submitted a formal request which NSFT had agreed they will report back on this request through the learning from deaths group by April 2025 and AS would like to see that being brought back to the Patients and Communities Committee too.

v. A View from Place

Claire Leborgne (CL) introduced this item by noting the key points from the presentation which had been circulated in advance of the meeting and was taken as read.

Questions and comments from member of the committee:

AS noted the wide range of activity in Norwich, but was keen to know what was happening with the Norwich Rest Hub as this did not feature in CL report despite it also providing crisis support. CL responded the hub is part of the local landscape of provision in Norwich and is a really important resource, and MIND is one of the providers that regularly attends the All-Age Strategy meetings.

TW also noted the huge amount of work that is happening in Norwich around mental health and working closely with communities and the important partners, and recognising the challenges of working through that with four different Primary Care Networks. TW also highlighted the population health needs are higher because of the incidence of those populations with mental health need and linked to this TW asked CL about the support available from a strategic perspective for those people who have higher population health needs.

CL responded that the enhanced recovery workers were a good example of the support available, working with strategic mental health colleagues and ICB Business Intelligence Team to get an understanding of mental health needs and using that data to allocate resources differently. Although this was a challenging thing to do, in order to address the inequalities that we know exist, we do need to make sure that we target our resource to the areas where we have the poorest outcomes, and we know where they are.

AD was aware that within the PCNs there are good outcomes, people enjoy the model and it does seem to work and the response time is good.

AD asked committee members for their comments or reflections on any of the areas discussed during the MH spotlight item or any areas which require action. ER felt it was important that people feel happy and confident submitting full and honest referrals and to know that they're not going to get turned away if it's very, very complex.

AS echoed ER request and added it would be helpful if there was parity of access across the whole of Norfolk and Waveney because currently is it dispersed and disjointed.

	MB reflected on the rich conversation and what is important is we follow up on this. MB acknowledged FS comment that mental health is everyone's business. **Actions:** **1 Clarification required regarding what happens when referrals don't get through or are not dealt with.** **2. Ensure ICB mental health transformation team connect with AS regarding learning from the SMI Project and needs to be taken forward.** **3. Co-production Strategy to be added to forward planner for revisiting at a future meeting.** **4. NSFT response to Healthwatch Norfolk's request around intensive services to be added to forward planner** The updates were noted.	MB MB RP RP
7.	**Community Voices in Practice**	
	Shelley Ames (SA), Head of Health Inequalities and VCSE Partnering introduced Steve Grey (SG) and Alison Matthews (AM) from Suffolk County Council who provided an update on the Healthy Hearts (Lowestoft) project. A presentation had been circulated in advance of the meeting which was taken as read. Question and comments from members of the committee: FS commented it was great to see projects coming to fruition and the positive impact they are having in communities. FS asked how Community Voices (CV) projects are chosen and prioritised, and how the integration of community voices and the wellness on wheels (WoW) bus is progressing. SA responded in terms of prioritisation of projects, so far the approach has been quite reactive to where there is resource / funding opportunities. However, all CV work is underpinned by the Health Inequalities Framework and next year the plan is to select two or three projects that align with the strategic ambitions in the Joint Forward Plan and be more proactive in seeking the resources to enable that to happen. In response to FS second question regarding the WoW bus, SA said that options for bringing CV and the WoW bus together are currently being considered. The update was noted.	
8.	**Communication and Engagement Update**	
	Chris Williams (CW) Head of Communications and Engagement at the ICB provided a verbal update on the following areas. **Warm and Well Campaign** which runs over winter in partnership with Norfolk County Council and involves a wide range of partners in delivering the campaign. Information is shared with health partners, councils, and the voluntary sector. Core themes for this year's campaign include: • Choosing the right health service to reduce pressure on A&E by encouraging people to visit and use other health services e.g. NHS111	

	• Vaccinations and encouraging people to have flu, covid booster and RSV vaccines if eligible. • Hardship support and improving awareness and uptake of hardship support and services, including providing access to the pension credit if residents are eligible. • Supporting people to care for their mental health and signposting to resources • Reminding people about the practical steps they can take to be prepared for winter and help prevent health problems from developing. The campaign is aimed at everyone in Norfolk and Waveney, but particularly residents aged 18 to 65 living in deprived areas, vulnerable residents aged 65 and over and their relatives and neighbours. The campaign is being promoted through multi-channels including social media, press advertising, outdoor digital screens, radio, and in free publications. CW thanked all partners attending today's meeting for their help promoting the campaign. **Engagement Plan** – a big engagement exercise has been launched by the government to inform the new 10-year health plan. People from Norfolk and Waveney can inform the development of the national plan by responding online however Norfolk and Waveney won't receive specific information to inform local plans. CW highlighted a mechanism to submit the results of engagement completed over the past two year and a 'workshop in a box' which has been developed to gather feedback. The box provides everything required to run a two-hour session with a group of people and the information gathered can then be uploaded to the national portal and this information can also be used locally. Timescales for the engagement exercise is for all feedback to be uploaded to the national portal by 14 February 2025. The update was noted.	
9.	**Urgent and Emergency Care: Resilience and Winter Planning**	
	Mark Burgis (MB) provided an update on seasonal resilience and keeping the Norfolk and Waveney population safe and well over the winter period, when health and care services typically have higher demands placed on them. A presentation has been circulated ahead of the meeting which was taken as read. MB highlighted the nine areas of focus for this year's plan which were based on the areas of greatest impact in previous plans. It was noted that for category two (C2) ambulance response times in Norfolk and Waveney, last year N&W had the second worst ambulance response times across the east of England but at the end of October 2024 they were the second best. MB added that much of the plan is already having an impact and it is important that we continue to support all colleagues across health and social care to ensure the plan is delivered. Comments and questions from members of the committee: AD asked MB whether there were any areas of concern. MB said capacity and strain on services be that the voluntary sector or statutory services and the pressures that we see right across the board. However, some of the examples presented to today's committee have demonstrated how prevention can really support people avoiding more acute presentation. People tend to think of ambulances and hospitals when we talk about urgent and emergency care but it's	

	much more than that and from a capacity perspective, we must ensure we support all areas of our system including the voluntary sector, social care and community teams, and primary care. The update was noted.	
10.	**Population Health and Inequalities Board Update**	
	Dr Frankie Swords presented the update which had been circulated in advance of the meeting and was taken as read. Key areas from the update included: **PHM Software Procurement** – a provider had been selected and will be announced via the Regional Procurement Hub once contracts are signed. **Equality Health and Impact Assessment** – The ICB EHIA process had gone live and is now business as usual. EHIA's are now reviewed by panel with external and independent scrutiny so is much more robust and the process is receiving positive feedback. **Health Inequalities Training** – is being rolled out and it's been really good to see the new cohort of Core 20 ambassadors. Several people had put themselves forward and NHS England will decide who has been successful. FS highlighted that health inequalities isn't just for the ICB, it's for all of us and getting the ambassadors embedded right across our system. **ICS Population Insights** - to raise awareness about the data available. PHM team is attending each Place Board to share data and explain how it can be utilised at PCN and practice level. FS added it's really important data that people can get to grips with and act on. FS added that BAF risk scores remained unchanged, and one risk had been closed linked to the procurement of the PHM software, and two risk scores had been reduced the first due to the governance in place with the working groups for health inequalities and secondly, because the equality impact assessments process is now live. Comments and questions from members of the committee: AD asked in relation to population insights, who should small organisation e.g. in the voluntary sector, contact if they want to get the insights if they're not party to any place or partnership meetings Suzanne Meredith (SM) responded that they have access to the Explorer dashboard but if they want to undertake any specific population health management projects, then they should come to the PHM team for advice and support as well. AD asked TG to communicate this to the VCSE sector to ensure we start connecting all the dots. TW added Norfolk and Waveney had the most Core20PLUS ambassadors in the region, and they cut across many sectors from the voluntary sector, district councils, healthcare providers, and primary care. Health inequalities training for primary care has been overseen by the primary care workforce team and more comms will come out about that to primary care generally over the coming weeks.	

	AD asked TW where people would find out about who the ambassadors are. TW responded that information is not publicly available. There are plans to develop a network across the Norfolk and Waveney system to support them, in addition to the regional network. SA added an ICS web page is in development to promote the work that SA and her team are doing. In addition, the new cohort of ambassadors will join the previous cohorts and there'll be an open invite out to grow the local network of ambassadors. SA will speak to ambassadors about their appetite to get their contact information on the website and be available, particularly if they've got specialisms or understanding about groups and maybe support health inequalities training. There's a need to really understand the network of individuals we have and where their interests lie. There are some great ambassadors across the system in various voluntary sectors, local government and the trusts, providers, etc, so a real cross section of representation. It would be good to get the ambassadors to this committee or the Population Health and Inequalities Board in the future to talk a little bit about the work that they're doing and to give them a platform for their work as ambassadors. The report was noted. **Action:** **Communicate with the VCSE Assembly to inform the sector on how to access population insights and data from the Explorer dashboard.**	TG
11.	**VCSE Assembly Update**	
	AD welcomed Tim Gardner (TG) to the meeting. TG had recently been appointed as chair of the VCSE Assembly, taking over the role from Emma Ratzer. TG presented the update which had been circulated in advance of the meeting and was taken as read. TG highlighted the following points: • TG will lead the development of a communications strategy, and a work programme for the VCSE Assembly is already underway. • TG said he saw the Assembly as a two-pronged approach in terms of how, as a sector, do we collaborate and coproduce together. There is work underway on how people request someone from the voluntary sector to be part of those conversations and ensuring the Assembly is involved in conversations at an earlier stage • The second part is around communication to the voluntary sector itself and making sure it's a two-way conversation, and that we can feed in what we think is important from a voluntary sector point of view into the ICB, into the committees and ensuring information about the work within the ICS is filtered down into the wider voluntary sector organisations. TG added there had been a successful roundtable event which gave a good insight into how we all feel and a good push to move forwards. AD commented that she had read with interest the notes and outcomes from the round table, and these were a very good starting point for the next phase. AD agreed with TG comment regarding engaging with the wider sector, and not just	

	those on the assembly, is paramount if we're to make this successful and actually get the voices of the sector. The update was noted.	
12.	**Healthwatch Suffolk Update**	
	Andy Yacoub (AY) provided a verbal update (a more detailed update was circulated following the meeting). AY highlighted the following: • An elective care survey is underway which HWS has coproduced with all three hospitals Suffolk including the James Paget. It will continue through to January 2025. The Paget has been really supportive, as has West Suffolk Hospital. • Will shortly be publishing a COPD report a link will be included in the paper that will be circulated. • Working on a co-production piece with Suffolk and North East Essex on trans or non-binary people's experiences of healthcare. Healthwatch England has also started a campaign around that and invited local Healthwatch's to contribute. • Will soon be publishing local results of Healthwatch England's National Eye Care survey. • HWS was commissioned some time ago by public health and communities in Suffolk to do some research around ageing well. The report can't be published until the beginning of January so that it coincides with Suffolk Public Health's annual public health report, over 400 people responded to the survey, and we had a significant number of others through collaborative, diverse community led workshops. • Suffolk Voluntary and Statutory Partnership (VASP) - in October, the Waveney locality of VASP ran a world Mental Health Day event. The update was noted.	
	Healthwatch Norfolk Update	
	AS highlighted one area on this occasion which was the budget and the impact it is going to have on primary care. Healthwatch have been speaking in general terms to some practises and one practice advised that its costs would be increasing by a minimum of £180,000 per annum and it's evident this is going to be completely unsustainable. AS understood the National Association of GPs have also undertaken a survey and are worried there's about 600 practices across England that could potentially close as a result. AS also highlighted this had been raised at the recent quality meeting as an area of action, and is something we should be very mindful of. Some of the issues are in relation to what practises can draw down and AS felt there's a consensus that everyone thinks that the NHS is funded, but we must remember that GP practises are private businesses and they aren't offered the same protections as hospitals for example, and this is causing a lot of angst. AS felt it should be included in the risk register moving forwards. MB responded that it was well recognised and confirmed it had been picked up by Sadie Parker, Director of Primary Care and her team, but MB said it was also important to think more broadly particularly the impact on the voluntary sector. The update was noted.	

13.	**Any Other Business and Reflections on the Meeting**	
	i. Revised Committee Terms of Reference The Terms of Reference (TOR) had been circulated in advance of the meeting and were being brought to today's committee for approval. However, it was noted the quoracy had not been updated, but this had already been raised with the ICB governance team who would be revising the TOR to reflect the change. FS also commented the reporting from the Ageing Well Programme Board is barely referenced in the TOR and if the ageing well update is coming to every meeting, then it should be referenced a little more in the TOR. It was agreed the TOR would be changed to reflect FS comments and come back to January's meeting for review and approval. **Action: TOR to be updated and brought back to January's meeting**	**MB / FS**
	ii. Patients and Communities Committee Policies The paper regarding the Patients and Communities Committee policies had been circulated in advance of the meeting and were for noting by the committee. AD asked for the policies to be included in the committee forward planner. **Action: Patients and Communities Committee Policies to be added to committee forward planner.**	**RP**
	iii. Reflections on the meeting The MH spotlight / deep dive was very good, but we should allow a little more time in future for these to ensure sufficient time for discussion.	
Date, time, and venue of next meeting: Monday 27 January 2024, 14:30-16:30hrs via MS Teams		

Minutes agreed as accurate record of meeting:

Signed: …… Date: ……...
Chair

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

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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	25.11.24	SMI Project Report	MB	Ensure ICB Mental Health Transformation team connects with Healthwatch Norfolk regarding learning from the project and areas to be taken forward	Update 16.1.25: Contact made with M Payne in MH transformation team to take this forward	27.1.25		
26	25.11.24	Mental Health Referrals	MB	Clarification required regarding NSFT referral process and what happens when referrals don't get through or are not dealt with.	Update 16.1.25: Rejected referrals has been a common theme through multiple fora, this has now been picked up by the NSFT and ICB Medical Directors who will be communicating with the LMC shortly. The NSFT triumvirate leadership teams are now in post and over the coming months should be settling into working more cohesively at Place level, enabling a forum for these conversations to be had between clinicians.	27.1.25		
27	25.11.24	Community Voices Data Access	TG	Communicate with the VCSE Assembly to inform the sector on how to access population insights and data from the Explorer dashboard.	Upate 23.1.25: Fits within the Community Voices workstream. As part of this we have integrated an objective around data sharing into the VCSE integration work programme and will include an update on progress in due course. The plan for sharing Community Voices insights with the wider ICS is in development and will be shared with the ICP once open access is available.	27.1.25		
28	25.11.24	Healthwatch Suffolk Update	RP	Circulate Healthwatch Suffolk update to committee	Update 26:11.24: Update circulated to committee	27.1.25		26.11.24
29	25.11.24	Terms of Reference	MB / FS	Revised TOR to come to January's meeting to include more reference re: Ageing Well Programme Board reporting	Update 23.1.25: Ageing Well now included in TOR. TOR to be approved at January's meeting.	27.1.25		
30	25.11.24	Items to be added to the committee forward planner	RP	The following items to be added to the forward planner: - Co-producton strategy - Learning from Deaths Report - P&CC Policies for review	Update 26.11.24: Items added to f/p	27.1.25		26.11.24

Norfolk and Waveney
Integrated Care Board

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:	**27 January 2025**

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:

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:	N/A
Finance and Performance:	A lack of investment in tackling health inequalities, population health management and prevention may increase system costs in the longer term
Impact Assessment (environmental and equalities):	A failure to address the identified risks may widen health inequalities in N&W
Reputation:	A failure to address the identified risks may have a negative impact on the reputation of the ICB
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	Risk of failure to meet NHS constitution requirements if identified risks are not suitably mitigated
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	BAF01 and BAF05

Governance

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

Norfolk and Waveney Integrated Care Board

NHS Norfolk and Waveney ICB – Board Assurance Framework

Version	V5	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**	**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**	**15**				

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

BAF01 (Inphase ref 00000008)				
Risk Title	**Health inequalities and Population Health Management**			
Risk Description Please include any collaboration and partnership aspects of the risk.	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.			
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**
• The HI Strategic Framework for action and the PHM strategy have been published. Implementation plans developed, with supporting programme management. • 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 population health management approaches. • 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	**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. NHSE reporting of NHS Inequalities Improvement Frameworks and annual reporting against NHS statement on Information for health Inequalities. Equality Health Impact Assessment (EHIA) process established, overseen by a QEAP (panel). **External**: Integrated Care Partnership Board Health Inequalities governance structure including a strategic steering group and co-ordination group.

receive) are raised by the HI team to be managed across the ICP. • Refresh of the VCSE Assembly and partnership working reporting into the PH&I Board. New Assembly Chair appointed.	

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. • 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**
06/12/24	ICS Health inequalities commitment sign-up underway and Organisations' baseline assessments to inform ICS improvement plan. The ICB Senior leadership Team workshop on HIs and PHM took place to inform the ICB's baseline assessment. Presentation to CDs on PHM awareness and accessing the new datahub , supporting clinicians to self-serve information.		**31/1/25**

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**	**12**	**12**			
Change	→	→	→	→	→	→	→	→	→			

Objective 5: Transforming care in later life

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 ***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: 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	Janice Shirley	**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
• 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	**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. **External**: Integrated Care Partnership Board

Gaps in controls or assurances

- 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.	**B**	**19/07/24**
01/07/24	Dementia Awareness education sessions delivered for Primary Care staff.	**B**	**08/07/24**
01/07/24	Population data analysis complete; social isolation and loneliness and falls prevention Joint Strategic Needs Assessment (JSNA) groups established.	**B**	**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.	**B**	**02/09/24**
01/07/24	Joint Care home support group established including wider stakeholders.	**B**	**06/09/24**
01/07/24	Facilitating an ICS Dementia Round Table event with findings to be shared with stakeholders to identify priority areas.	**B**	**25/09/24**
04/11/24	Dementia Charter to be signed by all statutory organisations and self-assessments completed by all providers to understand gaps in service delivery and what organisations must improve. 6/7 signatures received although executive leads have been nominated.	**A**	**31/03/25**
04/11/24	Winter Communications Plan for developed and finalised ahead of implementation.	**B**	**Complete**

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**	**15**	**15**			
Change			**NEW**	→	→	→	→	→	→			

NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 06i

Subject:	**Feedback Received in Relation to Patient Experience – Elective and Non-Elective Care Waiting Times**
Presented by:	**Alex Stewart – Chief Executive, Healthwatch Norfolk**
Prepared by:	**Alex Stewart – Chief Executive, Healthwatch Norfolk**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**27 January 2025**

Purpose of paper:

The purpose of this report is to provide the committee with an overview of issues that Healthwatch Norfolk has been made aware of by patients and carers over the past 12 months.

Report

Healthwatch received 44 pieces of feedback referencing patient's experiences of waiting lists and waiting times. From these, 18 related to waiting times while in A&E etc. and 25 related to waiting lists for surgeries and routine procedures with 1 piece making reference to both.

The majority of complaints were from patients at the NNUH, with 35/44 (80%) located there. The JPUH had 2 complaints, while the QEH had 7.

The most prominent theme, besides people naturally being frustrated with the waiting lists/times, is the lack of communication from the acutes in relation to how long they would have to wait. This is something that we also pick up on at GP surgeries; people accept that the NHS is under immense strain and expect to have to wait to be seen' However, Patients and carers, without exception, would like to be given an indication as to how long a wait might be. They all understand that external factors and pressures may result in the time line being changed but have said that they would be a lot more content to stick out the given time, or at least be afforded the opportunity to make preparations for the 'long-haul' should the need arise.

These pieces of feedback make good examples – all names and patient identifiable information has been redacted:

‘I brought my wife to A&E with a serious water infection and was told she'd have a simple treatment and be out so I went home to come back later. 6 hours later I'd heard nothing so came back and then they told me she'd be staying in. It was a shambles! I hadn't got any of her medication or clothes with me because they didn't ring. They had my phone number but nobody bothered so I had to go away and get them again. Hours and hours it took to sort everything out. An absolute shambles.’

Appointments get cancelled or moved and nobody tells you, they say they don't have time to let you know. It's ridiculous to cancel an appointment without speaking to patients. At the end of the day be considerate, we're human beings. I regularly turn up for a 9.30am appointment and they're already four hours behind which doesn't make sense, they say they book too many people in so it gets behind. My wife has brought me for appointments that should have taken a couple of hours but has ended up being five or six. She's self-employed but for others with employers this is a ridiculous situation. You can't get through on the appointment line and they said their answer machine was broken for four weeks. I have an emergency number for my dedicated nurse but you can't ever get through as people are calling that trying to sort out their appointments. They have no way to email or text patients. There's also inconsistency with what people are told, I've spoken to several who didn't know you could have free parking. It's hard to know what stars to give them as it would be four for clinical treatment but patient experience would be a two.

A similar theme is exhibited in relation to the lack of communication provided to those on lengthy waiting lists. People express frustration, not necessarily always about the size of waiting list but most definitely when their care plan is changed, or if they are removed from a list without receiving appropriate communication notifying them. People were also annoyed when a department would cancel a procedure because the patient hadn’t turned up to previous appointments but then the patient would have no record of said appointment.

Some examples of the themes described above:

‘Very long waits to be seen at rapid chest pain clinic (9 weeks), treatment plan changed without any explanation to me, long wait for two tests (24 hr heart monitor and Angiogram CT) waited in total over 7 months for CT. The extremely long waits and lack of communication re change of tests to be offered has caused much distress. My medication was changed with no monitoring reducing my quality of daily living. I can not get holiday insurance due to outstanding tests. A very poor and distressing service.’

My GP referred me for an MRI, for a suspected medial ligament and meniscus tears. I never received any contact from the hospital. When I followed up with the GP, the hospital had written to the GP cancelling this requirement, claiming they had written to me and called me. This is not the case, I received no letters and no calls.

I am very annoyed with this, my knee is now significantly worse. It has now effected my other knee and both are injured. I can no longer exercise, which is very important to me as I have a kidney disease and need to stay fit.

This is not the first time something similar has happened. Prior to covid I went through a series of very painful checks for another problem, only to receive a letter that I had not attended my appointments and my treatment was cancelled. Again, this was not true, I went to all appointments. I gave up on the process and live with the pain.

When patients were provided with appropriate and up to date information in the interim between their referral and treatment, they experienced a higher level of satisfaction. There appears to be a fear that people are on long waiting lists and will be forgotten about- this could be combatted by better communication- perhaps updates on waiting list lengths etc.

The feedback below illustrates a good example of where this has been effective:

I've used the centre since the beginning of this year. The centre itself has been very good, all the staff are friendly and appointments are on time if not earlier. Parking is a real issue especially as I have radiotherapy every other day. The treatment inside the centre has been perfect as far as I'm concerned. I was diagnosed in November and didn't start treatment until February which I felt was quite a long wait. I was given paperwork with information and support numbers in the meantime. The staff did everything in their power to make it as quick as possible, I guess it's just procedures.

The final two examples illustrate high levels of frustration in relation to organisational bureaucracy taking precedence over the right of patients to be provided with contemporaneous information, thereby easing a path and ensuring a potentially better outcome for the patients.

Mrs X's husband Toby, who is recovering from bladder cancer has been waiting for urgent surgery for over 7 months in relation to a colovesical fistula, in the meantime he has been experiencing worsening symptoms, including pain, solid faeces in his urinary tract, UTIs, and a risk of sepsis. He has repeatedly been overlooked or fallen through the gaps when trying to progress his care with the hospital, despite Mrs X repeatedly raising the issue with the PALS team as well as HWN raising it twice with the PALS team. In her most recent update Mrs X informed us that they had recently been informed by PALS that they would receive a response by the 20th March- all the while he remains in severe pain, with no end in sight.

Mrs Y's husband Ptolemy had been in need of his medical notes held by the local DGH in order to have his cataract surgery, without which his sight would remain severely inhibited. The surgery had been considered an emergency by the opticians. The DGH took over 6 months to deliver on this request- during which time Mrs Y lodged a complaint with PALS in April 2024, having not heard anything by September she rang to be told that she would then hear something by the end of November. When November had been and gone, Mrs Y then contacted Healthwatch, detailing her account of the past year trying to access the medical notes- this included the stress of trying to chase up the DGH while caring for her husband who was essentially blind by this point. Fortunately, Ptolemy had his cataract surgery on the 17th December.

All of the examples illustrated demonstrate a lack of understanding in relation to the power of good and effective communication. None of these issues should be reaching “crisis point” were those responsible for communicating appointment times etc more responsive and understanding to those at the end of the food chain. What may appear as “bread and butter” to the clinician or those staff who are dealing with complex workloads daily is acutely different for all individuals who are reliant on having issues, waiting times etc. explained to them.

Healthwatch recognise that all staff in the NHS are working under immense pressure and in a period of constant changing and challenging demands but consider that were a bit more time spent dealing with effectively communicating with patients (almost a type of triage) – this could potentially reduce, time, effort and expense of dealing with a formal complaint.
.

Recommendation to the Committee:

a) The committee considers proposing that an audit of how complaints across Trusts is undertaken

b) The report is noted.

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)	

Norfolk and Waveney
Integrated Care Board

Agenda item: 06ii

Subject:	**Complaints, Feedback and Concerns – Acute Hospital Waits**
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:	**27 January 2025**

Purpose of paper:

This paper provides some level of detail on the feedback the ICB has received from our patients regarding waiting times to be seen at acute hospitals across Norfolk and Waveney.

Executive Summary:

The ICB's Patient Experience Team has dealt with many contacts relating to waiting times at acute hospitals across Norfolk and Waveney. These typically are around elective surgery.

The ICB has received 47 contacts during the Q1 to Q3 of 2024-25 relating to wait times at acute hospitals. These comprise of 1 formal complaint, eight enquiries from local Members of Parliament and 38 informal concerns/enquiries.

36 contacts were about waits for services at the Norfolk and Norwich University Hospital, 6 were about the Queen Elizabeth Hospital Kings Lynn, with the remaining 5 regarding the James Paget University Hospital.

Often it is more expedient for a patient/member of the public to raise their concerns directly with the provider of care, and therefore the majority of complaints/concerns will have been made to the respective hospital teams directly. At the time of writing we do not have the detail around the volumes each hospital has received.

Patients made contact typically about specific disciplines, mainly Orthopaedics, Plastics, Gynaecology, Ear Nose and Throat and Pain Management.

Some patients were requesting their appointments to be expedited, others were looking to the ICB to explain their options and potentially transfer their care to another provider with shorter waits.

Two cases highlighted concerns with cancer waiting times being exceeded.

Additional waiting time queries

In addition to the waits to be seen at acute hospitals, the ICB continues to regularly receive queries about long waits to access community mental health services, neurodevelopmental diagnostic services and GP appointments.

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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Norfolk and Waveney Integrated Care System

Provider Performance and Planning Oversight Group – Long Waits Data

2nd January 2025

Created by N&W ICB BI Team

Waiting Lists – PTL 78 Weeks (RTT)

[Link to report: PTL - Power BI]

Plan | Revised Plan

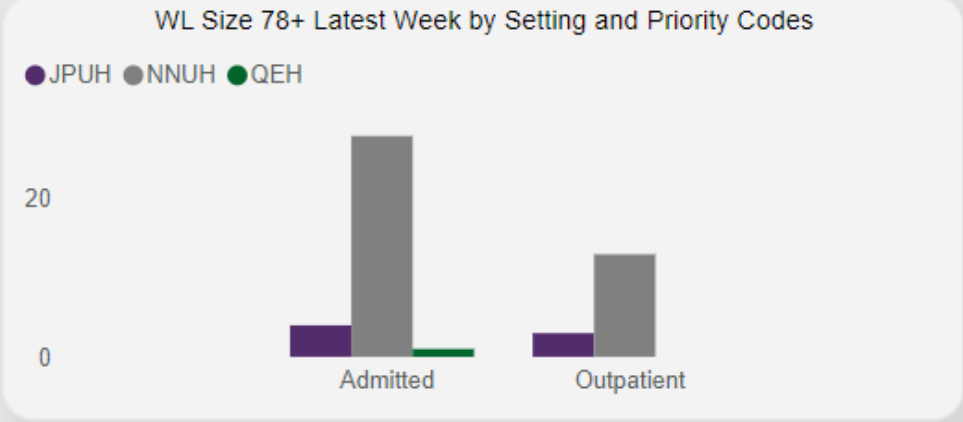
Latest Week: 05/01/2025

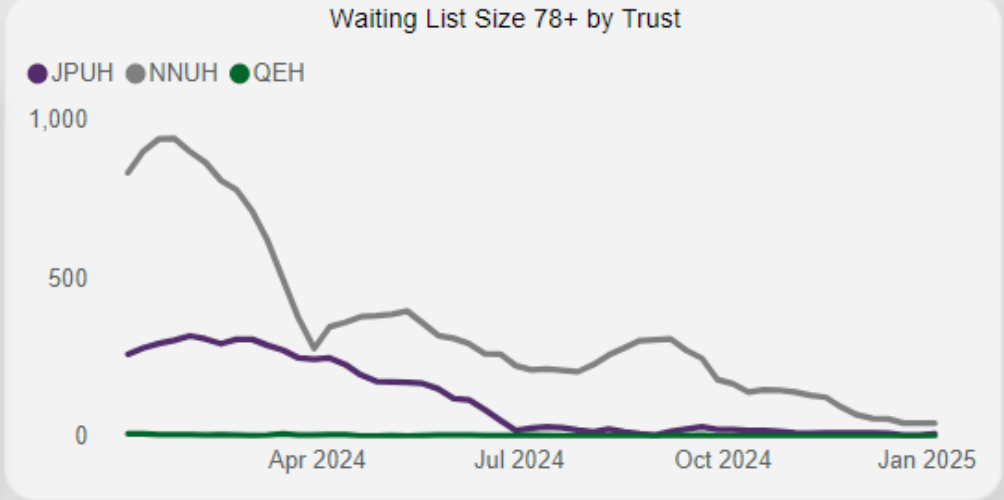
	Actual	Plan	Vs Plan
Total	49	0	0.00%
NNUH	41	0	0.00%
JPUH	7	0	0.00%
QEH	1	0	0.00%

Top 10 Specialties Latest	#
100 - General Surgery	0
101 - Urology	0
103 - Breast Surgery	0
104 - Colorectal Surgery	0
106 - Upper Gastrointestinal Surgery	0
107 - Vascular Surgery	0
108 - Spinal Surgery	0
110 - Trauma and Orthopaedic	0
120 - Ear Nose and Throat	0
130 - Ophthalmology	0
140 - Oral Surgery	0

Rachael Parker (01/2025 10:07)

Note: to drill down to Priority Codes please use 'Two Arrows' sign at the top right corner of the graph, Use Arrow Up to go back to Setting split.





Waiting Lists – PTL 65 Weeks (RTT)

[Link to report: PTL - Power BI]

Plan | Revised Plan

Latest Week: 05/01/2025

Total All Trusts

565 Actual	0 Plan	0.00% Vs Plan

NNUH

381 Actual	0 Plan	0.00% Vs Plan

JPUH

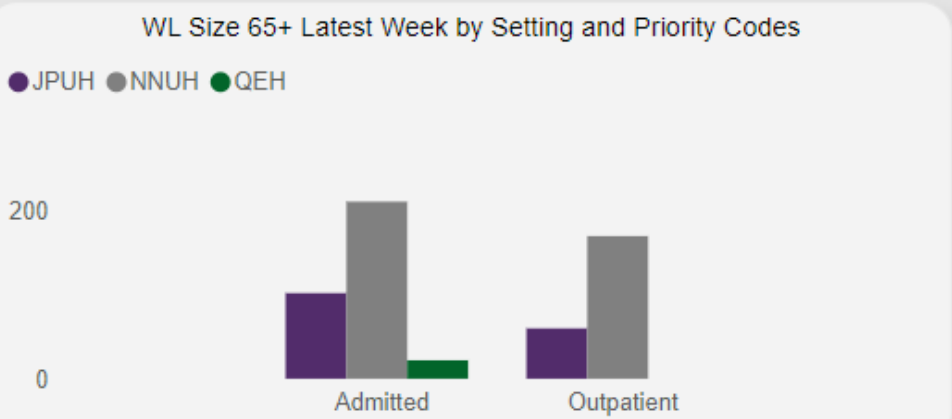
162 Actual	0 Plan	0.00% Vs Plan

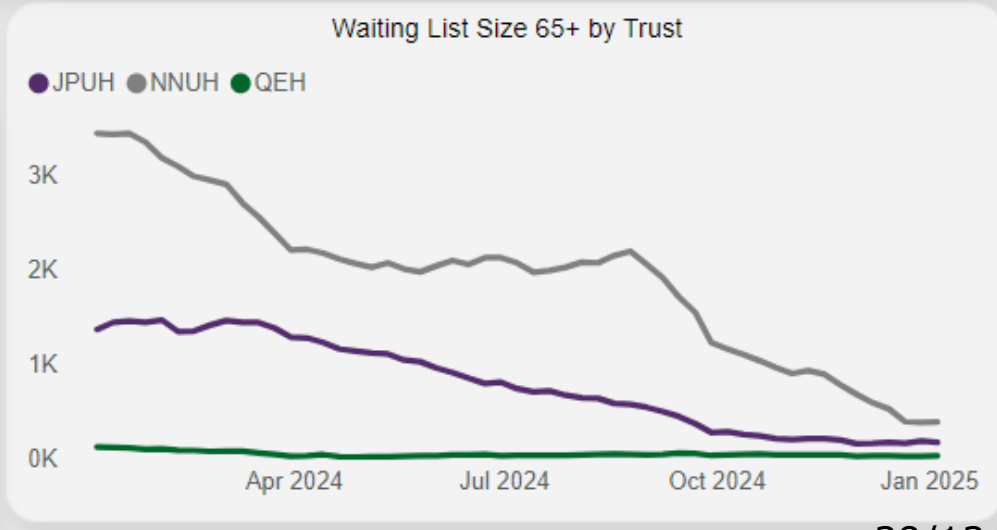
QEH

22 Actual	0 Plan	0.00% Vs Plan

Top 10 Specialties Latest	#
100 - General Surgery	0
101 - Urology	0
103 - Breast Surgery	0
104 - Colorectal Surgery	0
106 - Upper Gastrointestinal Surgery	0
107 - Vascular Surgery	0
108 - Spinal Surgery	0
110 - Trauma and Orthopaedic	0
120 - Ear Nose and Throat	0
130 - Ophthalmology	0
140 - Oral Surgery	0

Note: to drill down to Priority Codes please use 'Two Arrows' sign at the top right corner of the graph, Use Arrow Up to go back to Setting split.



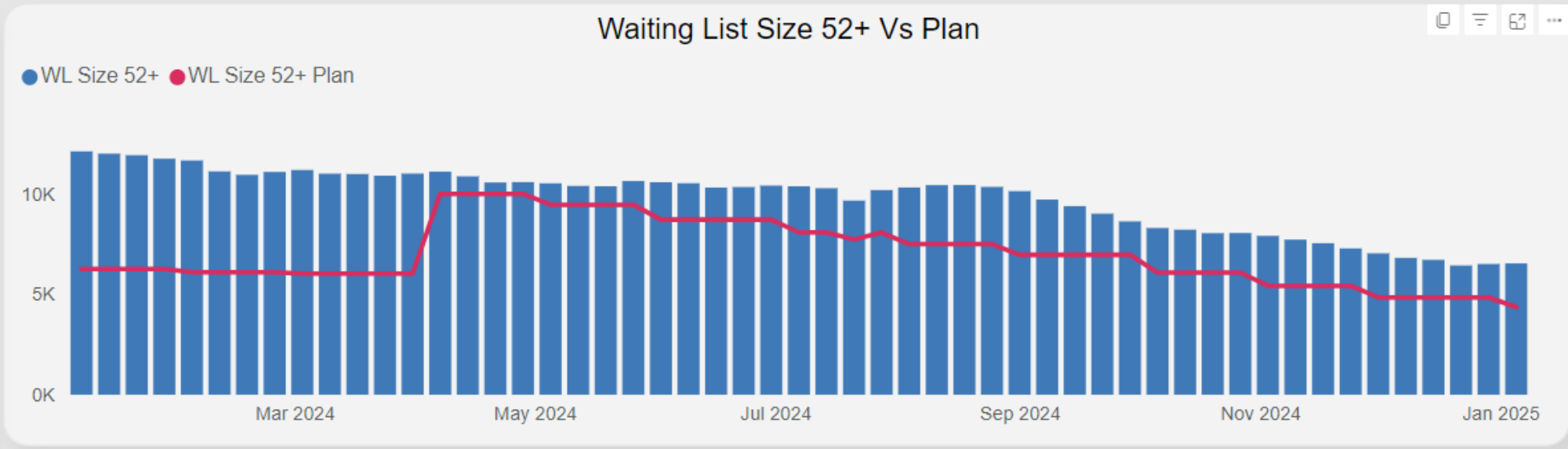


Waiting Lists – PTL 52 Weeks (RTT)

[Link to report: PTL - Power BI]

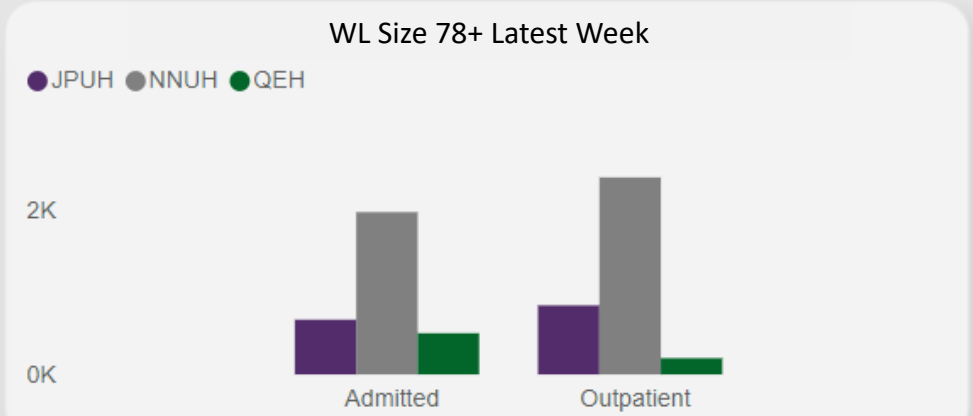
Latest Week: 05/01/2025

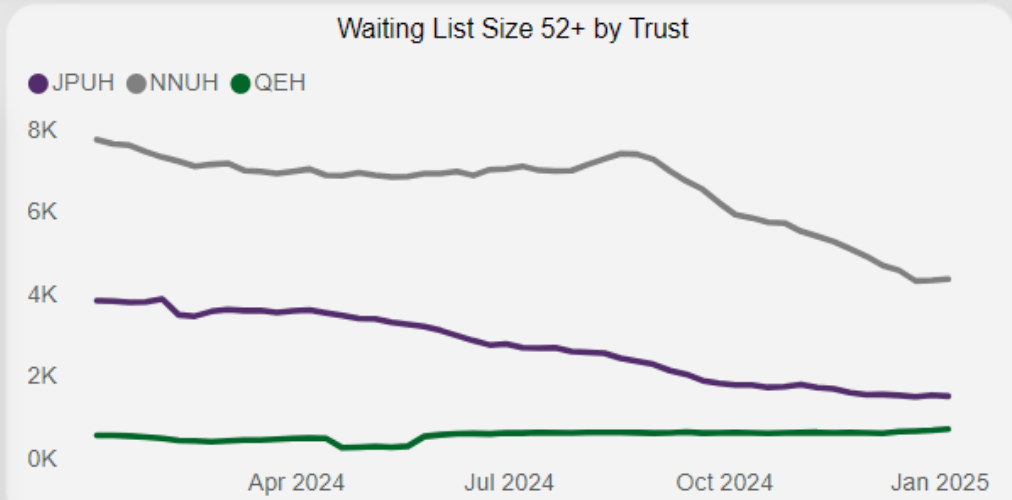
	Actual	Plan	Vs Plan
Total	6,527	4,356	149.84%
NNUH	4,340	2,932	148.02%
JPUH	1,494	1,183	126.29%
QEH	693	241	287.55%



Top 10 Specialties Latest	#
110 - Trauma and Orthopaedic	1,539
502 - Gynaecology	1,188
120 - Ear Nose and Throat	521
100 - General Surgery	508
101 - Urology	338
400 - Neurology	276
130 - Ophthalmology	250
320 - Cardiology	215
140 - Oral Surgery	208
341 - Respiratory Physiology	208

Note: to drill down to Priority Codes please use 'Two Arrows' sign at the top right corner of the graph, Use Arrow Up to go back to Setting split.





Norfolk and Waveney
Integrated Care Board

Agenda item: 06 iv

Subject:	**Place Waiting List Initiative – Waiting Well – North Norfolk**
Presented by:	**Heather Farley – Head of Place Development, Partnership sand Planning – North**
Prepared by:	**Heather Farley – Head of Place Development, Partnership sand Planning – North**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**27 January 2025**

Purpose of paper:

To give a Place based example of a waiting list initiative.

Executive Summary:

The Waiting Well project was funded by North Norfolk Place Board through the Community Transformation Fund and delivered by North Norfolk District Council and Broadland District Council. It was a waiting list initiative designed to support patients who were waiting for orthopaedic surgery. It ran from March 2022 – October 2023, had contact with over 1,200 patients and providing support to over 400.

Report

It is well documented that the Covid Pandemic has had a significant impact on waiting lists for non-urgent surgeries, whilst resources were further stretched and limitations were further imposed on hospitals. North Norfolk's predominantly older population saw a significant increase in waiting times for Orthopaedic surgery.

To support those residents on the waiting list Norfolk Place Board developed a project with the two districts in its area, North Norfolk District Council (NNDC) and Broadland District Council (BDC). 'Waiting Well' offered support and advice to residents who were awaiting Orthopaedic surgery or treatment and was a collaborative project with Norfolk and Norwich University Hospital (NNUH). BDC ran the project from March 2022 to July 2022 and this was more therapy based, the learning was used for a more comprehensive project in run by NNDC from October 2022 - October 2023 which focused on navigation and holistic services.

Patients were contacted by the district councils and offered support based on their level of need, including home adaptations, physiotherapy, and mental wellbeing support.

Project Aims

North Norfolk has a demographic majority of older age groups and additionally, the majority of residents waiting for Orthopaedic surgery at NNUH are elderly, therefore the support offered was to help them live safely and independently within their homes. In addition the scheme aimed to lift pressure from primary care, by minimising appointments.

- Provide support to those North Norfolk residents who were on the orthopaedic surgery waiting lists, through a signposting model.
- Increase knowledge and awareness of available council, statutory and voluntary organisations for support.
- Ensure a more proactive approach to offering support for those on the waiting lists who require housing adaptions or who have other needs highlighted or exacerbated by the waiting list delays.

Added Value

- Holistic and patient-led approach identifies and handles a wide range of support needs within one conversation
- Additional touchpoint between hospital and patients provides reassurance to vulnerable people who feel forgotten
- Important information is gathered for the hospital, e.g. patients who have already had their treatment elsewhere
- Patients voice can be heard earlier with hidden issues identified and resolved, deescalating potential complaints
- Earlier referral into community health and care services limits deterioration and promotes greater independence
- Likely falls prevention and hospital admission avoidance as patients are referred before they reach crisis point
- Project location within the council enables access to wider resources, such as Financial Inclusion and Community Connectors
- Patients income is maximised enabling some to self-fund minor aids and adaptations, avoiding need for therapy referrals
- Hidden community resources are being identified and utilised, such as independent mobility exercise classes
- Knowledge of resources collated and shared with relevant partners, such as ECCH, Pure Physio and Active NoW
- There is a shift in focus for services involved to earlier intervention - this approach is in line with Care Act 2014
- A working model has been developed that can be adapted to fit other requirements, e.g. other waiting lists or health outcomes

Lessons Learnt

- Data sharing issues were the key barrier to partnership working and the success of similar projects
- Data sharing agreements that allow for wider holistic conversations are more beneficial as they can increase engagement
- Privacy concerns raised by patients were resolved once they were aware we are working for and in line with the hospital privacy notice
- All patients who returned questionnaires agreed that the council and NHS should be working in partnership in this way
- Allowing the project to evolve organically enabled its approach to be highly patient-led and maximise its potential outcomes
- Wide range of support needs for this cohort of patients, some resolved in one conversation and others needing ongoing support
- Expecting patients to self-refer is unrealistic due to complexity of service structures and lack of awareness of community resources
- There was an ongoing need for a role, such as Waiting Well Officer, to support patients to navigate these structures and resources
- There was a willingness across all partner agencies in North Norfolk to work together in creative ways to benefit shared patients
- Need for rolling data to enable joint working with other partners to succeed, e.g. opportunity to work with Pure Physio missed
- Potential risk of duplication across similar projects and initiatives reduced if partner agencies are better enabled to work collaboratively

The biggest asset for the NNDC project was the Waiting Well officer who was dedicated to delivering the project. Having the right person in the role made a considerable difference.

This type of project would be more efficient and effective if it was available across all of Norfolk and Waveney with support from the three acute hospitals.

Next Steps

The Board took the learning from this project and the districts are currently funded to deliver a Frailty and Falls Project which offers the same support and advice but to anyone over 50 who attends NNUH Emergency Department following a fall and then is discharged direct from there. There is a challenge when delivering projects where there is a limited funding stream, North had approximately 50k available for 2023-24 and if it is to transform and innovate it needs to move on and try other things. This leads to a challenge on how to continue successful projects where the evidence base for cost savings may take some time to be seen. For this latest project there is a much great focus on evaluation through trusted research methods.

Recommendation to the Committee:

Note the value of preventative waiting list initiatives working with non NHS partners.

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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Norfolk and Waveney Integrated Care System

North Norfolk Place Board: Waiting Well Project

Heather Farley – Head of Place Development, Partnerships and Planning – North – N&W ICB

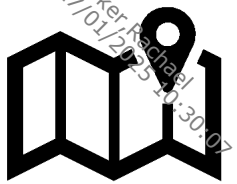
Background – What are the challenges in North Place?

Population

- 173,500 residents in North Norfolk in 2021.
- 1 in 3 were over 65 in 2021.
- 1 in 25 were under 5 in 2021.
- The population in the North Norfolk Place Board area is expected to grow by about 20,000 people between 2020 and 2040; the largest growth is expected in the older age bands.
- In North Norfolk, about 5% are non-white-British compared to 26% in England.

Deprivation

- Around 2,800 people in North Norfolk live in areas that are among the 20% most deprived in England.

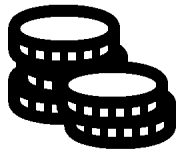


Rural geography

Limited transport options

Inequitable access to services

Ageing population



Hidden deprivation

Reliance upon community level support

Summary of Waiting Well Models

2022/23 Community Transformation Projects

Waiting Well – North Norfolk and Broadland District Councils

Aim: To support patients whilst they wait for total hip or knee replacements (Norfolk & Norwich Hospital)

→ District Councils engaging with patients/residents on orthopaedic waiting lists to offer holistic assessment to provide:

- → Low level home adaptations, access to wider District Council services such as financial support, benefits, housing
- → Access to voluntary services
- → Access to community therapies

Pre-hababilitation for those awaiting total knee or hip replacements (Pure Physio)

Aim: To support patients whilst they wait for total hip or knee replacements and prevent deterioration and optimise patient for surgery (Norfolk & Norwich Hospital)

→ First Contact Physio provides an assessment of current pain and develops a pain management plan to help patients remain well enough for surgery. The offer includes:

- → Assessment of function and pain
- → Evidence-based exercise plan
- → Promote holistic approach to self-management

Learnings

A great deal of learning was gathered from these projects which has helped to inform how we approach the work of the Place Board:

- We want to be truly transformational
- We need to be sustainable
- We need to build upon existing assets

→ *This fed into how we approached our CTF projects going forward*

Project Process

Stage One

- Data is sent from NNUH (and other participating Hospitals)
- Data is received at the Council as per the signed data agreement(s)

Stage Two

- Patients due to have their operations within 3 weeks are removed from the contact list.
- Initial contact letters sent - Telephone appointment booked to discuss any adaption or mobility needs during wait times and beyond.
- In response to this, patient may choose to contact us and opt out - Process therefore ends and data is deleted.

Stage Three

- Telephone appointment completed by Waiting Well Officer
- Patient may decline support - Process therefore ends. Data is deleted
- Patient requests support - Triaged to any and all relevant pathways.
- Non confidential data capture completed. Personal data deleted.

Overview of North Norfolk District Council Waiting Well

Background

- The North Norfolk Waiting Well Project was launched in November 2022
- Funding was used to recruit a Waiting Well Officer at North Norfolk District Council
- Post linked to and line managed within the Integrated Housing Adaptations Team
- Collaboration between the council and Norfolk and Norwich University Hospital
- Patient contact was held up by 2 months due to data sharing delay at the hospital

Summary of Approach Taken

- Patient contact details shared with the council (in line with hospital privacy notice)
- List shared for patients waiting 18 weeks+ for surgical treatments to hip or knee
- Patients sent initial letter and advised to expect phone call within specified date range
- Leaflet enclosed and webpage developed to provide authenticity and promote project
- A holistic approach to patient conversations and types of support need identified

NORTH NORFOLK DISTRICT COUNCIL

Project Delivery

361 patient contacts completed with take up rate at 90%

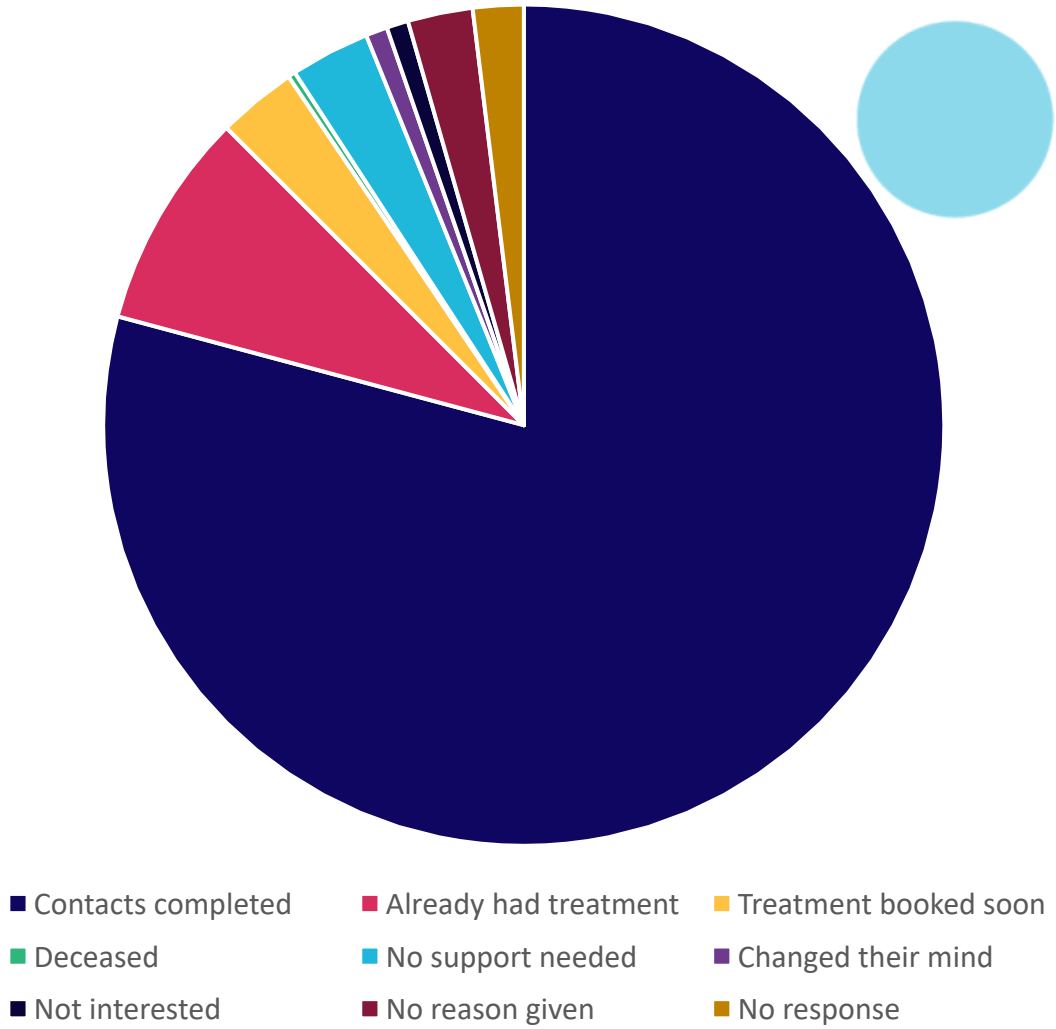
<u>Take up rate adjusted to account for</u>:

- 30 patients who already had treatment (NHS or private)
- 11 patients who had treatment booked soon
- 1 patient who was deceased

<u>Reasons for declining contact</u>:

- 11 patients stated no support was needed
- 3 patients changed their mind about surgical treatment
- 3 patients were not interested in engaging
- 9 patients gave no reason for declining
- 7 patients did not respond to contact attempts

Figure 1. Patient contacts and reasons for declining contact



Beneficiaries

Patients

- Majority of patients aged between 60 and 79 years
- 47% waiting for hip treatment and 53% for knee treatment
- Many patients waiting for multiple hip and knee treatments
- 100 patients accepted follow up, 15 required ongoing casework
- 35 patients identified in significant informal caring roles

Agencies

- Additional touchpoint between the hospital and their patients
- Promoting patients' fitness for surgery, e.g. exercise referral
- Contribution to falls prevention and ED admission avoidance
- Earlier referrals into community services and other resources
- Limiting patient deterioration and preventing referral in crisis

Pathways

Although the initial contact was to discuss housing adaptations and mobility supports, NNDC wished to take a more holistic approach, with information available for wider issues, should they be identified by the patients.

- Pathway One NNDC Housing Adaptions Team
- Pathway Two Trusted Traders guidance
- Pathway Three Occupational Therapy
- Pathway Four Social Prescribing
- Pathway Five Physiotherapy
- Pathway Six VCSE connections

Outputs

Housing Adaptations

- 32 referrals sourced and initiated within Housing Adaptation Team
- Applications relating to bathroom adaptation, access and stair-lifts

Occupational Therapy

- 43 referrals sent to single point of contact (SPoC) for OT assessment
- Earlier prescription of equipment usually issued for surgical recovery
- Promoted greater independence and falls prevention while waiting
- 14 patients signposted to independent disability aid providers
- 5 patients signposted to Trusted Traders for disability adaptations
- 12 patients signposted to community personal alarm services
- Many patients also supported to claim benefits used to buy equipment

Physiotherapy

- 15 referrals sent to single point of contact for physiotherapy
- 75 patients sent printed exercise sheets or links to exercise videos
- 61 patients signposted into local mobility exercise classes

Social Prescriber

- 19 patients supported to apply for Blue Badges
- 37 patients referred to Financial Inclusion for benefit claim support
- 10 patients referred to Foodbank or Energybank for financial support

VCSE

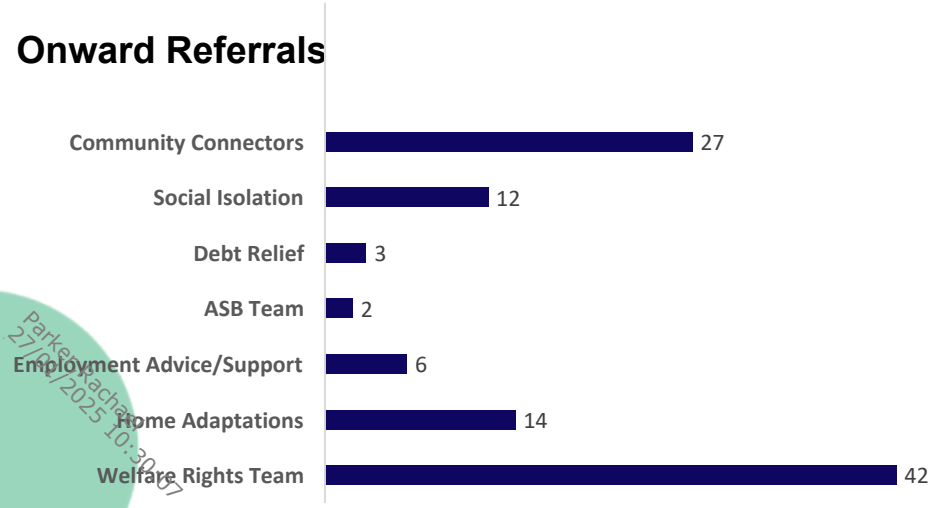
- 21 patients signposted to North Norfolk Community Transport
- 8 patients signposted to Slimming World or Your Health Norfolk
- 35 patients were identified in significant informal caring roles
- 25 referrals to Carers Matters Norfolk for carers assessments

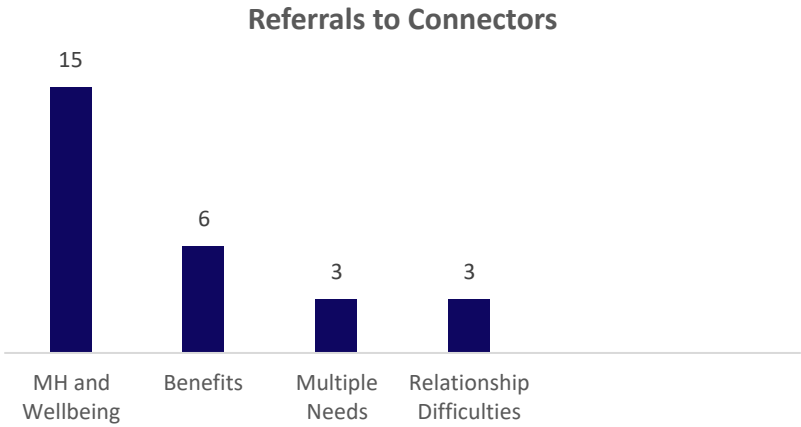
Broadland

Summary

- 797 on waiting list and visited
- 104 (13%) of those contacted required a referral
- Referral median age was 68

Onward Referrals





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Norwich Place Update

Claire Leborgne - Head of Place Development, Partnerships and Planning (Norwich)

Sarah Young – Head of Integrated Operational Delivery (Central Norfolk)

Tracy Williams – Clinical Advisor and Norwich Place Board Chair

Know Your Place....

	Crome	Sewell	Catton Grove	Thorpe Hamlet	Norfolk average
Life expectancy (women)	82	83	83	81	84
Life expectancy (men)	76	78	79	79	80
Deprivation ranking (out of 84 wards in Norfolk, where 1 is the most deprived)	8	17	13	19	N/A
Rate of preventable cancer deaths (per 100,000)	77	73	98	83	48
Mental health – rate of suicide deaths (per 100,000)	19	18	14	22	11.5
Dementia (adults 65+ with dementia)	5.2%	4.9%	3.8%	7.2%	3.8%
Emergency hospital admissions in 0-14s	125	108	115	124	92
Smoking	18.8%	13.7%	16.2%	15.1%	13.4%
Healthy weight – year 6 children who are obese	19.7%	21.2%	20.8%	18.0%	24%
Teenage pregnancy – per 1,000 girls aged 15-17	18.6				13
Domestic abuse incidents (per 1,000)	40	32	34	41	23

Community Conversations

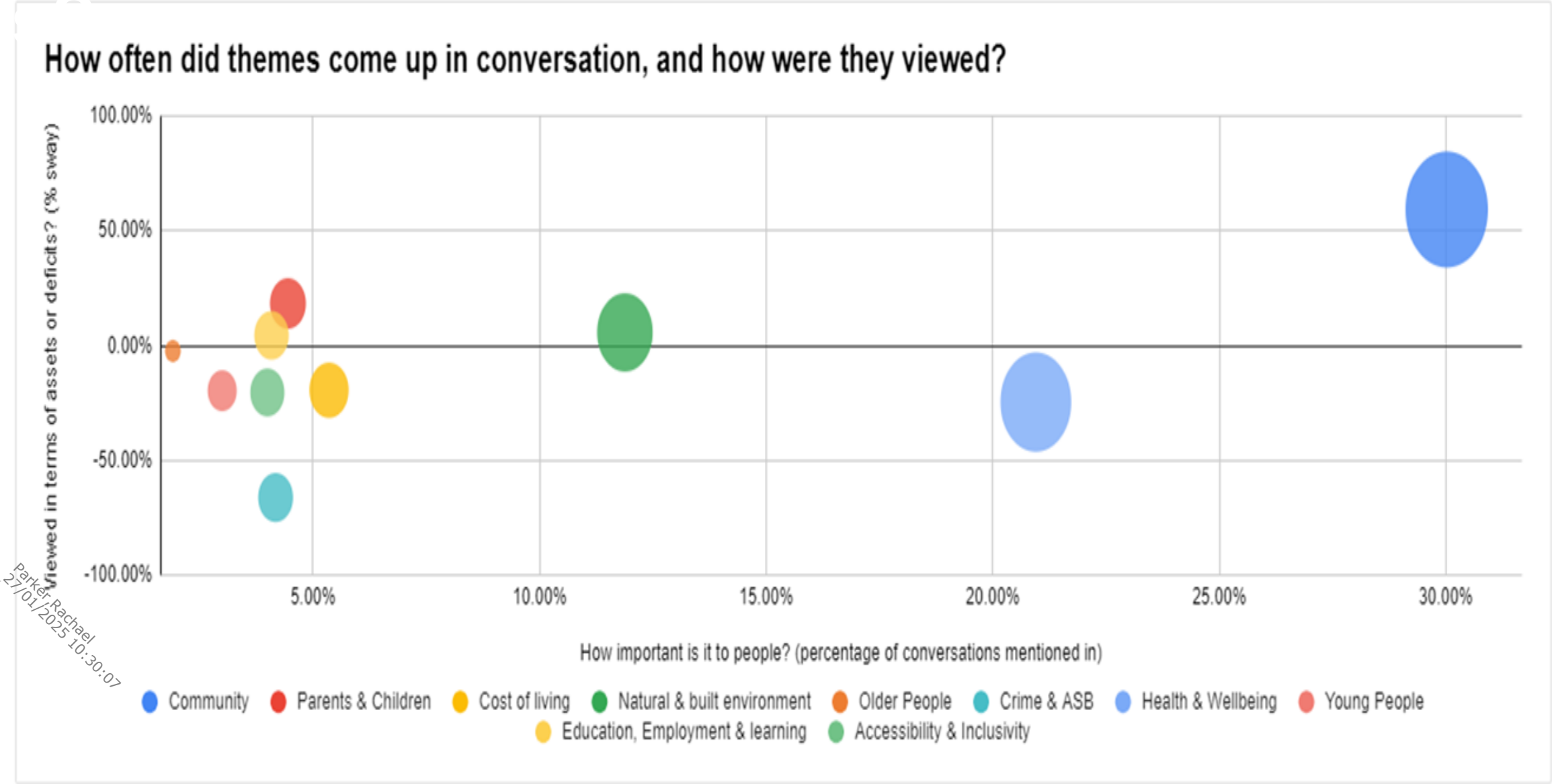
Since November 2021, our Community Connectors, hosted by The Shoebox Enterprises CIC, have been having conversations in their neighbourhoods with residents to **discover what matters to them**, what they are passionate about and what they want to do with others to help them flourish in community life.

Connectors have been talking to people in three of our RITAs (Reducing Inequality Target Areas) - Mancroft, Mile Cross and Earlham.

Insights gathered by connectors are analysed and summarised on a publicly accessible website and used to inform local decision-making. Work is underway to combine this information with other data for RITA to improve our understanding of hyper-local needs.

www.communityconversations.info

What are our people and communities telling



VIDEO link to be inserted here

- Inequalities in life expectancy in Norwich by ward
- Tea @ 3 – Supporting our local workforce
- INTERACT (Integrated Anticipatory Care Team)
- Safe and Habitable Homes
- CHESS (Complex Health and Enhanced Social Support
- Support NoW
- WARM (Warmth and Respiratory Management)
- Old Catton – Integrated Working
- Gurney – Integrated Working

Norwich Place Board

INTERACT

Tea @ 3
Connect, Communicate, Collaborate

SHHS
Supporting Better Living

Norwich Health & Wellbeing Partnership

Please get in touch if you'd like more details:

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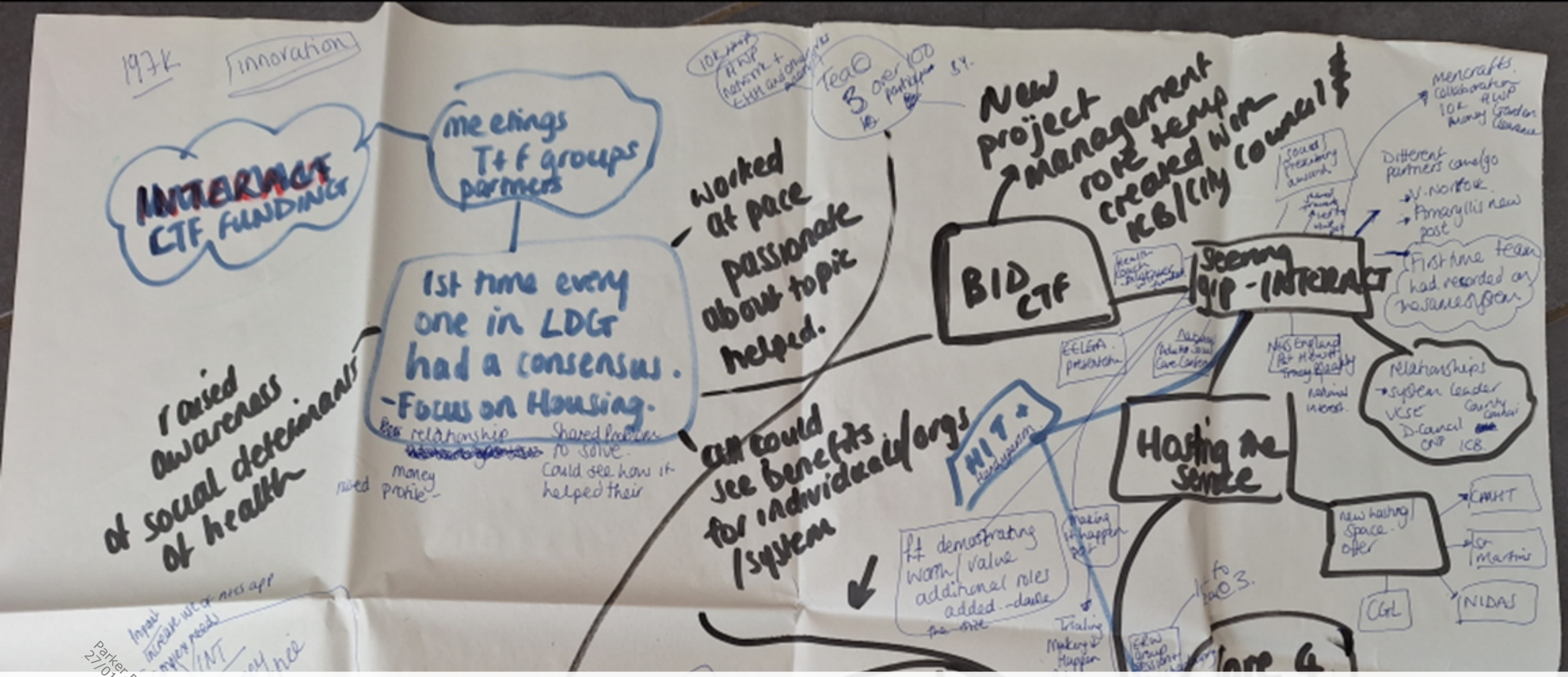

The Ripple Effect

Key ingredients for success…

Norwich Place Board

A **shared ambition** across Norwich system partners to focus on prevention, early intervention and the wider (social) determinants of health

A **proven track record** in the delivery of integrated projects within existing resources

A coalition of the willing based on well-established **local relationships**, high levels of trust and an appetite for piloting new approaches

Agreement to build on what we've got and join up existing assets to make best use of our finite resources

An **agile and flexible approach** to service development that evolves to deliver the best outcomes for people rather than organisations

Solid understanding of **place-based network** of provision and the effective use of hyper-local services and initiatives

Committed, strong, cross-sector partnership contributing resource, skills and knowledge

Clear roles and effective local leadership at all levels of integrated working

Evidence gathering and data sharing to evidence impact and inform future business cases

Thank you For listening

Any questions…?

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

Appendices

- Inequalities in life expectancy in Norwich by ward
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- INTERACT (Integrated Anticipatory Care Team)
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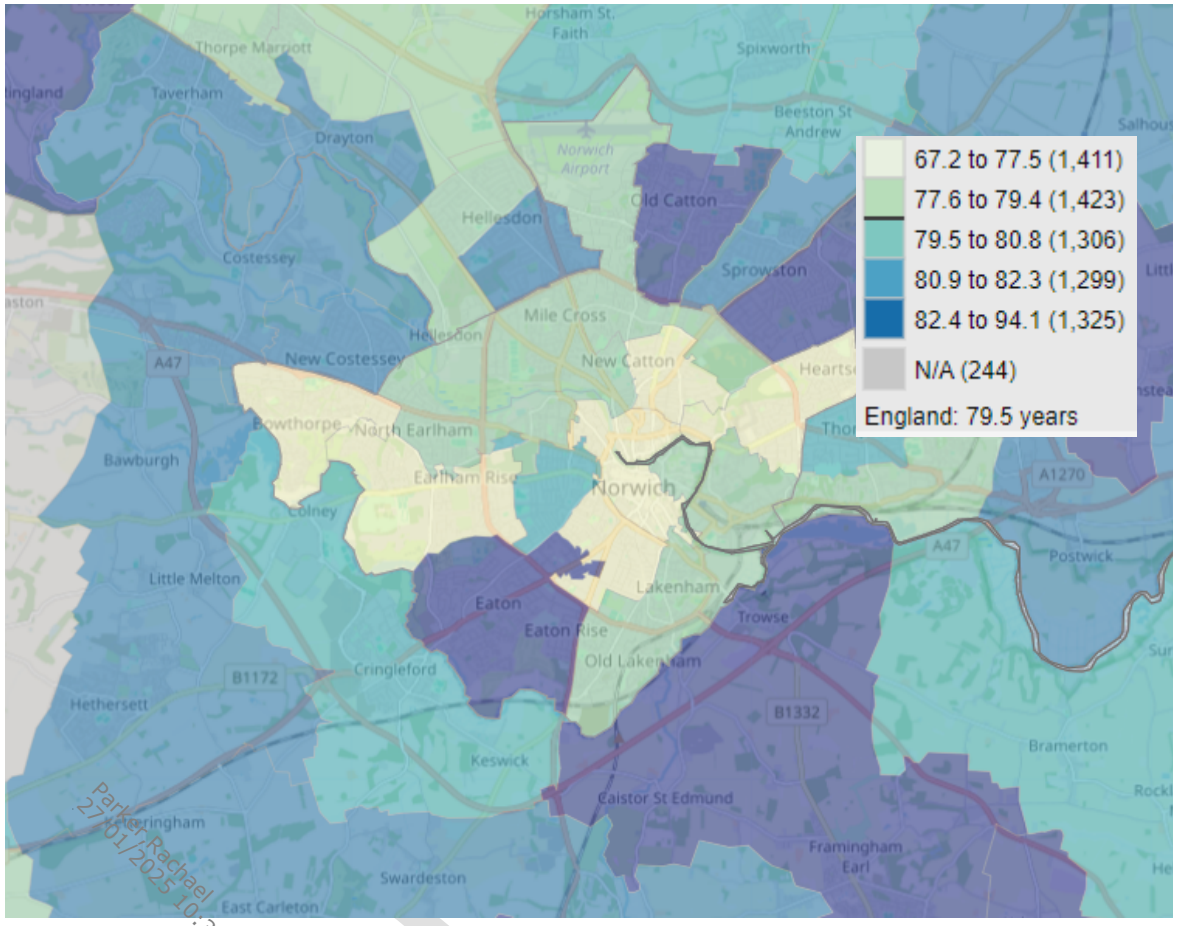
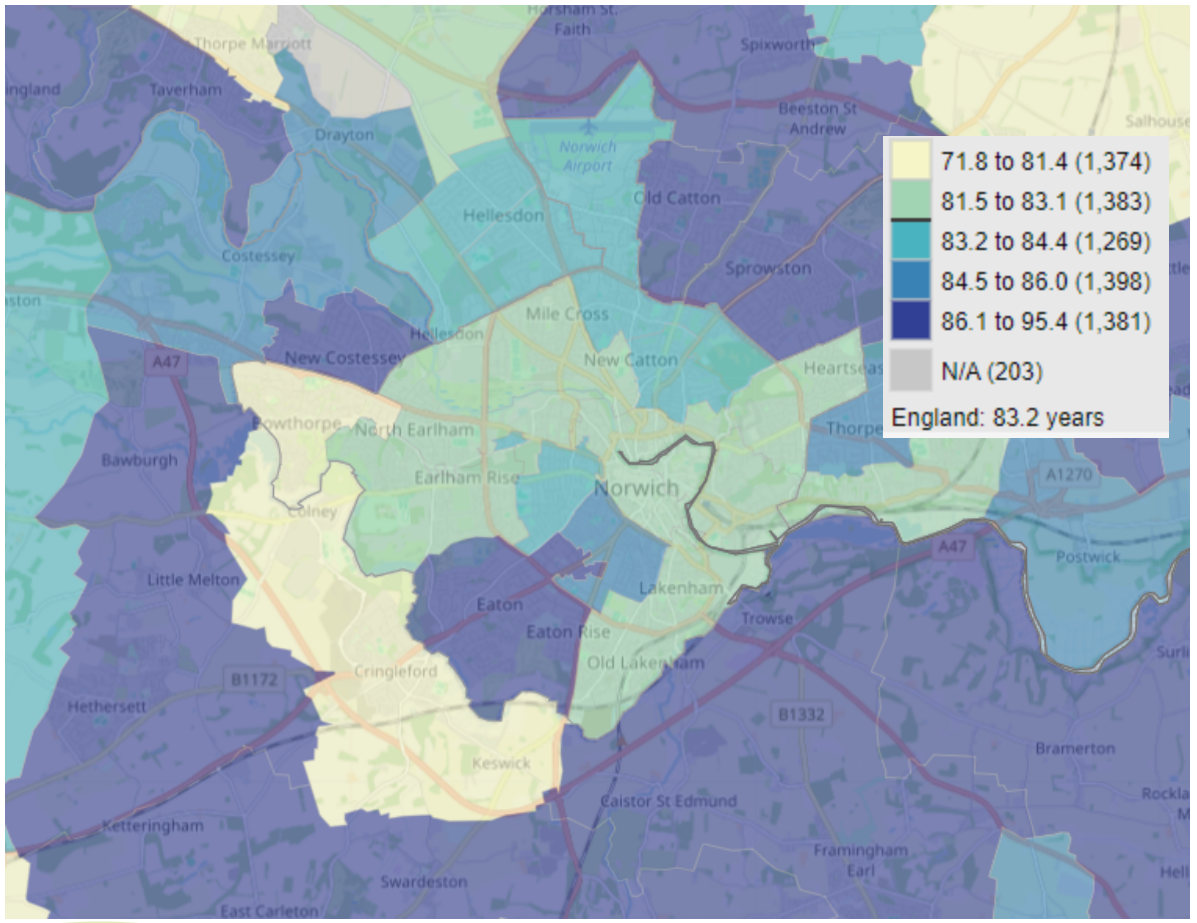
Inequalities in life expectancy in Norwich by ward



LE at birth, 2016-20. Males



LE at birth, 2016-20. Females

Norfolk County Council

https://www.localhealth.org.uk/#bbox=94917,6937062,92825,48628&c=indicator&i=t4.le_f_v&view=map12

Tea @ 3

- a local networking initiative started in March 2023
- encouraging 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 approach to ensure that community needs and challenges are addressed
- effectively rebuilding relationships impacted by high levels of demand, remote working and COVID-19

“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
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INTERACT
Integrated Anticipatory Care Team

- **INTERACT** is a multi-agency team providing holistic support for people whose housing or home environment is negatively impacting their health or wellbeing. It helps people achieve their goals like:
  - moving to a more suitable home (including practical support)
  - managing their home or garden, through cleaning, decluttering, and adaptations
  - increasing income and reducing isolation
- Developed by the Local Delivery Group (the precursor to the Norwich Place Board) and hosted at City Hall, **INTERACT** is delivered by Age UK Norwich, Norfolk Citizen's Advice, Norwich City Council and Norfolk County Council and has evolved over time to provide the mix of skills and organisational links to best support people with these issues. N&W MIND are now working with the team.

INTERACT
Integrated Anticipatory Care Team

- Working in an integrated way has brought challenges around data sharing and systems access but has delivered huge benefits from a wide range of skills, resources, and networks to support people in a personalised way
- Volunteers from Menscraft are now supporting **INTERACT** clients with garden clearances in an allied partnership project, supporting the wellbeing of both parties
- **INTERACT** has received over **900 referrals** from partners since it began in April 2022, around 80% of whom were aged 50+. Evidence demonstrates people's improved satisfaction with their accommodation, physical and mental health with an associated reduction in activity within statutory services

INTERACT – A case study

K's situation

K is a 49-year-old woman living in a third floor, 2 bed City Council flat

She has complex physical and mental health needs including diabetes, mobility issues and COPD

Having previously worked full time, she was struggling to manage her property and told us that she was lonely, grieving her partner and unable to leave the property

K's goals

To improve her mental and physical health
To declutter in preparation for a move
To identify a suitable ground floor property
To reduce her social isolation

Benefits

Improving K's health and wellbeing
Increasing her ability to remain independent at home
Building her resilience to future challenges
Reducing the need for intervention by other services

Working with K, INTERACT:

- Completed a medical assessment form and gained a disability rating on her Home Options application
- Helped her move from 3rd floor flat to an adapted bungalow
- Successful Blue Badge application
- Helped her access the diabetes clinic, REST, a weight management service and linked in with an Age UK Health Coach
- Sought grant funding to carpet her new home
- Reviewed benefits and successfully applied for PIP
- Provided gardening advice and support via Menscraft who made waist height planters
- Linked with Voluntary Development Worker to support volunteering opportunities – Age UK Befriending

INTERACT
Integrated Anticipatory Care Team

- One resident with limited mobility due to a long-term health condition, was supported to move into a ground floor home, increase his income and reduce his isolation.

> “I’d been trying to navigate the housing system for two years. I couldn’t have done it without you - you’ve been such a big help. I’m over the moon with how things have turned out.”

- **INTERACT** has improved our understanding about the housing issues facing local people and identified a gap around long-term, holistic hoarding support, leading to the development of its sister-service **Safe Habitable Homes**.

Safe Habitable Homes - Who are we?

- Safe Habitable homes was set up to support people around self-neglect and/or hoarding, a high-risk issue that affects a significant number of people in Norwich.
- We are a tenure-neutral, trauma-informed service delivered by a partnership of St Martin's, Norwich City Council and Norfolk County Council, working with wider partners such as the Fire Service.
- Since the start of the service 2 years ago, we have received 149 referrals. 30 people have already met all their goals, and we are currently supporting 37residents, 18 of whom were initially assessed as high risk in line with the NSAB guidance. This figure has now reduced to 7 due to the team's involvement. There are 11 people on our waiting list.
- We identify and prioritise people for SHH support based on information from Norwich City Council, Adult Social Care, NFST, fire services, and colleagues from the voluntary sector
- All our clients have physical and or/mental health needs. We see significant number of people with mobility conditions, drug and alcohol use, severe depression and psychotic disorders, many of whom we have supported to access health and social care support

SHHS

Supporting Better Living

Safe Habitable Homes – Our Aims

- Reducing fire risk
- Reducing the risk of falls
- Reducing the risk of poor health related to clutter, infestation, or infection
- Improving the person's self-reported wellbeing and addressing the wider determinants of health
- Improving the person's ability and confidence in engaging with wider services, including healthcare (we have identified a high prevalence of diabetes and pre-diabetes in the people we support)
- Reducing the risk of cluttering, hoarding and self-neglect behaviours restarting after clearance and support
- Engaging and supporting unpaid carers and families to be part of the support team, where appropriate
- Reducing the need for formal housing procedures such as eviction or enforcement by anti-social behaviour or public protection teams

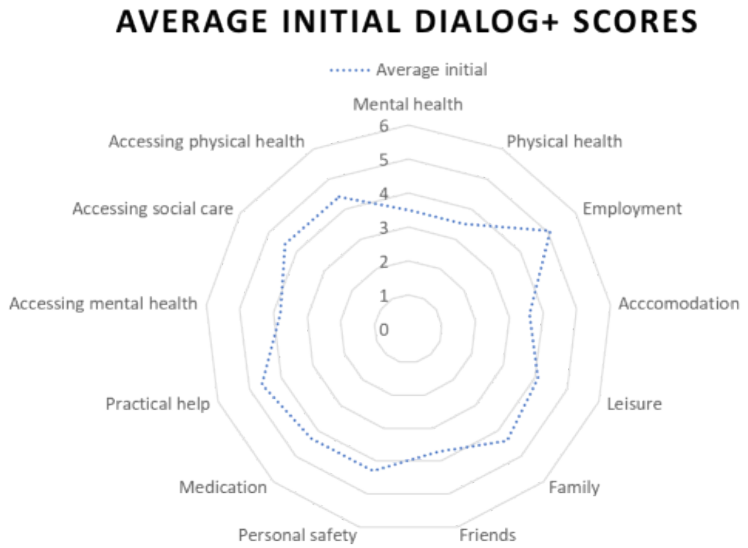
SHHS

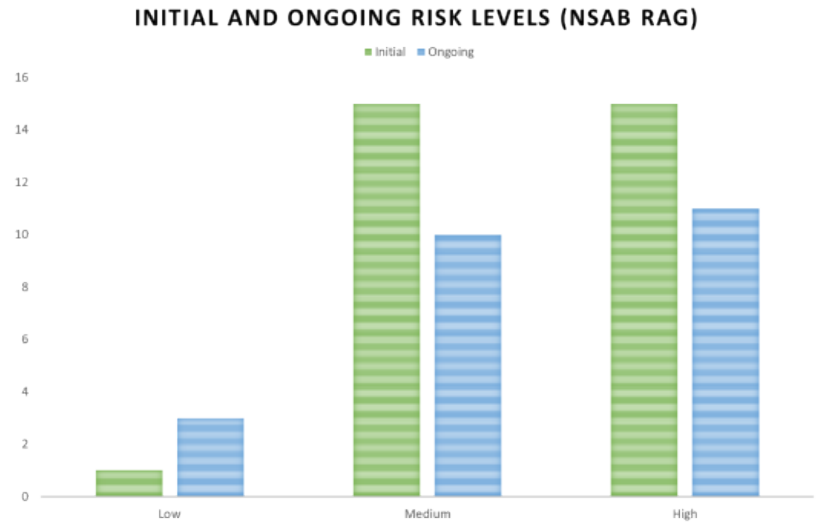
Supporting Better Living

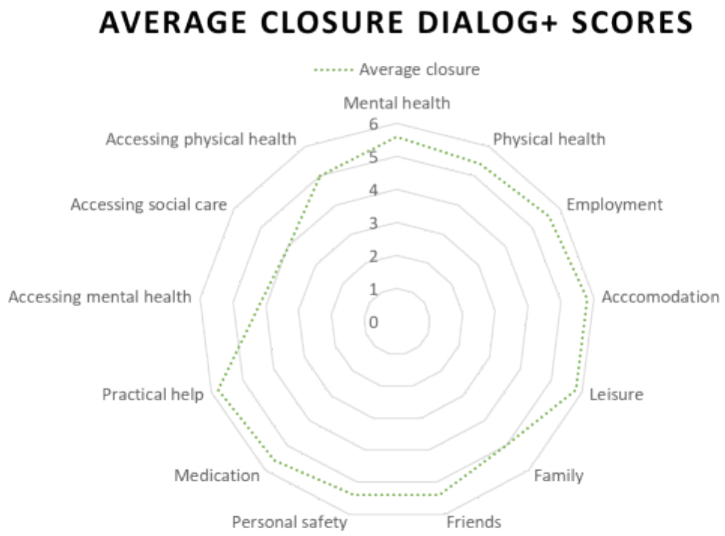
How has it affected the wellbeing of our residents?

Our risk levels (RAGs) and clutter scores (CIRS) have come down across the board

Our Dialog+ scores have ALL increased following support







What have we delivered in way of savings?

- We have a **70-80% engagement rate** with our residents who have all historically struggled to engage with services
- **34%** of our referrals are from Adult Social Services – we have supported many clients to make long-term changes where ASSD does not have the capacity for long-term work
- **41%** of our referrals come from housing teams at Norwich City Council, often allowing us to engage clients with support before their needs become higher, preventing the need for Social Care
- We have supported 5 council tenants to engage with outstanding gas and electrical works and 5 residents to receive property upgrades – preventing the need for legal processes to be actioned

CHESS – Complex Health & Enhanced Social Support

- **CHESS** is delivered by Age UK Norwich and funded by Norwich HWP until March 2025 from its Better Care Fund (BCF) allocation
- The service provides holistic support for frail and/or older people living with complex health or social needs to help them live as independently as possible for as long as possible
- People are proactively identified by adult social care or referred to the service by Norfolk First Support and our community nurses
- The **CHESS** team provide regular welfare checks to monitor health and other risks and deliver a range of personalised interventions for up to 12 weeks, such as physical activities, practical support with the home and garden, information and advice about health and care, and companionship.

CHESS – Complex Health & Enhanced Social Support

- People's health has improved significantly as a result of the flexible support on offer, with an increase of 31% in people's self-reported scores
- **CHESS** has also demonstrated its effectiveness in reducing demand for emergency health and care as, during CHESS support:

  ✓ 87% did not have an emergency GP appointment
  ✓ 92% were not hospitalised in an emergency
  ✓ 86% did not have an increase in home care services
  ✓ 80% did not have a fall or a trip

Support NoW Development - The Issue

There is growing need to help people in Norwich deal with life issues*

These issues make our population less healthy, and we lack a coordinated response to meet these needs.

This is our greatest population health risk.

**Non-clinical*; psycho-social; socio-economic; the social determinants of health that contribute to 80% of health factors; the stuff that makes you sick like finance, debt, housing, benefits, relationships, ACEs, employment, legal, etc.

The Ambition

A single system* to help anyone in Norwich to address their life issues.

That system to innovate, learn and deliver solutions to provide support to anyone who needs it in a sustainable and inclusive way.

* a set of things working together as parts of a mechanism or an interconnecting network; a complex whole; (not just a policy construct); everything, not exclusive

norwich 2040 city vision

Norwich
Health & Wellbeing Partnership

STRATEGIC PLAN 2023-2025

Improving lives together

Norfolk and Waveney Integrated Care Strategy and Norfolk Joint Health and Wellbeing Strategy

Setting the agenda for our Integrated Care System across Norfolk and Waveney

Parker Rachael
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Promoting Independence

Promoting Independence Strategy
Adult Social Services

Supporting people to be independent, well, and able to deal with life's challenges.

2024 – 2029

NORWICH City Council

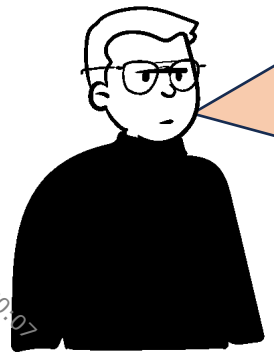
We are Norwich

A community-led plan
2024-2029

What benefits will Support NoW provide?

"It is easy for me to refer people for support and know that they will receive the help that they need"
"I am kept up to date about the support the person is receiving"
"I can work jointly with the service to coordinate a holistic package of care which reduces pressures on my time and my team's resource"

"I can get support from friends, neighbours and others in my community"
"When I need extra help, I know where to go and it's easy for me to access"
"I have a lead case worker who helps me navigate the system"
"The services that support me work together to coordinate my care and support me to achieve my goals"
"It's about what matters to me, not what's the matter with me"



"The support provided improves outcomes for the person and for my organisation, like reducing demand for statutory services now and in the future."
"If additional funding becomes available, Support NoW provides the evidence of what is needed, an effective and flexible way to deliver outcomes, and can demonstrate that they have been achieved."
"I can use shared data to target offers of support or communication campaigns at key audiences."

Parker Rachael
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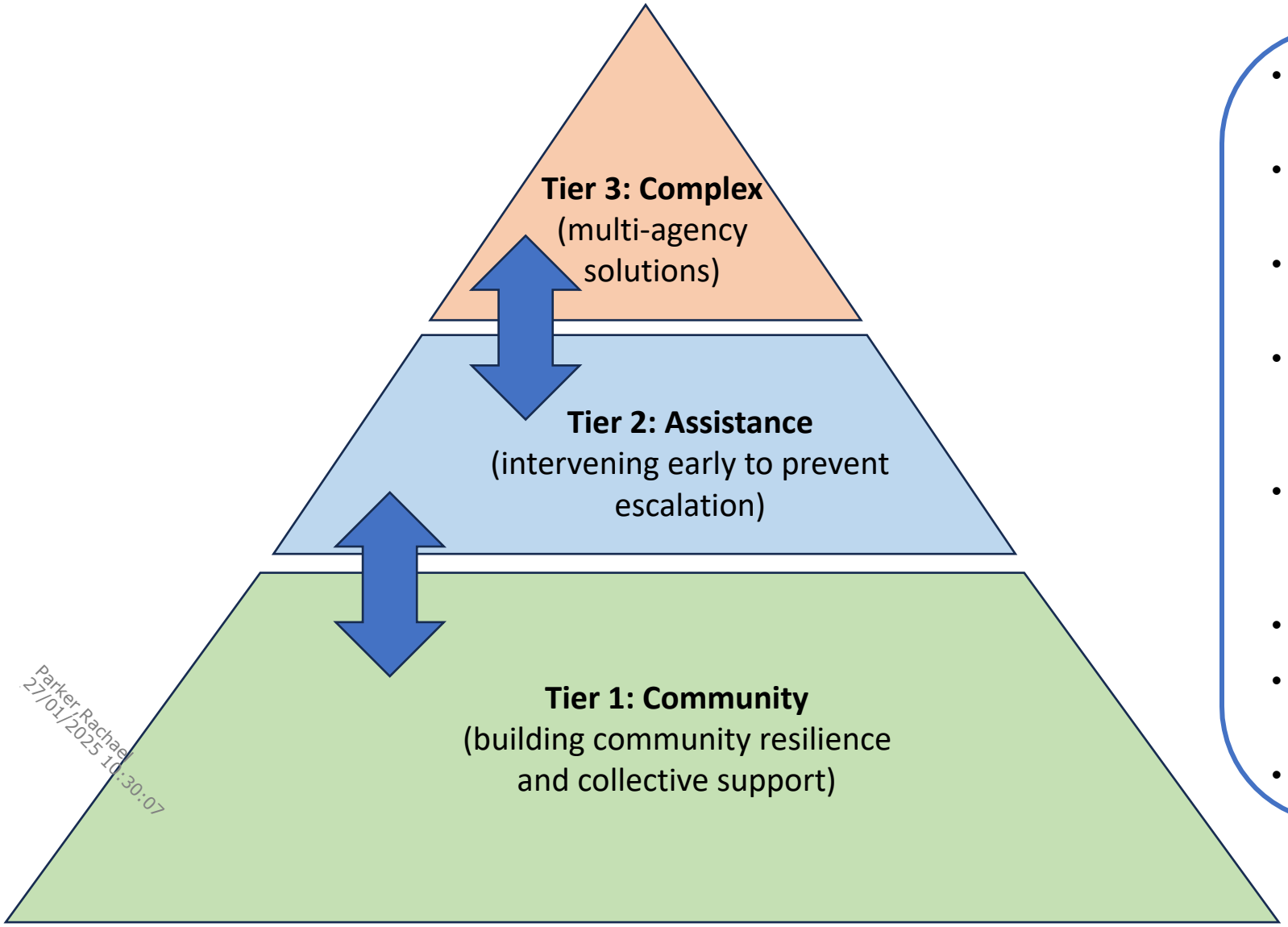
What would Support NoW look like in practice?

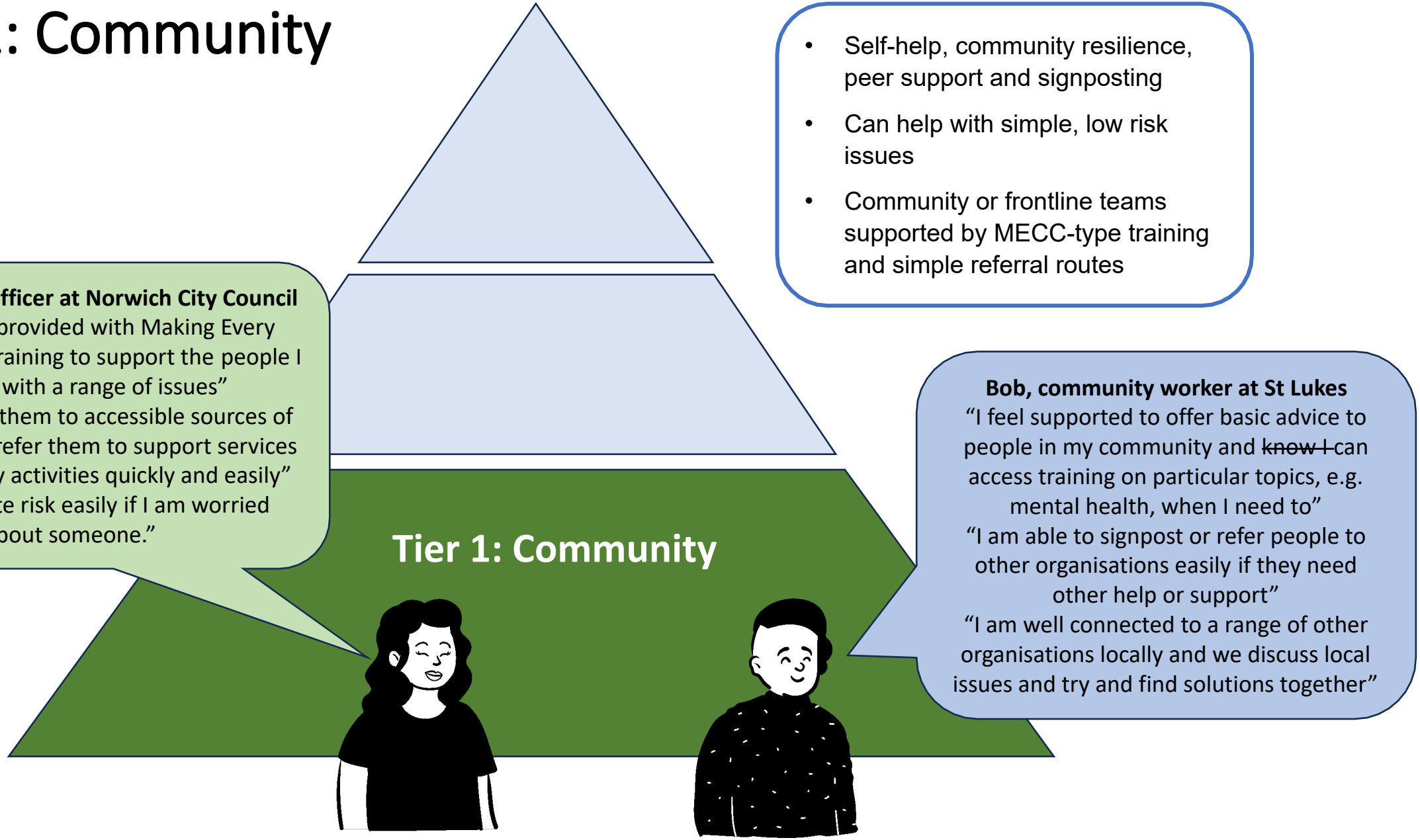


- Easy to access, directly by communities or via professionals
- All age, person-centred offer, supporting with range of life issues
- Coordinated support with clear point of contact
- Proactive case-finding and offer of support to those who need it most, or targeted communications campaigns
- Co-produced and flexible to emerging local needs based on data and community insights
- Delivered via shared resources
- Well networked teams with shared values, tools and information
- Demonstrates outcomes achieved

Tier 1: Community

- Self-help, community resilience, peer support and signposting
- Can help with simple, low risk issues
- Community or frontline teams supported by MECC-type training and simple referral routes

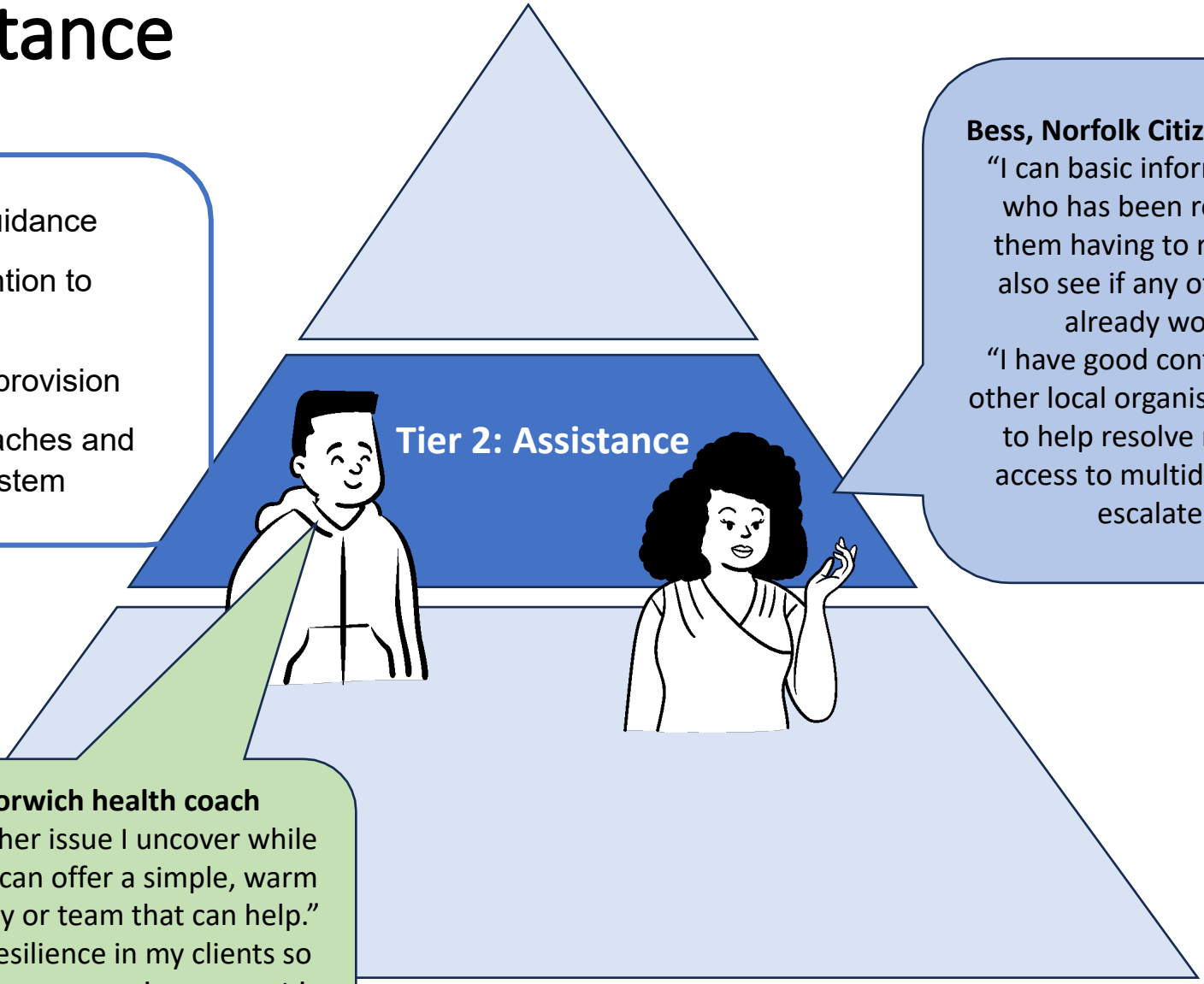
Jane, housing officer at Norwich City Council
"I have been provided with Making Every Contact Count training to support the people I speak to with a range of issues"
"I can signpost them to accessible sources of information or refer them to support services and community activities quickly and easily"
"I can escalate risk easily if I am worried about someone."



Bob, community worker at St Lukes
"I feel supported to offer basic advice to people in my community and ~~know I~~ can access training on particular topics, e.g. mental health, when I need to"
"I am able to signpost or refer people to other organisations easily if they need other help or support"
"I am well connected to a range of other organisations locally and we discuss local issues and try and find solutions together"

Tier 2: Assistance

- Specific advice and guidance
- Medium risk – intervention to avoid risk escalating
- Predominantly VCSE provision
- Using common approaches and information sharing system

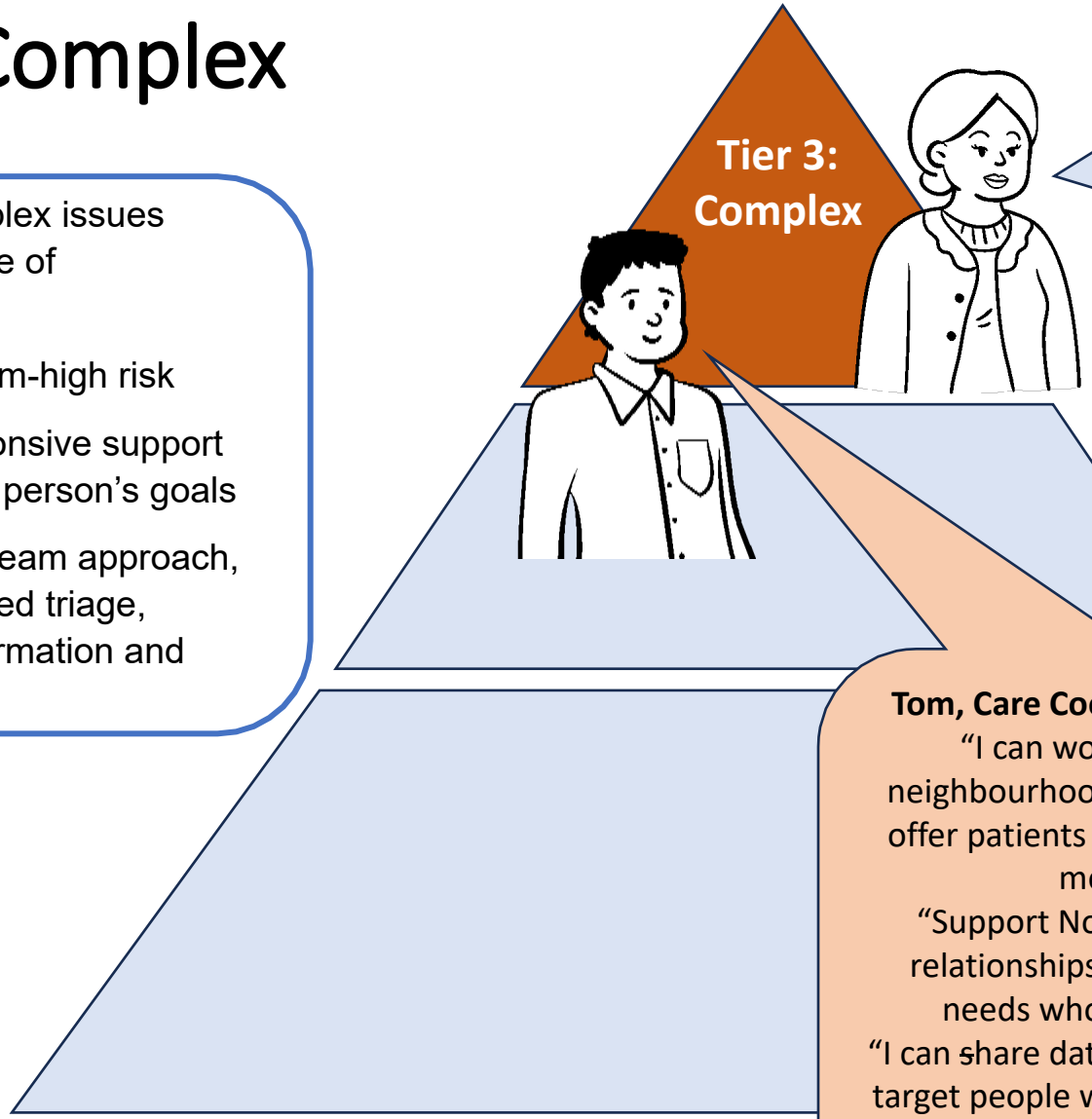


Bess, Norfolk Citizen's Advice debt advisor
"I can basic information about someone who has been referred to me without them having to repeat their story. I can also see if any other local agencies are already working with them"
"I have good contacts with colleagues in other local organisations who I can contact to help resolve my client's issues, and access to multidisciplinary meetings to escalate any concerns"

Steve, Age UK Norwich health coach
"If my client has another issue I uncover while working with them, I can offer a simple, warm handover to an agency or team that can help."
"My support builds resilience in my clients so that they are able to access ongoing support in their communities."

Tier 3: Complex

- Multiple, complex issues involving range of organisations
- High or medium-high risk
- Flexible, responsive support based around person's goals
- Multi-agency team approach, with coordinated triage, access to information and shared tools



Jo, social worker at Norfolk County Council

"It is easy for me to refer people for support with a whole range of tricky issues, and know that they will receive the help they need"

"I am kept up to date about the support the person is receiving"

"I can work jointly with the service to coordinate a holistic package of care"

"The support provided improves outcomes for the person and reduces the demand on my time and my organisation's involvement, now and in the future"

Tom, Care Coordinator at Gurney Surgery

"I can work across my integrated neighbourhood team and Support NoW to offer patients personalised care that really meets their needs"

"Support NoW is able to build working relationships with people with complex needs who we struggle to engage."

"I can share data with partners to proactively target people with an offer of support which helps reduce demand on my practice and the wider system."

WARM Pilot Project (Warmth & Respiratory Management)

Aim: To identify people who frequently present at their GP practice with respiratory related conditions and support them in an integrated and holistic way, by addressing issues such as housing, income and other factors which may be exacerbating their health.

136 people referred for support by GP Practices and the Vulnerable Adults Service in Norwich

99 people/families accepted support

26 people required onward referrals

45 onward referrals completed

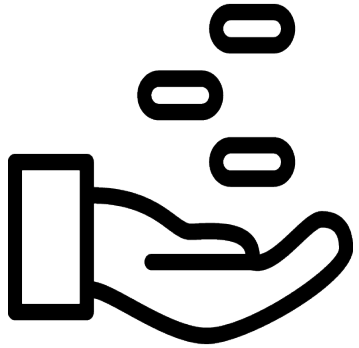
£21,748.00 hardship funding awarded

Additional Support Offered

Long Term Financial and Employment

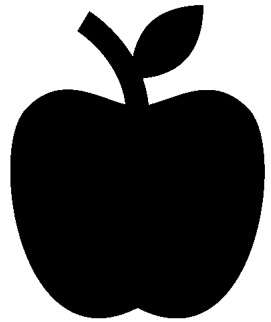
Community Matron

Housing Repairs & Maintenance



Financial Assistance

Carers Support



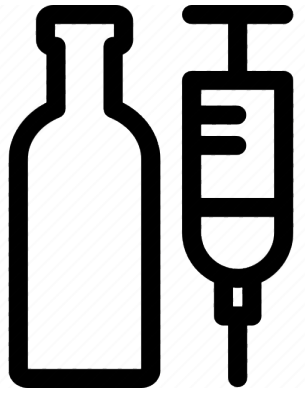
Food Insecurity

Mental Health

Welfare Rights

Settled Status

Court and Legal



Drug and Alcohol

Old Catton
Integrated Working Development Gr

During 2024 we:

- Established a development group that meets regularly
- Produced a survey that has been completed by 250+ patients. This will shape the community engagement plan for 2025
- Built and strengthened relationships across different organisations to support the practice population
- Completed a review of housebound patients, between the GP Practice and NCH&C, with a new process implemented by the practice to regularly review housebound status
- Setup a process for sharing discharge data from HomeFirst Hub to the GP Practice
- Reviewed the monthly multi-disciplinary meetings (MDMs) and adopted a proactive care approach

https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

Old Catton
Integrated Working Development Group

- Set up a Patient Participation Group (PPG) on the back of a coffee morning held at the practice, which was attended by over 30 people, 14 of whom formed the PPG
- Increased awareness that the Old Catton population straddles two district council areas
- Established a forum to raise awareness of and promote services which has improved understanding and fostered effective working relationships between providers
- Presentations to date include:

  - Mental Health in School Team
  - Family Hub
  - CYP Tier 2 Weight Management

Gurney
Integrated Working – Our starting p

Data tell us the health outcomes for people living in the catchment area of Gurney Medical Practice (part of Castle Partnership) are worse that the Norfolk average in several areas. Our resident voices work supports the data. highlighting loneliness, isolation, food and fuel poverty, poor housing and poor mental health as key issues. All 4 wards are in the top 20 most deprived areas of Norfolk, one ward is in the top 10 most deprived areas.

- Operational leaders from across organisations said they didn't know who was who, what services did and how to access them
- There was confusion about pathways, a lack of shared risk management, little continuity of care for those who need it, and many hours were lost each week with multiple staff trying to navigate a complex system, often without opportunity to have joined up dialogue in a psychologically safe environment
- Knowledge of community assets was limited, and focus was often on the case work presenting to individual organisations rather than 'coming together to support a local community'

https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

Gurney Integrated Working

Improvements in Multidisciplinary meetings

Developed new documentation which focuses **on risks, protective factors, actions and the person's voice**

Increased engagement and shared gaps with the operational leader's group for them to resolve

Proactively identified people who need a multi-agency response

Built in time for **specific case discussion** e.g. between community matrons to discuss cases with GP practice

Weekly Operational Leadership Huddles

Share an overview of multiple pathways, services and information

Improved connectivity in and outside of the meeting

Building trust

Information sharing, better understanding of each other's pressures

Led to a separate group to understand how we can provide support for people with complex needs

Gurney Integrated Working

Build relationships across our connector roles

Connector type roles often had a range of support options available but could be a stronger offer as a 'team'

Specifically Social Prescriber, Care Coordinators and Integrated Care Coordinators

We would support them to work closer together by…

sharing office space at the practice, regularly discussing cases, Improving transfer/pathways between the roles

Build Community Connections

We knew that the local community groups had knowledge, skills, capacity and expertise that we could not manage without

Such as local church groups, VCSE groups and local businesses

We started to reach out to a few key groups to build relationships between the community and health and social care system.

We aim merge workstreams across this area together in 2025

Norfolk and Waveney
Integrated Care Board

Agenda item: 08

Subject:	**VCSE Assembly Update**
Presented by:	**Tim Gardiner, Chair VCSE Assembly**
Prepared by:	**Tim Gardiner, Chair VCSE Assembly**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**23/01/2025**

Purpose of paper:

Chairs Report to update on the most recent VCSE Assembly Board meeting and actions arising.

Executive Summary:

The VCSE Assembly Board held its first formal meeting since the appointment of the new Chair on 22nd January 2025. New members from across the Integrated Care System (ICS) attended the meeting for the first time, ensuring greater input from those who partner with the Voluntary, Community and Social Enterprise (VCSE) sector.
The Board received a verbal presentation from Tracey Bleakley, CEO of the Integrated Care Board (ICB), regarding the financial update across the ICS and its potential impact on VCSE partners in the forthcoming financial year, particularly those delivering ICB-commissioned services.
The meeting also focused on new governance structures and processes within the assembly, including a risk register to identify and address sector-wide risks as system challenges.

Chair's Update

Since commencing my role in October 2024, I have prioritised engagement with partners and colleagues across the ICS and the VCSE sector. I have met with all VCSE Board members, as well as colleagues from Norfolk County Council, Place Board leads, and ICB staff, including members of the Executive Leadership Team.

I have also engaged in learning from VCSE assemblies across the country, with the aim of implementing best practice and ensuring the effectiveness and efficiency of the VCSE assembly within Norfolk and Waveney. Colleagues from Suffolk and North East Essex (SNEE) have been invaluable in sharing their experiences, and I will seek to incorporate this learning into future assembly board workstreams.

The Norfolk and Waveney Assembly is now an established member of a wider East of England VCSE Assembly network, providing an opportunity to contribute to a broader national VCSE Assembly network.

New Terms of Reference were presented at the most recent meeting for comment and agreement, alongside other governance documents such as role profiles, which will be agreed upon in the near future and will come into effect at the next VCSE Assembly Board meeting in March 2025.

A new process for requesting VCSE representation has been established, enabling colleagues from across the ICS to submit requests for VCSE support and representation. This will also allow ICS colleagues to request agenda items for assembly board meetings.

A risk register was established as a key agenda item, identifying significant risks within the VCSE sector. This register will serve to highlight these risks as system-wide challenges, impacting patients and communities across our region. It will also facilitate a collaborative approach with ICS partners to mitigate these risks.
The risk register will be instrumental in developing workstreams across the assembly, assisting in determining the appropriate ICS partners responsible for each workstream.

The register categorises risks into three key areas:

- **Commissioning the sector**
- **Partnering with the sector**
- **Resilience within the sector**

Furthermore, the risk register will provide the assembly with a tangible document to complement an action log, enabling the assessment of the impact and effectiveness of all workstreams.

"Innovation Hubs" will be introduced in the new financial year (2025/26), providing an opportunity to engage the wider VCSE sector on a specific issue. The first "Innovation Hub" is scheduled for May/June 2025. This initiative will facilitate broader engagement and representation from across the sector. ICS colleagues can utilise the new representation process mentioned above to suggest topics for these "Innovation Hubs".

It has been acknowledged that there is a need to enhance engagement and communication across the VCSE sector and ICS structures to increase awareness of the assembly. A communications plan for engaging the VCSE sector has been drafted to support a period of engagement, alongside plans to ensure that meeting notes and relevant papers are accessible to the wider VCSE sector, promoting transparency and encouraging active membership. Consideration is being given to submitting a paper at an upcoming ICP committee meeting to highlight the VCSE assembly to the wider ICS and encourage engagement from ICS colleagues.

Recommendation to the Committee:

Key Risks	
Clinical and Quality:	
Finance and Performance:	
Impact Assessment (environmental and equalities):	
Reputation:	
Legal:	
Information Governance:	
Resource Required:	
Reference document(s):	
NHS Constitution:	1. The NHS provides a comprehensive service, available to all 3. The NHS aspires to the highest standards of excellence and professionalism 4. The patient will be at the heart of everything the NHS does 5. The NHS works across organisational boundaries 6. The NHS is committed to providing best value for taxpayers' money 7. The NHS is accountable to the public, communities, and patients that it serves
Conflicts of Interest:	
Reference to relevant risk on the Board Assurance Framework	

Governance

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

Norfolk & Waveney VCSE Assembly Board – Notes (AI)

Tuesday 21st January 2025, 14:00-15:30 Venue: Virtual by MS Teams

(Please note that these notes were produced by the Microsoft Teams AI function and it has been identified that these notes are not a full representation of the meeting that took place and full minutes will be produced in due course.)

1	**In attendance:** Tim Gardiner (TG), Mark Hitchcock (MH), Dan Skipper (DS), Ali Gurney (AG), Emma Ratzer (ER), Dan Mobbs (DM), Hannah Edge (HE), Mark Burgis (MB), Lucy Hogg (LH), Amanda Gabrielson (AGa), Tracey Bleakley (TB), Shelley Ames (SA), Philippa Gregory (PG) **Apologies:** Nick Clinch (Ali Gurney deputising), Daniel Williams, Ash Bunn
	Standing Items
2	**Conflicts of interest:** There were no newly declared conflicts.
3	**Governance Requests:** TG, PG, and SA discussed the new governance request process for the ICS, which involves a Microsoft form for requesting representation from the voluntary sector assembly. This process aims to safeguard members' time and ensure appropriate representation. ○ **New Governance Request Process:** TG introduced the new governance request process for the ICS, which involves a Microsoft form created by PG and SA. This form will be sent out to members within the ICS to request representation from the voluntary sector assembly. The process aims to safeguard members' time and ensure appropriate representation by evaluating requests based on expertise and capacity. ○ **Form Preview and Feedback:** PG mentioned that the form is currently in preview mode and will be circulated with meeting papers for feedback. If there are no objections, the link will be made live for utilisation. ○ **Time Management:** SA emphasised the importance of this mechanism to safeguard members' time, as there have been numerous requests for voluntary sector representation. The process will help manage these requests and ensure appropriate allocation of time and resources. ○ **Standing Agenda Item:** TG stated that the governance request process will be a standing item on the agenda, allowing for discussion and decision-making on requests during meetings. ○ **Public Sector Collaboration:** HE highlighted the importance of understanding the nature of requests from the public sector and reflecting on how the public sector can change its behaviour to facilitate better collaboration with the voluntary sector.
4	**Meeting Minutes:** TG emphasized the importance of sharing meeting minutes and notes across the Assembly board and the wider voluntary sector. He mentioned utilising the web page and newsletters for this purpose.
5	**Action-Decision and Risk Log:** *Item missed due to time.*
6	**Terms of Reference:** *Item missed due to time.*
	Discussion Items
7	***Please note the AI function did not capture all the discussion for this item – full minutes will be produced.*** **ICS Finance Update:** TB provided an update on the ICS financial situation, highlighting the challenges and potential impacts on the VCSE sector and wider system. TB described the financial obligations of the ICB to raise awareness of existing commitments and how ICB budgets are spent. TB discussed the importance of understanding the impacts, risks and mitigations and ensuring we improve collaboration between the public sector and VCSE to develop solutions together.
8	***Please note the AI function did not capture all the discussion for this item – full minutes will be produced.*** **Collaboration and Engagement:** HE and TG discussed the importance of improving collaboration and engagement between the public sector and the voluntary sector. They emphasised the need for better communication, early involvement, and understanding the challenges faced by both sectors. ○ **Improving Collaboration:** HE and TG discussed the importance of improving collaboration and engagement between the public sector and the voluntary sector. They emphasised the need for better communication, early involvement, and understanding the challenges faced by both sectors to facilitate effective collaboration.

	○ **Challenges in Engagement:** HE highlighted the challenges in engagement, including the need for more time and energy for meaningful engagement and the difficulties in moving from single contract solutions to broader collaboration. She emphasised the importance of building the infrastructure for good engagement. ○ **Role of Elected Members:** HE discussed the role of locally elected Members in engagement, highlighting their involvement in communities and their potential to facilitate better collaboration between the public sector and the voluntary sector. ○ **Procurement Legislation Changes:** HE mentioned the upcoming changes in procurement legislation, including the requirement for earlier market engagement and the publication of procurement pipelines. She emphasised the need to get these processes right to facilitate better engagement with the voluntary sector. ○ **Addressing Misconceptions:** HE emphasised the need to challenge misconceptions about the voluntary sector, including the idea that the voluntary sector can always provide services cheaper or quicker. She highlighted the importance of recognising the value and capabilities of the voluntary sector in delivering services.
9	***Please note the AI function did not capture all the discussion for this item – full minutes will be produced.*** **State of the Sector Work:** PG provided an update on the state of the sector work, which aims to better understand the voluntary sector landscape at a local level. This includes gathering information through surveys, workshops, and one-on-one conversations to inform future engagement and collaboration efforts.
	Closing Business
	AOB: ***Please note the AI function did not capture all the discussion for this item – full minutes will be produced.***
	Actions
	• **Governance Requests:** Send the Microsoft form link for voluntary sector representation requests to the assembly members for feedback and utilisation. (PG) • **Governance Requests:** Keep the governance requests as a standing item on the agenda to discuss any new requests and involvement. (TG) • **Meeting Minutes:** Ensure that minutes and notes from the meetings are shared across the Assembly board and the wider voluntary sector, utilising the web page and other communication channels. (TG) • **Risk Register:** Capture and collate risks discussed during the meeting into a formalised risk register to be presented to the Patients and Communities Committee. (PG, TG and SA) • **State of the Sector Survey:** Share the state of the sector survey across relevant networks to ensure wide engagement and participation. (All Assembly Members – PG to share communications) • **CQC Inspection:** Prepare and share information about the upcoming CQC inspection with assembly members, including potential focus groups and questionnaires. (AG) • **Terms of Reference:** Review and provide feedback on the terms of reference for the assembly via email. (All Assembly Members)

Norfolk and Waveney
Integrated Care Board

Agenda item: 09

Subject:	**Population Health & Inequalities (PH&I) Board – 17/12/2024 – Assurance & Escalation Report**
Presented by:	**Dr Frankie Swords**
Prepared by:	**Dr Frankie Swords**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**27 January 2025**

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 17 December 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 and put in place new models of care to deliver improvements in health and well-being. This work is fundamental to the delivery of our ambitions in relation to Prevention and addressing Health Inequalities. There

	is a risk we do not achieve the impact we seek if we do not develop the infrastructure, the culture and approaches advocated as best practice.
Finance and Performance:	None identified
Impact Assessment (environmental and equalities):	N/A
Reputation:	None identified
Legal:	None identified
Information Governance:	None identified
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	1. The NHS provides a comprehensive service, available to all 3. The NHS aspires to the highest standards of excellence and professionalism 4. The patient will be at the heart of everything the NHS does 5. The NHS works across organisational boundaries 6. The NHS is committed to providing best value for taxpayers' money 7. The NHS is accountable to the public, communities, and patients that it serves
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	BAF 01 (Previously BAF 06)

Governance

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

Population Health & Inequalities (PH&I) Board - Points of Assurance / Escalation [17/12/2024]

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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
48.	PH&I Board	17/12/2024	Introduction to PHM Webinar – 06/02/2025,12-1pm	Webinar scheduled to promote awareness and usage of systems (Outcomes Framework Dashboard, Data Hub – Population Explorer, Eclipse). To assist to embed PHM approach within the ICS	N/A	N/A	For assurance	
49.	PH&I Board	17/12/2024	Energy efficiency West, and Affordable warmth and home upgrade grants Waveney	First cohort of 309 householders contacted in West. Initial 70 letters sent for similar Waveney project. Both target low income households, living in the least energy efficient homes, with long term conditions which could be affected by cold, to help access heating support.	N/A	N/A	For assurance	
50.	PH&I Board	17/12/2024	Wider determinants of health - maternity	Extension to project to support newly pregnant people living in IMD1-2 post codes with proactive telephone support and signposting.	N/A	N/A	For assurance	
51.	PH&I Board	17/12/2024	Cambridge and Peterborough CVD support	VST calls commenced for C&P project to improve CVD prevention. Income generating for PHM team and ICB.	N/A	N/A	For assurance	
52.	PH&I Board	17/12/2024	Evaluation and planned work	Evaluations underway for 3 closed projects. Pipeline of 5 further projects in scoping phase.	N/A	N/A	For assurance	
53.	PH&I Board	17/12/2024	PHM strategy implementation plan	Strategy implementation plan agreed. PHM, BI and IG teams working closely to align work and streamline IG processes Raising awareness of PHM and ECLIPSE tools Metrics and dashboard drafted to track effectiveness of multiple projects and strategy	N/A	N/A	For assurance	
54.	PH&I Board	17/12/2024	PHM Programme Risk Register	PHM and HI teams are reviewing their risk registers to ensure they represent all programme risks, new groups terms of reference and governance	N/A	N/A	For assurance	

Parker Rachael 27/01/2025 10:30:07

Population Health & Inequalities (PH&I) Board - Points of Assurance / Escalation [17/12/2024]

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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
55.	PH&I Board	17/12/2024	Board maturity assessments	Board maturity assessments undertaken by ICB & 5 NHS providers, developing improvement plans				
56.	PH&I Board	17/12/2024	HI training	HI training and inclusion health event held for primary care, including POD				
57.	PH&I Board	17/12/2024	Core20Ambassador wave 3	45 colleagues successfully appointed. HI team are capturing the projects being undertaken to ensure overall HI programme alignment, ICS Network event scheduled in January 2025.	N/A	N/A	For assurance	
58.	PH&I Board	17/12/2024	Inclusion health	Primary care inclusion health events planned, gaps addressed in IH LCS				
59.	PH&I Board	17/12/2024	VCSE Assembly Relaunch – January 2025	New Chair and HI team relaunching assembly Jan 25. ToR and delivery plan agreed. State of the sector reports being established. Working with county councils about integration /alignment of resources	N/A	N/A	For assurance	
60.	PH&I Board	17/12/2024	VCSE – Risk Management	Sector round table event taken place. HI team capturing sector risks within the VCSE Assembly	N/A	N/A	For assurance	
61.	PH&I Board	17/12/2024	Outcomes Framework Dashboard	System presented, pulling national data sets into one place to enable view of key JFP/ PHM/HI measures. Dashboard to be finalised then shared more widely from Jan	N/A	N/A	For assurance	
62.	PH&I Board	17/12/2024	NWICB Health Inequalities Improvement Plan	Presentation of progress provided. Agreed for the plan to be provided to February 2025 PH&I Board. Currently being progressed via NHS Anchors Group. Good NHS provider engagement & partnership working.	N/A	N/A	For assurance	

PH&I Board - New Risks [17/12/2024]

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Programme Risks as of 17/12/2024 – PH&I Board

Overarching BAF01 (previously BAF06) PHM &HI risk, updated and continues to score at 12.

The PHM & HI teams have taken actions to update their risk registers and to also progress the inclusion of VCSE risks.

The PHM team reported 1 risk, no new risks were added, no risks scored above 15.

- ''PHMI18 Lack of allocated PHM Budget. Impacting PHM projects and Protect NoW VST team' , risk score remained at a 10. Following further team discussions, the risk scoring is expected to reduce and potentially be archived. A new risk regarding PHM team resources to respond to the system demand will then be added following the next risk register review.

The HI team reported 7 risks, no new risks were added & 3 risks were agreed to be archived.
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. The HI team have taken an action to review the risk description, detail & action to ensure this risk is still being accurately reported.

3 risks remained the same:

- 'HI02 Incomplete data picture for health inequalities' risk score 6.
- 'HI04 Risk of not delivering against NHSE directives e.g. Core20plus5 health inequalities improvement framework for adults and CYP, anchor institutions' risk score 6. Following discussions, the HI team will be reviewing this risk further & increasing the risk scoring.
- 'HI07 Lack of Place resources to support HI strategy development & implementation' risk score 12. This risk is to be discussed further at the next HIOG with Place colleagues, and risk score may be increased.

3 risks agreed to be archived:

- 'HI01 Not completing HI Strategy as per JFP ambition/objective'. Framework completed.
- 'HI03 Lack of coordination of HI workstreams'. HI & VCSE team in place. Action plans in development for all agreed workstreams and programme risks being mapped.
- 'HI06 No PMO process for Equality Impact Assessments (EIAs)'. New process developed and launched. Staff training to be developed as part of ICB improvement plan.

Norfolk and Waveney
Integrated Care Board

Agenda item: 10i

Subject:	**Ageing Well Programme Board – Assurance & Escalation Report**
Presented by:	**Dr Frankie Swords**
Prepared by:	**James Allen**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**27 January 2025**

Purpose of paper:

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

Executive Summary:

The Ageing Well Board meets bi monthly and was last held on 9th January 2025. 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:	The period that older people spend in ***ill*** health in Norfolk and Waveney is getting longer and, with the continuing increase in the number of older patients, there is a risk that services will be unable to continue to meet the increasing demand and needs of our ageing population with complex health needs. This will lead to an increase in costs of care and/or a reduction in the quality of care if not mitigated.
Finance and Performance:	None identified

Impact Assessment (environmental and equalities):	N/A
Reputation:	None identified
Legal:	None identified
Information Governance:	None identified
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	1. The NHS provides a comprehensive service, available to all 2. The NHS aspires to the highest standards of excellence and professionalism 3. The patient will be at the heart of everything the NHS does 4. The NHS works across organisational boundaries 5. The NHS is committed to providing best value for taxpayers' money 6. 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 05

Governance

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

N&W ICB Ageing Well Programme Board
Points of Assurance / Escalation [27/01/2025]

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Item No.	Meeting Name	Date of meeting where item was first raised	Details of Item for Escalation /Assurance	Requested Outcome/Support	Financial Implication (if any)	Is item recorded on Risk Register	Board Decision	Fed back to Meeting Group Date
001	Ageing Well Programme Board	27/01/2025	Development of SOP for care home staff to identify deteriorating residents	Work with Place Leads to share learning and to prevent duplication of work	-	-	For assurance	
002	Ageing Well Programme Board	27/01/2025	Terms of Reference	ToR (v1.8) reviewed at 09/01 Programme Board, feedback collated and implemented and to be taken to the Mar-25 P&CC for approval.	-	-	For assurance	
003	Ageing Well Programme Board	27/01/2025	Programme Blueprint	Document in development that will detail core strategic documents such as Joint Forward Plan, Strategic Framework, JSNA's, Carers Strategy etc and link this with Programme structure, priorities and associated projects etc.	-	-	For assurance	
004	Ageing Well Programme Board	27/01/2025	Ambition 5 Joint Forward Plan 2025/26 refresh	Initial first draft of JFP Ambition 5: Transforming Care in Later Life completed and will be shared with the P&CC once finalised.	-	-	For assurance	
	Ageing Well		Standardising use of single	Opportunity to extend use of the scoring tool				

N&W ICB Ageing Well Programme Board
Risks [27/01/2025]

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Programme Risks – N&W ICB Ageing Well Programme Board

The current Risk Register was reviewed at the Ageing Well programme Board on 09/01/2025.

Currently there are **4** risks monitored at Programme Board. No new risks were highlighted.

- **3** of these risks score under 12 (post-mitigation)
- **0** of these risks score between 12-14 (post-mitigation)
- **1** of these risks score 15 or above (post-mitigation) and are a Board Assurance Framework risk

BAF05: Increasing numbers of older people with complex health needs in Norfolk and Waveney
Pre-Mitigation Score: 20 (5x4) | Post-Mitigation Score: 15 (5x3)

AW3: Acute Workstream Capacity
Pre-Mitigation Score: 6 (3x2) | Post-Mitigation Score: 4 (2x2)

AW4: Risk in relation to NICE DMT Dementia medication.
Pre-Mitigation Score: 12 (4x3) | Post-Mitigation Score: 6 (2x3)

AW5: Capacity and programme support in relation to Dementia programme
Pre-Mitigation Score: 8 (4x2) | Post-Mitigation Score: 6 (3x2)

The programme team are currently being trained on the new InPhase Risk Management System and will update using this new system once adopted by the committee.

Ageing Well Overview - Programme Workstreams

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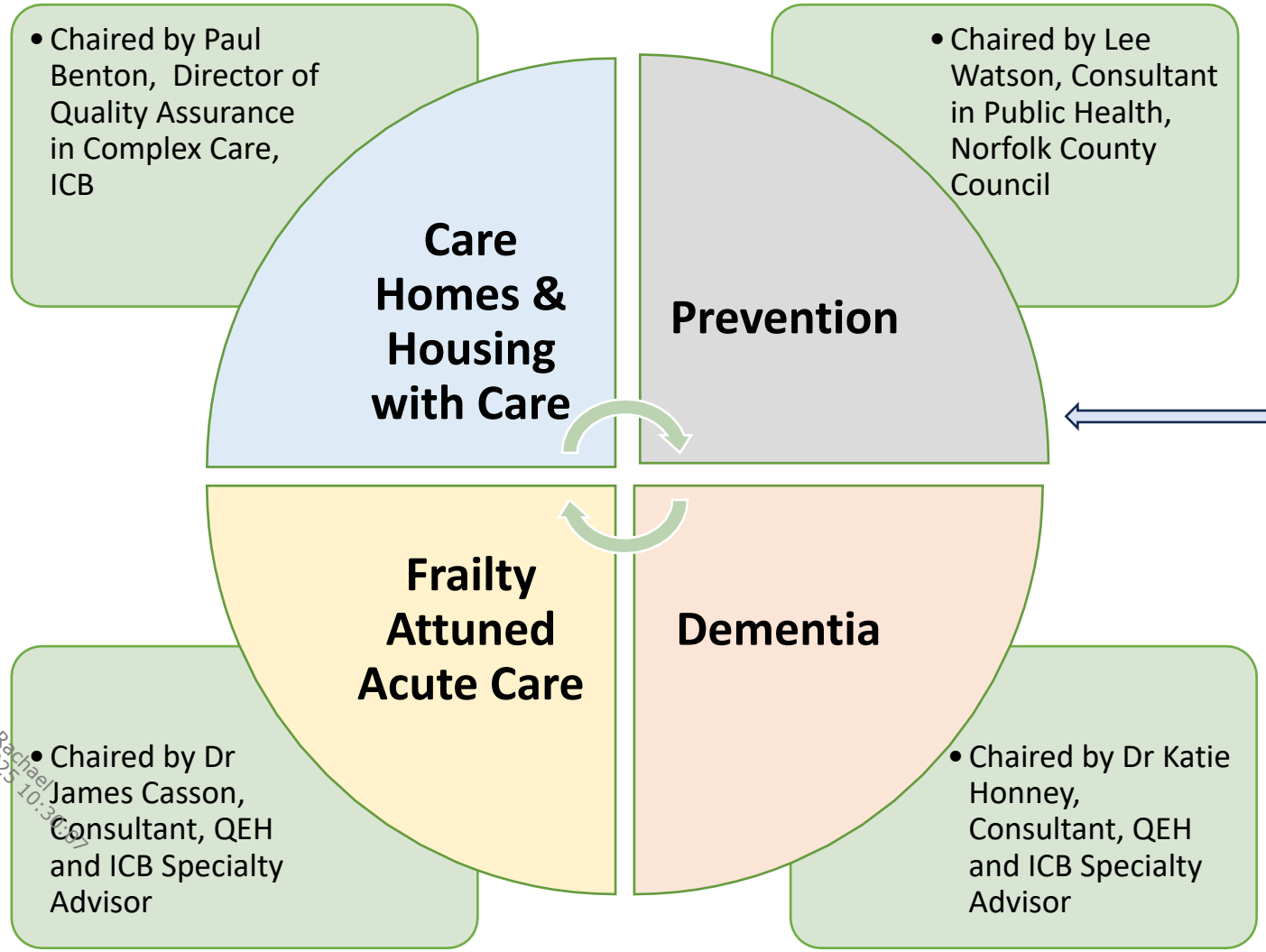

Senior Responsible Officer:
Ian Hutchison, CEO, ECCH

Senior Programme Manager
James Allen

Programme Manager
William Lee

Interdependent Workstreams

Palliative and End of Life Care

Medicines Optimisation

Acute Specialty Network

Community Falls

Fracture Liaison

North Norfolk Dementia

PH&I Board - Programme Summary [17/12/2024]

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Programme	**Ageing Well Programme**	**SRO**	**Ian Hutchison**	**Overall Prog RAG**
		Programme Manager	**James Allen**	

What have we achieved since last report

- Further work on Draft Programme Blueprint
- In-person logic modelling scheduled for Feb-25 to support dashboard development with Research team facilitating
- Met with Alzheimer's Society and ICB Mental Health team to consider any further Dementia priority projects and agreed additions
- Dementia prioritisation scoring worksheet sent to stakeholders for completion and return by end of Jan-25
- Met with UEA around Cognitive Decline Screening tool and assessed potential for earlier identification in Dementia
- ICS Newsletter developed and issued to all stakeholders
- Dementia Charter signatures chased and self-assessment forms in review
- Discussed and considered approach to Falls, proposal paper in development
- Ambition 5 of Joint Forward Plan (JFP) initial draft complete and shared with colleagues for comments and considerations
- Discussed Age Friendly Status potential project, drafting letter to HWB Boards and intention to add to JFP
- Terms of Reference review completed for Programme Board and v1.8 sent to Corporate Governance for feedback prior to P&CC submission
- Frailty report due for ICB P&CC; paper and presentation developed and to be presented 27/01

Activities planned for next reporting period

Joint Forward Plan final version completed and signed off at Ageing Well Board (Mar-25). Finalise draft programme blueprint for Ageing Well. Agree population health metrics for dashboard development through in-person logic modelling meeting. EEAST Care market data to be triangulated with virtual wards, digital teams, the ICB and UCCH to give a richer dataset and outcomes. Quality Improvement Nurses looking to widen their Champions sessions with social care providers and in line with the ECHC Framework. Agreement of a more detailed action plan for public health approach to healthy ageing in Norfolk and a delivery mechanism. Further scope of prevention communications and engagement plan for 25/26. Explore the impact the Rockwood frailty pilot is having in primary care and if they have sight of frailty scoring. Feedback received from stakeholders on Dementia priorities for workstream ahead of Blueprint development. Falls JSNA to be published.

Key Programme Milestones (for this time period)

- Ageing Well ICS Newsletter published
- In-person logic modelling session for metrics scheduled for Feb-25
- Dementia prioritisation scoring sent to stakeholders for completion

Planned Care and Long Term Condition Clinical Transformation Programme Oversight Group Assurance / Escalation / Risk Update January 2025

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Norfolk and Waveney Integrated Care System

Item/Risk No.	Meeting Name	Date of meeting where item raised	Details of Item for Escalation	Requested Outcome/Support	Financial Implication (if any)	Is item recorded on Risk Register	"EXAMPLE" Board Decision
1.	CTPOG	24/12/24	**Assurance:** Ageing Well – attended various ICB/ICS committees to deliver presentations about the programme and progress to date. Dashboard for Rockwood Score is operational. Annual refresh of the programme plan underway for 2025/26.	To note	No	No	For assurance

Risk AW3	Ageing Well Programme Board	22/02/24	**Risk:** Acute colleagues may not have the capacity to support Ageing Well Programme, impacting progress.
			RAG Rating (Pre-Mitigation): Low (3x2 = 6)
			Progress and Actions:
			• **Mitigation:** Acute organisations confirmed protected time for engagement in the Ageing Well Programme (Sep-24).
			• **Update:**
			  • Specialty advisors, a senior programme manager, and a clinical manager are now in post.
			  • The Board has agreed to close this risk.
				To note	No	Yes	Update

Risk AW4	Ageing Well Programme Board	07/03/24	**Risk:** New NICE guidance on dementia drugs may impact diagnostic capacity and increase medication costs.
			RAG Rating (Pre-Mitigation): High (4x3 = 12)
			Progress and Actions:
			• **Mitigation:** Awaiting NICE guidance confirmation.
			• **Update:**
			  • NHSE holding seminars/workshops for system leads regarding disease-modifying treatments and diagnostic pathways in the coming weeks.
			  • Jo Dickinson (NHSE) has offered to liaise and support if needed
				To note	Yes	Yes	Update

Planned Care and Long Term Condition Clinical Transformation Programme Oversight Group Assurance / Escalation / Risk Update January 2025

Improving lives together
Norfolk and Waveney Integrated Care System

Item/Risk No.	Meeting Name	Date of meeting where item raised	Details of Item for Escalation	Requested Outcome/Support	Financial Implication (if any)	Is item recorded on Risk Register	"EXAMPLE" Board Decision

Risk AW5	Ageing Well Programme Board	07/03/24	**Risk:** Lack of capacity (programme support, clinical advisor) may hinder progress on the Dementia workstream.
			RAG Rating (Pre-Mitigation): High (4x2 = 8)
			Progress and Actions:
			• **Mitigation:**
			  • Specialist dementia advisor roles advertised.
			  • Programme team restructured to include Ageing Well and Dementia portfolio (Jul-24).
			• **Update:**
			  • Band 7 is now in post with Dementia as part of the wider remit.
			  • The Board is considering closing this risk.
				To note	No	Yes	Update

BAF05	Ageing Well Programme Board	20/06/24	**Risk:** Increasing Numbers of Older People with Complex Health Needs in Norfolk and Waveney Risk:
			• Growing ill health among older people could strain services and financial resources.
			• Risks include declining quality of care if demand exceeds capacity.
			RAG Rating (Pre-Mitigation): Critical (5x4 = 20)
			Progress and Actions:
			• **Mitigation:**
			  • Substantive programme manager in place.
			  • Increased focus on early intervention and upstream prevention via Ageing Well Board (Dec-24).
			  • Reporting now integrated with InHealth risk system.
			• **Update:**
			  • FS has requested the overarching BAF risk to be discussed at each Board meeting, with scoring recommendations made to the Patients and Communities Committee (New Action).
			  • Workstream leads have been tasked to identify additional risks within their workstreams (New Action 62).
			  • JA to discuss workstream risks at the upcoming Workstream Leads meeting (New Action).
			  • IH requested Board members evaluate risks within their organisations and flag any significant issues not covered by current workstreams (New Action).
				To note	Yes	Yes	Update

Norfolk and Waveney
Integrated Care Board

Agenda item: 10iii

Subject:	Update on the Frailty Attuned Acute Care Workstream
Presented by:	Janice Shirley, Head of System Clinical Transformation Programmes James Allen, Senior Clinical Programmes Manager William Lee, Clinical Programmes Manager
Prepared by:	Dr James Casson, Clinical Advisor for Frailty and Older People
Submitted to:	N&W ICB Patients and Communities Committee
Date:	27th January 2025

Purpose of paper:

To provide an update to the ICB Patients and Communities Committee on the work of the Norfolk and Waveney Ageing Well Programme, specifically relating to the Frailty Attuned Acute Care Workstream.

Executive Summary:

Frailty Attuned Acute Care is one of four workstreams in the Ageing Well Programme. The Ageing Well Programme Board reports to the Patients and Communities Committee, System Executive Management Team (EMT) and the Integrated Care Board (ICB) Board.

The Ageing Well Programme Board receives progress and escalation reports from the Palliative and End of Life Care Programme Board, along with additional reporting from the Medicines Management Programme, UEC Programme and Population Health Management.

Report - Update on the work of the Frailty Attuned Acute Care Workstream in the Norfolk and Waveney Ageing Well Programme

Background

The Frailty Attuned Acute Care Workstream is underpinned by the Ageing Well Strategic Framework and the principles of the NHS RightCare toolkit supporting the delivery of the NHS Long Term Plan for frailty.
Norfolk and Waveney has a higher than average population of older people living with frailty – many with complex needs and co-morbidities. Severe frailty often brings over four times the costs of non-frailty. Older people with frailty account for a large proportion of unplanned care at the three acute trusts in the region. People living with mild, moderate or severe frailty could often have their needs met best in settings outside of acute hospital care.

Workstream Objectives

- Create and run a Clinical Ageing Network
- Undertake a survey of frailty services and assessment tools across the three acute trusts
- Agree upon a system-wide definition of frailty and single assessment tool and implement
- Lead on frailty attuned acute care

Core system priorities

- Develop an Integrated Dementia-Frailty pathway and the associated commissioning approach
- Improve Identification of frailty in the community and targeted assessments to promote ageing well

Progress update

The N&W Frailty Attuned Acute Care Workstream meeting (previously known as the Clinical Ageing Network) is held bimonthly, chaired by the specialty clinical advisor James Casson with representation from the three acute trusts, community trust, EEAST and primary care. This allows clinicians from across the system to form a community of best practice, share ideas and innovations and assist with the implementation of workstream objectives across the ICS. The last meeting took place on 9th December and the next meeting is due on 25th February 2025.

The workstream has agreed on the Rockwood Clinical Frailty Scale as the tool for assessing frailty across the ICS. Work has commenced on embedding this into the Electronic Patient Record and translating this to primary care with enhanced frailty assessments based on metrics agreed at the workstream meetings. A pilot at QEH is underway and will finish in February 2025. The Rockwood scoring frailty scale can be found in the appendices.

The Queen Elizabeth Hospital Education Faculty has developed a ‘Frailty is Everybody’s Business’ training programme open to attendees from across the

system. There have been five sessions to date with over 120 attendees and excellent feedback. The 2025 programme will be published soon. This initiative supports better care and understanding of frailty across the workforce.

The Specialty Clinical Advisor for the workstream Dr James Casson attended the Frailty Specialty Clinical Network meeting hosted by Norfolk and Waveney Acute Hospital Collaborative on 5th November 2024 to contribute to the Draft Strategic Service Development Plan. Working towards being a national leader in delivering acute care for older people living with frailty across Norfolk and Waveney.

Innovations/projects

'Silver phone' The QEH offers rapid consultant geriatrician advice to EEAST, primary care and community clinicians 8am-8pm seven days a week via a Silver phone service. This work has been presented nationally. There are discussions to extend the service to cover Norfolk and Waveney and collaborate with the virtual ward frailty pathway.

Virtual ward and urgent community response The Virtual Ward Frailty Pathway offers across Norfolk and Waveney, Advanced Clinical Practitioner oversight, remote monitoring and ongoing support for up to 14 days for patients who are frail with a worsening acute or chronic condition who are able to be managed at home or their care home rather than hospital. Frail patients who are treated on a virtual ward compared to an acute setting are five times less likely to acquire an infection and eight times less likely to experience functional decline and deconditioning. The service has managed over 800 frail patients in 2024 with an ambition to increase their caseload and strengthen the team in 2025. A recent case involved supporting a 90 year old patient living with severe frailty to remain at home during an acute respiratory illness and heart failure and then offering palliative care provision to facilitate her preferred place or care and dying which was home.

Recommendation to the Committee:

To note the content of the report.

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

Reference document(s):	Rockwood Frailty Scale rockwood-frailty-scale_.pdf
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	BAF05

Governance

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

Improving lives **together**

Norfolk and Waveney Integrated Care System

N&W ICB Ageing Well Update to N&W Patients & Communities Committee

Frailty Attuned Acute Care Workstream

Janice Shirley, Head of System Clinical Transformation Programmes

James Allen, Senior Clinical Programmes Manager

William Lee, Clinical Programmes Manager

Ageing Well Overview - Vision and Mission

The Vision….

Norfolk and Waveney will be a place where people in later life, and their carers:

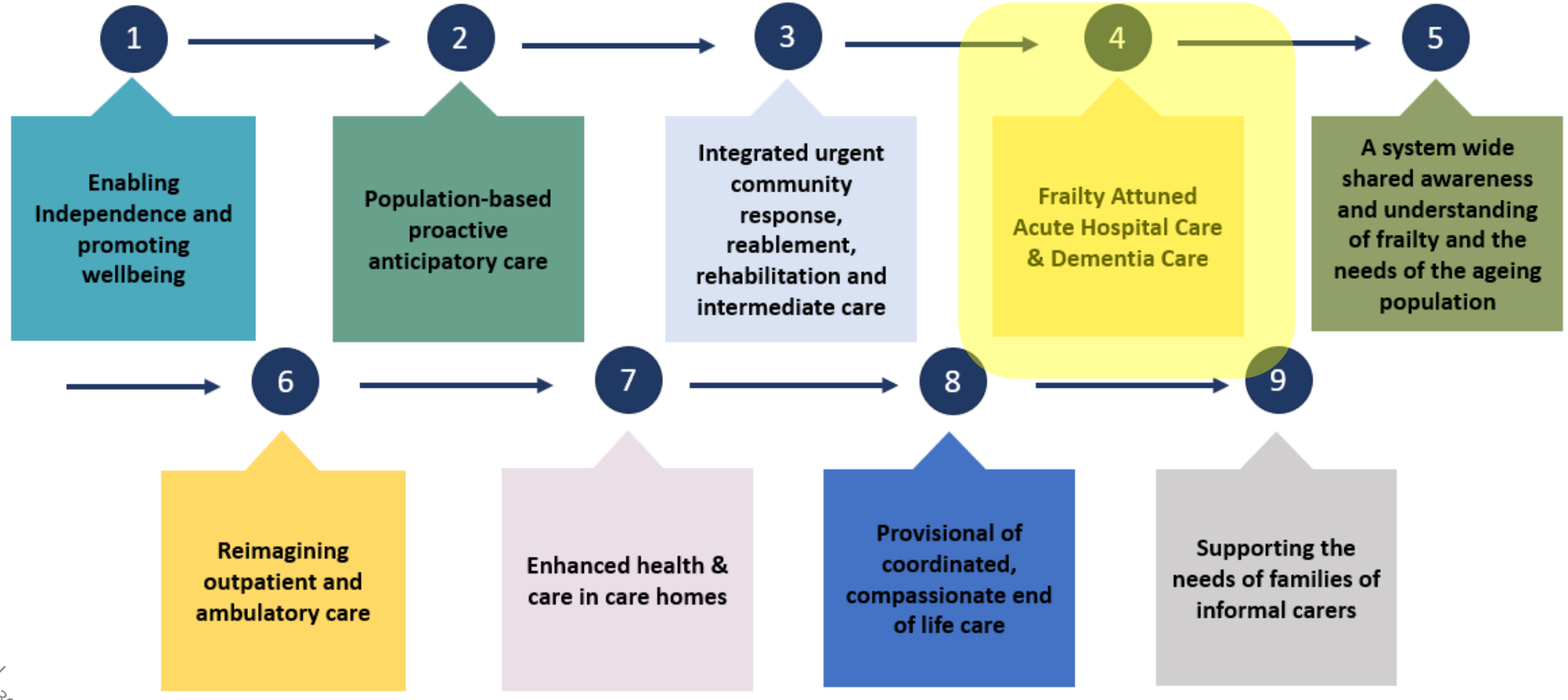
- Are helped to age well, living happier, healthier lives, living as independently as possible for as long as possible
- Feel heard and respected, and know they will be treated as individuals
- Experience services that ask, “what matters most to you” and proactively act upon their answer

The Mission..

is to have health, care and support services that are fit for our ageing population – supporting people as they age, to lead longer, happier, healthier lives

Ageing Well Overview - Strategic Framework

Nine Goals under the Strategic Framework



Parker Rachael
27/01/2025 10:30:07

This framework should inform ICS partners' thinking, planning, commissioning and delivery of services for people as they age.

Older people, their carers' and loved ones' views are properly represented in decision making, design and evaluation of services

Background

Frameworks and Principles

- Based on the Ageing Well Strategic Framework and NHS RightCare toolkit
- Supports the NHS Long Term Plan for frailty

Population Context

- Norfolk and Waveney: Higher-than-average older population with complex needs
- Severe frailty incurs costs 4x higher than non-frailty care

Current Challenges

- Older adults with frailty account for significant unplanned acute care
- Many could be better supported outside acute hospitals

Objectives & Core Priorities

Workstream Objectives

- Survey frailty services and assessment tools across three acute trusts
- Establish a **Clinical Ageing Network** to promote best practices
- Define and implement a **system-wide frailty definition** and assessment tool
- Lead on delivering **frailty attuned acute care**

Core System Priorities

- Develop an **Integrated Dementia-Frailty Pathway** and commissioning model
- Improve community frailty identification and promote targeted assessments

Progress Update (1)

Workstream Meetings

- Bimonthly, chaired by Dr James Casson, with ICS-wide representation, this facilitates best practice sharing and innovation

Ageing Well Dashboard

- Metrics agreed by workstream stakeholders & pending development by ICB BI team

Frailty Assessment Tool

- Agreement to adopt the Rockwood Clinical Frailty Scale across system
- Pilot activated at QEH and completing in Feb-25
- Pilot commenced at NNUH led by Place
- Commenced embedding in Electronic Patient Records (EPR)

Progress Update (2)

Education Programme Delivered

- “Frailty is Everybody’s Business”
  - ✓ 5 sessions, 120+ attendees, excellent feedback
  - ✓ Supports workforce understanding of frailty

Engagement with ICB Innovation team

- Recognition of potential earlier identification tools such as “Eclipse” to identify those patients likely to be admitted in 30/60/90 days
- Opportunity to explore potential integration with acute/community teams for admission avoidance and enhance patient health

Innovations and Projects

- **Silver Phone Service**
  - Consultant geriatrician advice for EEAST, primary care, and community clinicians (8 am - 8 pm, 7 days a week)
  - Presented nationally with plans to expand ICS-wide

- **Virtual Ward Frailty Pathway**
  - Oversight by Advanced Clinical Practitioners
  - Remote monitoring and support for up to 14 days
  - Key Benefits
    - 5x less risk of infection, 8x less functional decline vs. acute care
  - Managed 800+ patients in 2024, aiming for further expansion
  - Supported a 90-year-old patient with severe frailty during an acute illness, through managing her care at home with palliative support, respecting her preference for end-of-life care, this demonstrates personalised, patient-centric care aligned with our frailty objectives

Conclusion & Any Questions?

Norfolk and Waveney aims to become a **national leader** in delivering acute care for older adults with frailty.

- The workstream focuses on:
  - Building networks and pathways
  - Enhancing tools and training
  - Implementing innovative services like the Virtual Ward and Silver Phone

- Continued collaboration and innovation are essential to improving outcomes for frail individuals

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

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 fiveeight 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.

Overseeing the Ageing Well programme

- The Ageing Well Programme Board has been set up in response to the changing patterns of demand and demography of our population, and drives and coordinates the implementation of the ICS Ageing Well Strategy.
- This collaborative Board aims to coordinate and transform the services available to prevent deterioration in health and wellbeing, which may reduce the likelihood of unplanned hospital admissions, premature admission into residential care and suboptimal outcomes and experiences of care for older people.
- The Committee will receive regular assurance and escalation reports from the Integrated Care System Ageing Well Programme board, regarding the effectiveness of this programme of work.

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 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

Norfolk and Waveney ICB Patients and Communities Committee Forward Plan

Agenda Item / Issue	Lead	Jul	Sept	Nov	Jan 2025	Mar	May	July	Sept	Nov	Notes
Standing agenda items											
Introductions, Apologies, Declaration of Interest	Chair	X	X	X	X	X	X	X	X	X	
Minutes, Matters Arising, Actions Update	Chair	X	X	X	X	X	X	X	X	X	
Risk Register	MB	X	X	X	X	X	X	X	X	X	
Population Health Management and Health Inequalities Update	FS	X	X	X	X	X	X	X	X	X	
Ageing Well Programme Board Update	FS	X	X	X	X (*Frailty update)	X (*Prevention update)	X	X	X	X	Will also present at each meeting on one of the four workstreams (at AW team discretion): Dementia, Frailty, Prevention, Care Homes/Housing
Healthwatch Norfolk Update	AS	X (AR)	X (V)	X (V)	X (V)	X (V)	X (V)	AR?	X (V)	X (V)	AR=Annual Report, V=Verbal
Healthwatch Suffolk Update	AY	X	X (AR)	X (V)	X (V)	X (V)	X (V)	AR?	X (V)	X (V)	AR=Annual Report, V=Verbal
Any Other Business	All	X	X	X	X	X	X	X	X	X	
'Spotlight' On Item(s)	MB	X	X	X	X	X	X	X	X	X	
Complaints Report (quarterly)	JP	X			X		X		X		
VCSE Assembly Updates (monthly)	TG		X		X	X	X	X	X	X	
People and Communities Approach (twice yearly)	CW			X			X				
Community Voices (quarterly)	MB			X		X		X		X	
Communication and Engagement Plan (annually)	CW			X						X	
Place Board Reports (monthly)	MB	X	X	X	X	X	X	X	X	X	West – March, NN – May, GYW - July, South - Sept, Norwich - Jan
Lived Experience item (monthly)	MB	X	X	X	X	X	X	X	X	X	
P&CC Focus Group Update (quarterly)	MB			X		X		X		X	
P&CC Policies for Review	MB						People & Communities Approach	i. Media Policy ii. Complaints Handling Policy & Procedure			

Future items

Coproduction Strategy - NCC engagement Team - check in (raised 25/11)

NSFT response to Learning from Deaths group request around intensive services (raised 25/11)

Place deep dive X

Key:

Chair - Aliona Derrett
MB - Mark Burgis
FS - Frankie Swords
AS - Alex Stewart
AY - Andy Yacoub
JP - Jon Punt
TG - Tim Gardiner
CW - Chris Williams

Previous Spotlight Items:

2024

November - Mental Health
September - Dementia
July - GYW Place, and CYP, Flourish & NDD provision
May - ICB Long Term Dental Plan
March - GYW Place - Insights and Experiences
January - Community MH Transformation, and Planned Care and Cancer Activity

2023

November - Primary Care including GP and POD
September - Older People's Strategy
July - CYP
May - UEC
March - MH Transformation