Patients and Communities Committee

Mon 19 May 2025, 14:30 - 17:00

Virtual via MS Teams

Agenda

14:30 - 14:30
0 min

Meeting Agenda

00. P&C Committee - Agenda 19.5.25 - FINAL.pdf (2 pages)

14:30 - 14:30
0 min

1. Chair's welcome and apologies for absence

Cathy Armor

14:30 - 14:30
0 min

2. Declarations of Interest

Cathy Armor

02 ICB Patients and Communities Committee Register March 2025.pdf (3 pages)

14:30 - 14:30
0 min

3. Minutes from previous meeting (21.1.25) and matters arising

Cathy Armor

03 NW ICB PC Committee Minutes 27.1.25 Part One - DRAFT.pdf (10 pages)

14:30 - 14:30
0 min

4. Action log

Cathy Armor

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

14:30 - 14:30
0 min

5. Risk Register

Mark Burgis

05i Risk Register cover sheet May 2025.pdf (2 pages)
05ii Patients and Communities Committee 09.05.25.pdf (3 pages)

14:30 - 14:30
0 min

6. Patients and Communities Committee - Terms of Reference

Mark Burgis

06 Patients and Communities Committee ToR.pdf (8 pages)

14:30 - 14:30
0 min

7. Spotlight on: The Future of Place

7.1. Patient Experiences

Emma Bugg, Rebekah Collett, Rachel Hunt

07i Patient and Communities Committee Place 080525 V3.pdf (19 pages)

7.2. Complaints, Feedback and Concerns

Jon Punt

07ii P and C report - Place based contacts.pdf (3 pages)

7.3. Healthwatch Perspective

Judith Sharpe, Andy Yacoub

14:30 - 14:30
0 min

8. Place Board Report: West

Rebekah Collett, Carly West-Burnham

08 West Norfolk Slides 19th May.pdf (15 pages)

14:30 - 14:30
0 min

9. Learning From Deaths Report Summary

09 2025 05 13 Summary of the 24-25 Learning from Deaths Annual Report for P&C committee.pdf (8 pages)

14:30 - 14:30
0 min

10. Healthwatch Suffolk & Healthwatch Norfolk - Feedback on the Learning From Deaths Report, and General Updates / Escalations

Andy Yacoub, Judith Sharpe

14:30 - 14:30
0 min

11. VCSE Assembly Update

Tim Gardiner

10i VCSE Assembly report_P&CC May25.pdf (4 pages)
10ii VCSE Risk Register__PHI Board_ DRAFT Assembly operational risks.pdf (9 pages)
10iii VCSE Risk Register__PHI Board_ DRAFT VCSE Integration Risk Scoring.pdf (6 pages)

14:30 - 14:30
0 min

12. Ageing Well Programme Board Update including Prevention Workstream Update

William Lee, Zoe Nash, Lee Watson

11i 2025.03.24 - Ageing Well Highlight Report v1.1 - PC Committee.pdf (4 pages)
11ii 2025.04.14 Prevention Workstream Report March 25 v2.pdf (6 pages)
11iii 2025.04.14 - Ageing Well Prevention Presentation Final v4.pdf (11 pages)

14:30 - 14:30
0 min

13. Population Health and Inequalities Board Update

Dr Frankie Swords

12i 2025.04.15_PHI Board Report Cover Sheetv1.pdf (2 pages)
12ii 2025.04.15_PHI Board Assurance-Escalations- v3.pdf (3 pages)

14:30 - 14:30
0 min

14. Items for Escalation to ICB Board

Cathy Armor

14:30 - 14:30
0 min

15. Any Other Business

Cathy Armor

14:30 - 14:30
0 min

16. Close

14:30 - 14:30
0 min

17. Shared for Information

- For info - i Patients and Communities Committee Forward Planner 24-25.pdf (1 pages)
- For info - ii Norfolk and Waveney 10 Year Plan - Feedback Report 2025.pdf (15 pages)

NHS
Norfolk and Waveney
Integrated Care Board

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

Monday 19 May 2025, 14:30-17:00hrs

Part One – Meeting Held in Public

Meeting to be held via MS Teams

Chair: Cathy Armor

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	14:30-14:50	**Chair's welcome and apologies for absence**	V	Chair
2		**Declarations of Interest**	P	Chair
3		**Minutes from previous meeting (21.1.25) and matters arising**	P	Chair
4		**Action log**	P	Chair
5	14:50	**Risk Register**	P	Mark Burgis
6	15:00	**Patients and Communities Committee – Terms of Reference**	P	Mark Burgis
7	15:05	**Spotlight on: The Future of Place** i. Patient Experiences ii. Complaints, Feedback and Concerns iii. Healthwatch Perspective	Pr P V	Emma Bugg, Rebekah Collett Rachel Hunt Jon Punt Judith Sharpe Andy Yacoub
8	15:50	Place Board Report: West	Pr	Rebekah Collett Carly West-Burnham

	16:00	**BREAK (5 mins)**		
9	16:05	Learning From Deaths Report Summary	Pr	Tricia D'Orsi
		Standing Items		
10	16:15	Healthwatch Suffolk & Healthwatch Norfolk: i. Feedback on the Learning from Deaths Report ii. General Updates / Escalations	V	Andy Yacoub Judith Sharpe
11	16:25	VCSE Assembly Update	P	Tim Gardiner
12	16:35	Ageing Well Programme Board Update including Prevention Workstream Update	P / Pr	William Lee Zoe Nash Lee Watson
13	16:45	Population Health and Inequalities Board Update	P	Dr Frankie Swords
14	16:55	Items for Escalation to ICB Board	V	Chair
15	16:58	Any Other Business and Reflections on the Meeting	V	Chair
16	17:00	Close		
		***Shared For Information**:* *i. Patients and Communities Committee Forward Plan* *ii. Norfolk & Waveney 10 Year Plan – Feedback Report*		
Date, time and venue of next meeting: Monday 28 July 2025, 14:30-17:00hrs via MS Teams				
Any queries or items for the next agenda please contact: rachael.parker9@nhs.net				

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

Declared interests of the Patients and Communities Committee

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Aliona Derrett	Non-Executive Member, Norfolk and Waveney ICB	Norfolk and Norwich University Hospital			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
Catherine 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		Chair of Council, Norwich University of the Arts	2024		
		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	Heathgate Surgery, Poringland			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
		Great Yarmouth Borough Council	X				Executive Director – People, Great Yarmouth Borough Council	May-18	Present	Will declare an interest as required

		Great Yarmouth Health & Wellbeing Partnership		X			Lead for the Great Yarmouth Health & Wellbeing Partnership	Mar-21	Present	
		Norfolk Youth Justice Board		X			Member of the Norfolk Youth Justice Board	Sep-23	Present	
		Norfolk and Waveney Integrated Care Board		X			Member of ICB Patients and Communities Committee	Mar-23	Present	
Patricia D'Orsi	Executive Director of Nursing, Norfolk and Waveney ICB	Royal college of Nursing			X	Indirect	Professional Body - RCN Union			
Mark Burgis	Executive Director of Patients and Communities, Norfolk and Waveney ICB	Lakenham Practice	X			Indirect	Wife is Nurse Prescriber who is currently undertaking occasional locum work at Lakenham Practice in Norwich. Wife receives an income from the practice when undertaking locum shifts at the practice	Aug-21	Present	Declare at any relevant meetings and remove myself from any significant discussions or decisions relating to the practice
		Drayton Medical Practice			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		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
		Healthwatch Norfolk		X			Healthwatch Norfolk is commissioned by the ICB and other stakeholder partners across the Health and Social Care System	2013	Present	We withdraw from discussions from services that we may be being commissioned to provide
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

NHS Norfolk and Waveney Integrated Care Board

DRAFT Minutes of the Patients and Communities Committee meeting

Held on Monday 27 January 2025

Meeting in Public

Committee members present:

- Aliona Derrett (AD), Non-Executive Director and Chair of the Patients and Communities Committee, NHS Norfolk and Waveney Integrated Care Board
- Cathy Armor (CA), Non-Executive Director and Deputy Chair of the Patients and Communities Committee, NHS Norfolk and Waveney Integrated Care Board
- Mark Burgis (MB), Executive Director of Patients and Communities, NHS Norfolk and Waveney Integrated Care Board
- Dr Frankie Swords (FS), Executive Medical Director, NHS Norfolk and Waveney Integrated Care Board
- Tricia D'Orsi (TD), Executive Nursing Director, NHS Norfolk and Waveney Integrated Care Board
- Emma Ratzer MBE (ER), Norfolk and Waveney Voluntary Community and Social Enterprise Assembly (VCSE) Chair, and Chief Executive Officer of Access Community Trust, VCSE Board Member

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 and for item 7
- Andy Yacoub (AY), Chief Executive Officer, Healthwatch Suffolk
- Alex Stewart, (AS), Chief Executive, Healthwatch Norfolk
- Karin Bryant (KB), Associate Director of Commissioning, Norfolk and Waveney Integrated Care Board
- Tim Gardner (TG), VCSE Assembly Chair

Attending to support the meeting:

- Heather Farley (HF), Head of Place Partnerships, Development and Planning – North Norfolk, NHS Norfolk and Waveney Integrated Care Board for item 6
- Matt Dooley (MD), Executive Director of Commissioning and Performance, Norfolk and Waveney Integrated Care Board for item 6
- Claire Leborgne (CL), Head of Place Development, Partnerships & Planning (Norwich), NHS Norfolk and Waveney Integrated Care Board for item 7
- Sarah Young (SY), Head of Integrated Operational Delivery (Central Norfolk), NHS Norfolk and Waveney Integrated Care Board for item 7
- James Allen (JA), Clinical Programmes Senior Manager Planned Care and Cancer, NHS Norfolk and Waveney Integrated Care Board for item 10

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 the following committee members: • Paula Boyce, Executive Director – People, Great Yarmouth Borough Council • Stuart Lines, Director Public Health, Norfolk County Council	
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**	
	The action log was reviewed and updated accordingly.	
5.	**Risk Register**	
	Mark Burgis (MB) introduced the item and updated that risks BAF01 and BAF05 remained the same. No operational risks had met the threshold to be escalated to the committee however MB suggested that some of the operational risks were brought to a future meeting for the committee's awareness and discussion. Comments and questions from members of the committee: • AD commented about the amount of planning and meetings and are we any closer to implementing the plans and actions agreed in those meetings. MB said some of the agenda items at today's meeting would provide examples of some of the progress being made. • Karin Bryant (KB) queried whether an additional control was required around health inequalities and the impact of the system's financial position. • Tracy Williams (TW) agreed that having sight of the operational risks will be helpful to see the challenges and the operational risks the teams experience. • Tricia D'Orsi (TD) commented that clarity is required around which committee is holding the risks and when a new risk is identified a conversation between committee chairs will be helpful regarding where they feel is most appropriate that oversight is provided. The update was noted. **ACTION** **Risk Register update for March to include operational risk across place**	**MB**
6.	**Spotlight on: Waiting Times**	
	1. Patient / Healthwatch (HWN) Perspective Alex Stewart (AS) presented the paper which was taken as read. AS highlighted that whilst the feedback presented in the paper had been received over a 12-month period, HWN receives calls daily from the public about waiting times and how to	

complain, and although most people understand they have to wait for treatment, what does bother them is the fact that they're not communicated with in any way while they are waiting.

AS asked that the committee considers proposing that an audit is carried out focussing on how complaints across Trusts are undertaken.

Questions and comments from members of the committee.

- Cathy Armor (CA) asked where ownership of the communication with patients sits and is there consistency across the three acute hospitals. FS responded the responsibility lies with the provider whose waiting list a patient is on. There is also a very clear policy which stipulates how frequently patients on waiting lists should be contacted. FS agreed it will be helpful to look in more detail at the data and a handful of individual patient experiences.
- AD asked how the policy is communicated and embedded – is it specified in provider contracts. FS said the policy was originally developed through the Elective Recovery Board which had now evolved to the Commissioning and Performance Committee. FS thought that KB would be able to find out where the policy is sitting.
- Suzanne Meredith (SM) reflected that the information provided for today's meeting relates to people who can complain but in addition we should also be considering health inequalities and thinking about those people who didn't make a complaint. KB added the recently published elective recovery guidance focuses on health inequalities, health equity and referral to treatment (RTT) which will be picked up in the implementation plan.
- Tricia D'Orsi (TD) would welcome an audit in some specific areas.

ACTION
KB to find out where policy re: contacting patients on waiting lists is sitting. **KB**

2. Complaints

Mark Burgis (MB) presented the paper which was taken as read. MB highlighted the complaints report didn't include the complaints received by the acute hospitals directly, and he was surprised how few complaints the ICB had received directly but acknowledged, as already discussed, many of these go to the providers directly. MB also said there is a hidden piece not highlighted in the report which is that many people on waiting lists are struggling in pain and are often linking with their GP practice, and primary care more broadly, which creates additional activity.

MB agreed with AS recommendation to get behind the data at the acutes and, more importantly, there's a real opportunity as an ICB and as a committee to say we are not doing as well as we could and what do we need to do differently to try and make it better.

Comments and questions from members of the committee.

- AD suggested triangulating data from primary care to identify trends and understand the broader impact of waiting times on patient experience.

	• TW said it was important to recognise and capture underserved communities who don't always feel they can complain, and when elective procedures have taken place getting feedback and insights from people who have waited a long time, to learn and reflect on that too. • Emma Ratzer (ER) added there will be lots of vulnerable people who won't make a complaint directly into the system but might make a complaint to the VCSE provider supporting them. Are we linking in with providers in the voluntary sector to collate what information they may have about long waits. **ACTION** **MB and JP to triangulate data from the acutes and primary care to identify trends and understand the broader impact of waiting times on patient experiences.** **3. Waiting Times** Matt Dooley (MD) provided some background to waiting times pre and post Covid noting the impact of Covid on waiting times was significant for patients, and backlogs grew quickly as the NHS paused elective treatment in April 2020 to prioritise hospital capacity for Covid emergency patients. It was noted the number of patients waiting 78 weeks or more had reduced considerably over the past year. Those waiting more than 65 weeks had been reducing but the rate of dissent had slowed because of industrial action. MD said that as well as impacting on primary care, patients waiting longer for elective interventions will also end up coming through as urgent patients and the demand for urgent front door care increases too. It was noted that the elective care reform plan published earlier this month, which KB had already touched on, has made a commitment to return to an 18-week referral to treatment target by the end of Parliament. Operational Planning Guidance is also awaited which will give more detail on what that means for waiting times in Norfolk and Waveney, specifically in terms of activity and affordability. The system is considerably pressured financially and there is likely to be some very difficult conversations around how close can we get to delivering the governments ambition for March 2026 against what we can afford. MD explained the acute trusts meet regularly with NHSE and the ICB for 'check and challenge' on their latest and forecast positions, where the capacity challenges might be, and any mutual aid opportunities to work together in a different way. MD also mentioned the group model (as the three acute providers start to move towards this model) and the opportunities this might present to work collaboratively in different ways, and doing something right once instead of doing it in multiple ways and perhaps less effectively. Comments and questions from members of the committee: • AD said it will be helpful to see which specialities have the longest waiting times, how that links to the complaints received, and how it links to workforce recruitment in those specialities, adding we must make better use of the data available and how it influences our actions. • Cathy Armor (CA) sought clarification regarding the group model and whether there would be an adverse impact on someone who lived in Gt	**MB**

	Yarmouth for example and was offered a procedure at QEH but was unable to go to the QEH. MD confirmed it would have no impact, and the patient would remain in the same position on the waiting list. • AD said it would be helpful to reconnect to this item at a future meeting. **4. Waiting Well – Place Example** Heather Farley (HF) provided a presentation about 'Waiting Well', a local initiative funded by the North Norfolk Place Board through the Community Transformation Fund and delivered by Broadland and North Norfolk District Councils. The initiative, which ran from March 2022 to October 2023, supported patients waiting for hip or knee replacements. Patients were offered support (home adaptations, physiotherapy, and mental well-being support) based on their level of need. A major success of the project was the individual who delivered it who had a very personalised and holistic approach. HF highlighted that 30 of the people contacted about the initiative had already received their treatment which goes to show the timeliness of data is important. Comments and questions from member of the committee: • AD asked if there is any evidence that offers were taken up or contact was made when people were referred or signposted to other agencies. HF said it was mixed; some issues identified the blockages in the system, but having a caseworker approach helped patients navigate the process. The updates were noted.	
7.	**Norwich Place Update**	
	Tracy Williams, Claire Leborgne and Sarah Young presented the update from Norwich Place which has a long history of very strong partnership working and good collaboration. The committee watched a video about the work ongoing to help the population of Norwich to live longer and happier lives. Comments and questions from members of the committee: • AS commented about funding and the tremendous difference to people lives and outcomes a relatively small investment can make, but AS felt there was short sightedness in the system and a lack of investment in prevention. MB acknowledged AS comment and assured AS the system is determined to use money in the most effective way and recognised the value and difference that many of the projects and initiatives have to people. • AD commented it was not always about new money but about using existing resources better. AD asked how providers are brought into projects as there are some which would be a good fit for some of the projects, but they are not featured. SY responded that it was still early days, and a comms and engagement strategy is in development which will ensure the right people and providers are involved. • AD said there were pockets of good work which need pulling together. • FS asked for clarification whether Community Conversations and Community Connectors was the same as Community Voices or separate. Shelley Ames (SA) responded all three were aligned but Community	

	Conversations and Community Connectors were the original model, however work is in progress to integrate all three. • SA mentioned the concept of proportionate universalism around the way investment is spent at a local level and that everybody needs something, but some people need more. • Tim Gardiner (TG) said the VCSE Assembly is aware of the work in Norwich. There will be conversations taking place around engagement and extending more widely to voluntary sector organisations in the area. • TD asked how outcomes are being captured from the work already achieved. CL stated it was a struggle to capture outcomes and acknowledged that to secure ongoing investment evidence of outcomes was required. Where services are integrated it is difficult to unpick outcomes, sometimes the outcomes won't be known for several generations e.g. obesity or diabetes. CL said the system was reliant on finding savings quickly when it should focus on prevention. • AD felt that we need to pick up case by case and look at who measures what and what outcomes are we achieving. We cannot say we're unable to measure across the board because it just isn't true. • TD commented that until we start to have more robust economic modelling for these types of initiatives, we will end up in the same cycle as CL commented upon which cannot be the way forward. We've got to lift ourselves strategically and start to think about how we'll use outcomes and evidence more effectively. The update was noted.	
8.	**VCSE Assembly Update**	
	Tim Gardiner (TG) presented the VCSE update which had been circulated in advance of the meeting. TG highlighted the following: • TG had recently chaired his first VCSE Assembly Board. The Assembly is looking at process and governance and there is a new process in place whereby ICS partners can request VCSE representation and support. This will be communicated out in due course. • The Assembly is developing a risk register which will identify some risks within the VCSE and will also be highlighted as system risks which will impact on patients and communities. • Ensuring Assembly Board reports and meeting minutes are shared with the wider VCSE, and utilising the resources available such as network newsletters in which all the information should be going out and ensuring that everything is open, available, and transparent • Looking at having an engagement session / innovation hub in May or June which will be an in-person event to relaunch the VCSE assembly. Comments and questions from members of the committee: • FS commented on the VCSE Assembly widening its reach and offered to put TG in touch with the ICBs Head of Innovation. • ER asked where the areas of risk identified by the VCSE Assembly would sit as ER thought the VCSE risk register would come to the Patients and Communities Committee. TG said work is currently ongoing to identify the risks and they should be presented to the next Patients and Communities Committee in March. ER asked if it can be available sooner as some risks end at the end of March. SA advised the risks would go to the next PHI	

	Board but they were also being escalated to the ICB EMT so they would not be held or 'lost'. The update was noted.	
9.	**Population Health and Inequalities Board Update**	
	Dr Frankie Swords (FS) presented the update which had been circulated in advance of the meeting and was taken as read. FS highlighted the following aspects: • Population Health Management: - Energy efficiency support in Kings Lynn and Waveney, targeting low-income households, and people with underlying health conditions living in the least energy efficient homes, to identify, contact and offer them signposting to heating support. - Extending an existing project to specifically look at newly pregnant people living in the most deprived postcodes and provide telephone support and counselling. • Health Inequalities: - Board maturity assessments undertaken by the ICB and five NHS providers, developing improvement plans which will start with how good are we at addressing health inequalities. - Successful and positive health inequalities training and inclusion event had taken place recently for primary care including pharmacy, dental and optometry. - 45x Core20 ambassadors have been appointed. • VCSE: - New VCSE Assembly Chair and VCSE relaunch FS also highlighted a new outcomes framework dashboard will be launched imminently. The dashboard pulls together in one place all the population data in the public domain. Questions and comments from members of the committee. • In relation to energy efficiency support, AD asked who was carrying out this work. FS said the ICBs virtual support team was working with the two councils which cover these areas and signposting people to the right support. The update was noted.	
10.	**Ageing Well Programme Board Update including Frailty Attuned Acute Care Workstream Update**	
	FS introduced the item and reminded the committee that it had been agreed at a previous meeting that reporting for the ageing well programme would change, and a brief update will be provided for the four workstreams and a deep dive of each workstream would be presented to the committee once per year.	

James Allen (JA) presented the update for the frailty attuned care workstream within the ageing well programme. A presentation had been circulated in advance of the meeting and was taken as read. JA highlighted the following:

- In terms of costs, severe frailty in Norfolk and Waveney is four times higher than non-frailty care
- Older adults with frailty account for significant unplanned acute care – many could be supported outside of this through community initiatives and prevention
- A N&W Frailty Attuned Acute Care Workstream meeting (previously known as the Clinical Ageing Network) is held bimonthly and chaired by the specialty clinical advisor with representation from the three acute trusts, community trust, EEAST and primary care. This provides opportunities for 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.
- Work to embed the Rockwood Clinical Frailty Scale into the electronic patient record has commenced. The pilot at the QEH will end in February 2025.
- The QEH Education Faculty has developed a 'Frailty is Everybody's Business' training programme open to attendees from across the system. This initiative supports better care and understanding of frailty across the workforce.
- The QEH offers rapid consultant geriatrician advice to EEAST, primary care and community clinicians 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.
- The Virtual Ward Frailty Pathway is working well, key benefits include 5x less risk of infection, 8x less functional decline vs. acute care.

Questions and comments from members of the committee.

- AD asked whether JA was linked in with the frailty work that HF had presented earlier in the meeting. JA confirmed they were linked adding HF is supporting the implementation of the clinical frailty scoring tool being implemented at the NNUH and being piloted, and much wider around frailty too.
- TW highlighted work ongoing at locality place level, working with the partnerships and colleagues in adult social care at the county councils around proactive intervention and some is based on the frailty score. There are opportunities to support and join up in that work. Place colleagues are now going through the process of working out what their plans will be and there's an exercise underway so the frailty work could add real value to that. JA said historically there had been links with the community falls programme via an NCC intervention project so if that worked it could be expanded much wider.
- FS reminded the committee that the programme board is overarching and is not the delivery group. The delivery groups are largely the Places which is why each place has been asked to identify their local gaps and support required to address these.
- TD said that it was fantastic the coordination and personalisation was around the individual rather than the service. TD complimented JA on the clear presentation and it felt to TD there was some rigour in that space now. Many of our frail people are of working age or in transition, TD wondered if

	we need to think about all the different assets and resources, we have within the ICB and start to lift it up a little bit into the programme approach that JA described because it might result in better outcomes. JA agreed and said conversation were ongoing because the acutes (depending on which one) obviously focus on age 50 or 55+, but when you get into that Community intervention piece it's lower but where is the cutoff point. FS added further context that the N&N frailty at one stage, because demand was so high, was only seeing people over the age of 87. We're persuading them to bring that down and to abolish the age cut off altogether and to go on a frailty basis hence all the work and scoring. The James Paget Hospital is in a very challenging situation because of the lack of geriatricians and so a specialty clinical network between the three trusts is being formed and hopefully the trialling and pushing the boundaries of some of our trusts will have a very positive knock-on effect. The updated was noted.	
11.	**Healthwatch Suffolk Update**	
	AY provided a verbal update as follows: • HWS has recently provided some information about pharmacy experiences, including from the pharmacists themselves to an All-Party Parliamentary Group • During March HWS will be publishing a report on experiences of hospital care from across the county. • HWS is supporting the Suffolk and North East Essex (SNEE) ICB and Healthwatch England around experiences of people living with ADHD. Healthwatch's work on this can be found online • HWS has been commissioned by West Suffolk Foundation Trust to evaluate virtual wards. The work was commissioned by the regional spinal team to explore the experiences of patients with back, neck and spinal care. This work also covers the Waveney area, and the report is due to be published in March. Comments and questions from members of the committee: • AD asked which part of pharmacy is being explored. It was noted that it was the impact of medicines shortages in England, the contributing factors and potential solutions. • AY agreed to share the links to the reports mentioned in his update once they are available. The update was noted.	
12.	**Healthwatch Norfolk Update**	
	Due to time pressures, it was agreed that the HWN update would be circulated via email. However AS highlighted the following concern: • Waiting times and issues around communicating with patient's links with the advent of the three acute hospitals group model and AS is incredibly concerned about the lack of public engagement around that and the potential for backlash from the public if it is seen as way of saving money.	

	TD, FS and MB took an action to connect AS with the person leading on this from an ICB perspective to ensure conversations and feedback are happening. TD added that HOSC had reached out to Norfolk to say it would like to be better cited on plans, so it has been communicated internally, but the same considerations are needed for the James Paget Hospital and the impact in Waveney. **ACTION** **MB to connect AS with the person leading on the group model from an ICB perspective, to ensure conversations and feedback are happening. Update to be provided at March committee on how this is being brought together.**	**MB**
13	**Items for Escalation to ICB Board**	
	The committee agreed the following items should be escalated to ICB Board: • Waiting times • Norwich place report and the broader issues around health inequalities and risk including the VCSE risks	
14.	**Any Other Business and Reflections on the Meeting**	
	i. Revised Committee Terms of Reference Amendments to quoracy and membership were noted. The committee **approved** the revised Terms of Reference.	
Date, time, and venue of next meeting: Monday 24 March 2025, 14:30-17:00hrs via MS Teams		

Minutes agreed as accurate record of meeting:

Signed: …… Date: ……...
Chair

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

Improving lives together
Norfolk and Waveney Integrated Care System

Norfolk & Waveney ICB Patients and Communities Committee
Action Log

No	Meeting date added	Description	Owner	Action Required	Action Undertaken / Progress	Due date	Status	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 **Update: 27.1.25: Healthwatch Norfolk advised there had been no contact from the ICB MH Transformation team to date. Action to remain live for update at the next meeting on 24.3.25. Healthwatch Norfolk and Healthwatch Suffolk to contact M Burgis before this date if there's been no contact.**	19.5.25 ~~24.3.25~~ ~~27.1.25~~		
26	25.11.24	Mental Health Referrals	MB / TD	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. **Update 27.1.25: There is a lot of work ongoing in this area and the ICB will be meeting with NSFT to look at the issues around referral processes. An update will be brought to the March meeting as to the actions that have been put in place.**	19.5.25 ~~24.3.25~~ ~~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. Update 27.1.25: Noted this action was not specifically in relation to Community Voices but wider communication in general with the VCSE sector about accessing and using the Explorer dashboard. TG to update at next meeting on 24.3.25. **Update 13.5.25: Is being added to the VCSE action plan to address as a wider issue than just community voices related to how the ICB shares data with the VCSE sector and a complex issue to unpick. Will provide updates on progress via PHI Board and direct Assembly report. Recommend to close action.**	19.5.25 ~~24.3.25~~ ~~27.1.25~~		
31	27.1.25	Operational Risks	MB	Operational risks across Place based teams to be included in March Risk Register update.		19.5.25 ~~24.3.25~~ ~~27.1.25~~		
32	27.1.25	Policy for contacting patients on waiting lists	KB	Find out how the policy is monitored.	**Joint NNUH/JPUH/QEHKL Access policy** https://www.nnuh.nhs.uk/publication/referral-to-treatment-pathway-rtt-access-policy-and-procedure-1-7/ **Patient choice policy - recently published on ICB website** https://improvinglivesnw.org.uk/~documents/uncategorized/httpsimprovinglivesnworgukdocumentsroute3adownload1246/?layout=file	19.5.25 ~~24.3.25~~ ~~27.1.25~~		
33	27.1.25	Waiting times	MB	MB and JP to triangulate data from the acutes and primary care to identify trends and understand the broader impact of waiting times on patient experiences.	**Update 12.5.25: Regular reports will now be prepared to cross check areas of concern with actions being identified where necessary.**	19.5.25 ~~24.3.25~~ ~~27.1.25~~		
34	27.1.25	Group model	MB	TD, FS and MB to connect AS with the person leading on the group model from an ICB perspective to ensure conversations and feedback are happening. Update to be provided at March committee on how this is being brought together.	**Update 12.5.25: In progress**	19.5.25 ~~24.3.25~~ ~~27.1.25~~		

NHS
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:	**19 May 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)	

Ref 00000008

Risk Title	**Health inequalities and Population Health Management**		
Risk Description	There is a risk that the ICB will not meet its statutory requirements to reduce HI or use PHM techniques to their full potential in line with the PHM strategy and HI strategic framework for action. If this happens, specific groups of people will experience poor outcomes which could have been prevented		
Risk Owner	**Responsible Committee**	**Operational Lead**	**Risk team**
Frankie Swords	Patients and Communities Committee	Shelley Ames	Primary Care
Risk programme board	**Date Risk Identified**	**Target Delivery Date**	**Date risk last reviewed**
N/A	**01/07/22**	**31/03/25**	**06/12/24**
Risk type	Health inequalities		

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 tolerated:**			

Controls

- Community Voices gathering insights into HI and connecting with local communities to help address.
- Datahub Population Health dashboards in place to support reporting and population health management approaches.
- External factors that impact on “Plus groups” (such as the moving of hotels for asylum seekers which impacts on the services they receive) are raised by the HI team to be managed across the ICP.
- Health and wellbeing partnerships and place boards overseeing local work programmes.
- Health Inequalities & VCSE Partnering team appointed to lead health inequalities work programme development.
- The HI Strategic Framework for action and the PHM strategy have been published. Implementation plans under development.
- The Health Improvement Transformation Group (HITG) focusses on Primary Prevention: smoking, physical activity and Healthy weight, report to ICP.
- ICS groups set up for Inclusion health groups, vaccines inequalities, Core20plus5 programme group, NHS Anchors group, access and support programme group, reporting to HIOG
- Refresh of the VCSE Assembly and partnership working reporting into the PH&I Board. New Assembly Chair appointed.
- 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

Actions

Date opened	Action	Owner	Target completion
31/01/25 Parker Rachael 16/05/2025 12:58:56	Cross-sector organisational sign-up to the Health Inequality Framework commitments. Organisational baseline assessments are underway with a good response from the VCSE. This is informing the ICS Health Inequalities improvement plan. The ICB improvement plan will be presented at the March ICB Board meeting. ICB panel for QIAs and EHIAs established to assess current impact assessments being undertaken by the ICB, with PMO process supporting this.	Shelley Ames	**31/03/25**

	A new Population health and Inequalities strategic dashboard has been developed and released.		

Visual Risk Score Tracker – 2024/25												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	**16**	**16**										
Change	-	-										

Ref 00000031

Risk Title	**Increasing numbers of older people with complex health needs in Norfolk & Waveney**		
Risk Description	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**	**Risk team**
Frankie Swords	Patients and Communities Committee	Olga Emmerson	Planned Care and Cancer
Risk programme board	**Date Risk Identified**	**Target Delivery Date**	**Date risk last reviewed**
N/A	**20/06/24**	**31/03/28**	**30/04/25**
Risk type	Workforce & people		

Risk Scores

Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**4**	**3**	**12**	**4**	**3**	**12**

Risk appetite:		**Risk tolerated:**	

Controls

- Increased focus upon early intervention (identify and intervene)
- Increased focus upon upstream prevention and remaining active
- 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

Actions

Date opened	Action	Owner	Target completion
04/11/24	Ageing Well Programme Blueprint developed to establish priorities and align workstreams and agreed at Programme Board	William Lee	**31/03/26**
04/11/24	Develop appropriate system Dashboard with all core workstream metrics	William Lee	**30/06/25**

Visual Risk Score Tracker – 2024/25

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	15	12										
Change	-	↓										

Agenda item: 6

Norfolk and Waveney
Integrated Care Board

Subject:	**Terms of Reference**
Presented by:	**Mark Burgis, Executive Director of Patients and Communities**
Prepared by:	**Nikki Bartrum, Corporate Governance Senior Manager**
Submitted to:	**Patients and Communities Committee**
Date:	**19 May 2025**

Purpose of paper:

For information.

Executive Summary:

The annual Risk Management Audit, undertaken by Tiaa in March 2025, has highlighted that the Terms of Reference for this Committee does not make reference to risk management.

In line with Tiaa's recommendation, the Terms of Reference (Appendix 1) has been updated to include responsibilities in relation to risks assigned to the Patients and Communities Committee.

Recommendation

The Committee are asked to agree with the proposal to add risk management to the Terms of Reference and that this is presented to the ICB Board on 21 May for formal approval.

Key Risks	
Clinical & Quality:	Lack of oversight and scrutiny of risks may impact on clinical and quality aspects of service provision.
Finance & Performance:	N/A
Impact Assessment (environmental & equalities):	N/A
Reputation:	There may be a risk to the ICB's reputation if risks are not appropriately managed via the Committee.
Legal:	N/A
Information Governance:	N/A
Resource Required:	Risk owners, Operational Leads, Committee members
Reference document(s):	Risk Management Audit, Tiaa, March 2025
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)	

NHS
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
10 April 2024	Section 2 (purpose) and section 6 (responsibilities of the committee) both updated to include risk management.	Nikki Bartrum	1.7

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 and, will also consider the management of risk in all its work.

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 five members including at least the Chair or Deputy Chair, and one ICB Executive Director.

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

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

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

Decision making and voting

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

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

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

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

Urgent decisions

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

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

6. RESPONSIBILITIES OF THE COMMITTEE

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

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

Complaints

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

Listening to, engaging and working with people and communities

- Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote the involvement of patients, their carers and representatives in decisions about their healthcare.

- Approve annual changes to the Norfolk and Waveney People and Communities Approach that sets out how the ICB and wider ICS will deliver on the system wide approach to working with people and communities in Norfolk and Waveney.

- Receive regular reports setting-out the ICB's implementation of its annual communications and engagement plan and the organisation's contribution to delivering the Integrated Care System's approach to working with people and communities in Norfolk and Waveney.

- Consider how the ICB and the Integrated Care System could improve how we listen to, engage and work with people and communities.

- Oversee the sharing of insight gained from engagement with people and communities across the ICB and the Integrated Care System.

- Provide assurance to the ICB Board regarding the effectiveness of the organisation's approach to listening to, engaging and working with people and communities.

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

Using Population Health Management Approaches and addressing health inequalities

- Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to have regard to the need to reduce inequalities and use population health management approaches to help achieve this.

- The Committee will receive regular reports from the Norfolk and Waveney Health Inequalities Oversight Group about the Integrated Care System's work to reduce health inequalities.

- Consider how the ICB and the Integrated Care System could improve its work to address health inequalities.

- Provide assurance to the ICB Board regarding the effectiveness of the organisation's work to address health inequalities.

Integration with the voluntary, community and social enterprise sector

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

- Consider how the ICB and the Integrated Care System could improve integration between the statutory and voluntary, community and social enterprise sectors.

Development funding

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

Place

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

Risk Management

- Provide oversight and scrutiny of risks assigned to the Committee.
- Provide assurance, through regular reports to the ICB Board, that risks are being identified, monitored and managed appropriately.

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

Improving lives **together**

Norfolk and Waveney Integrated Care System

Norfolk & Waveney Place-led partnerships.

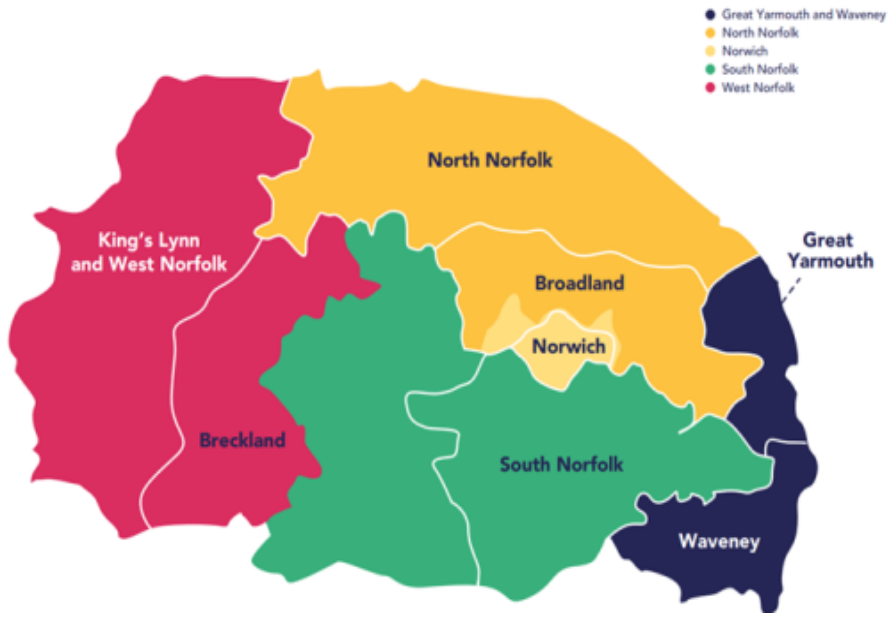
Understanding the benefits of Place-led activity for local people and their experiences of support.

Update for the Patient and Communities Committee May 2025

Introduction

- **Place** has been previously acknowledged both nationally and locally, as a critical component within the '**organising architecture**' of ICS's and key for delivery of transformation policy.
- Recently, the Secretary of State has tasked ICBs to be '**pioneers of reform**' through 'strategic commissioning', by driving the **three shifts** for health services: from **hospital to community**, from **illness to prevention** and **from analogue to digital**.
- A Model ICB Blueprint has now been published (May 2025), supporting the national ICB reorganisation programme. Going forward, the four core functions of ICBs will be
  1) understanding local context,
  2) developing long term population health strategy,
  3) using contract design and management to support strategic delivery and
  4) evaluating impact.
- As signalled in Neighbourhood Health Service guidance (Jan 2025) and with further policy direction due in the 10yr Health Plan a key factor is shifting resources towards earlier intervention.

ICB Place boundaries x 5 and overlapping Health and Wellbeing Partnership x 8.



Approx. patient population Central Norfolk 700k, GY&W 245k and West Norfolk 190k = Total N&W population of 1.135 mil

- To ensure the impending reform agenda is deliverable, its paramount we understand, harness and **build upon the mechanism** for ICS partners to work most effectively together to drive prevention and tackle health inequalities.
- Existing Place-based partnership bring together partners, so plans and decisions about health and care take place closer to, and are made together, with local people. Challenges our N&W Place-partnerships face in achieving the national and local aspirations has been previously shared with this Committee.
- Today, we will highlight how Place arrangements have enabled delivery of valuable patient services and the **experiences of patients in receipt of Place-led support,** particularly for some of our most vulnerable communities.

Population Health Management & Patient experience

Keeping Warm & Well pilot in Waveney & West Norfolk

- A joint initiative between Local Authorities and the NHS to support the most vulnerable households through intelligent use of data and sharing existing resources; A targeted Population Health (PHM) approach and one of the identified areas we must harness and build upon.
- Pilot initiated in Waveney and West Norfolk; the first collaborations of their kind across England (and short listed for an LGA award June 25)
- Aligns with the 3 strategic shifts for health services:-

Treatment to Prevention:	• Fuel poverty can exacerbate health conditions. This project comprises identification and proactive contact with the most vulnerable, offering free heating improvements that significantly reduce energy bills and reduce risks of ill health, potentially for generations.
Hospital to Community:	• By working with Local Authorities and energy suppliers, we are able to leverage existing community-based resources to shift support where it can have the greatest impact
Analogue to Digital:	• The project involves using data sharing tools and techniques at scale, enabling many more households to benefit compared to conventional service delivery methods

Why this PHM pilot is of significance

ICB future core functions as per the Model ICB Blueprint, will rely heavily on the use of Population Health Management (PHM) and risk stratification tools. This will ensure resources are best used and directed to where they will have most impact, with a particular lens on tackling health inequalities.

NHSE definition of PHM – "***improving population health through data driven planning and delivery of proactive care to optimise health outcomes***".

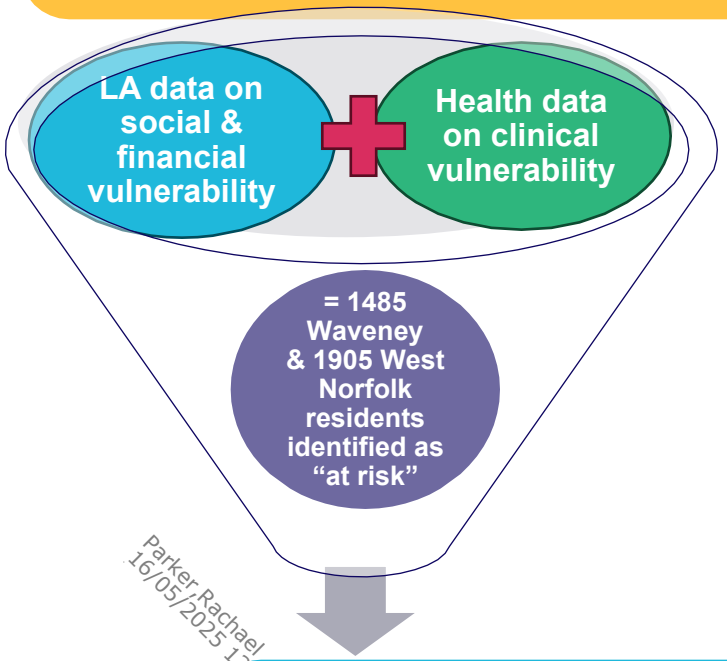
- The **Waveney and West Norfolk** home energy efficiency pilots aims to harness PHM principles by:
  - ➢ Switching from reactive to proactive contact of vulnerable communities
  - ➢ Switching from random to targeted engagement approach
  - ➢ Switching from variable need to prioritise those most in need
- Ultimately, this will tackle health inequalities by:
  - ✓ Reducing heating costs (freeing up income / reducing financial worries)
  - ✓ Reducing health risks for those most at risk of living in a cold home
  - ✓ Enhancing housing for generations to come
- The method adopted used a risk stratification approach by overlaying publicly available housing stock data (inc. home energy ratings), with IMD, and household financial vulnerability data (held by the council) and with chronic health condition data resulting in a data set of home eligible for national home improvement grants and where the occupants have poor health & at risk of exacerbations from their cold home.

Keeping warm and well

ECO4 & HUG2 government / energy supplier backed grants schemes and administered by local authority partners.
**data summary is for Dec 24– March 25 in Waveney & March to May 25 for West Norfolk

Our Place Partnerships have enabled a data-driven, preventative scheme to support clinically vulnerable Core20 communities at risk of living in a cold, damp, energy-inefficient home.

Place partners are working together to protect vulnerable residents with chronic illness from the associated risks of living in a cold home. A PHM approach demonstrates the benefits of linking health and local authority data, to identify specific vulnerable households eligible to receive non-clinical support, which will positively affect their health.



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Critical enablers for success:

- Willingness of local government partners to adopt a risk stratified approach to target existing multi-million pound* home upgrade funding.
- Use of NICE Guidelines specifying chronic health conditions at risk of exacerbation from cold, damp homes (cardiovascular, respiratory, immunosuppressed, or limited mobility).
- Robust IG and data sharing agreement to join local authority and health data, identifying residents living in poor quality housing (inc. low EPC rating) in Core20 Communities and living with serious health conditions.
- Patient identifiable data (PID) shared with East Suffolk Council & Kings Lynn Borough Council, to enable Housing teams to proactively contact residents and help households to understand their eligibility for grants and wider social and welfare support. (Note: minimal info provided; only regarding one of the conditions being present)

***Collective impact so far** =*

1078 vulnerable residents in 707 households in Kirkley, Lowestoft & West Norfolk

235 households responded = 33%. Significantly higher than traditional mailout response rate

50 home visits completed and further 8 booked, initiating the grant schemes.

Wider support inc. Fire service referral , heater loan, financial benefits assessment

Patient Experience

CASE STUDY:

Case Study: Urgent Support for Family Living in Poor Housing Conditions
A couple in their late 30s, both with health and mobility issues, moved into a property purchased at auction without viewing. Upon moving in, they discovered it had no gas supply, non-functional electric heaters, and only an electric shower in an outbuilding. There was no other source of hot water. Much of the property was in disrepair, with bare walls and only three usable rooms:
•The living room, where the eldest child slept on a sofa
•A bedroom shared by the couple and their youngest child, lacking a door and very draughty
•The kitchen

Immediate Support Provided Via Home Visit:
•A Winter Warmth Pack, including a thermal curtain (for the bedroom), electric throw, and four loan heaters
•Behavioural advice to reduce damp and mould

Referrals Made:
•Disability Advice Northeast Suffolk (DANES) for PIP support and help for their eldest child
•Suffolk Fire Service for heat and smoke detectors
•Suffolk Centres for Warmth for benefit checks
•ECO4 referral for insulation and permanent heating

Additional Support:
•Link to Local Welfare Assistance Scheme (£150 toward fuel, food, or white goods)
•Registration with the Priority Services Register for enhanced energy provider support

Outcomes: The family received a **£30,185.00 ECO4 grant** which mean free solar panels, air source heat pump, loft insulation, wall insulation/plastering. The family described the thermal curtains, heaters, and electric throw as a "godsend" during the cold weather.

Project: Kirkley, Lowestoft

Heath and Housing Support Officer

Contact:
Teresa.Howarth@eastsuffolk.gov.uk
Housing Strategic Lead, ES

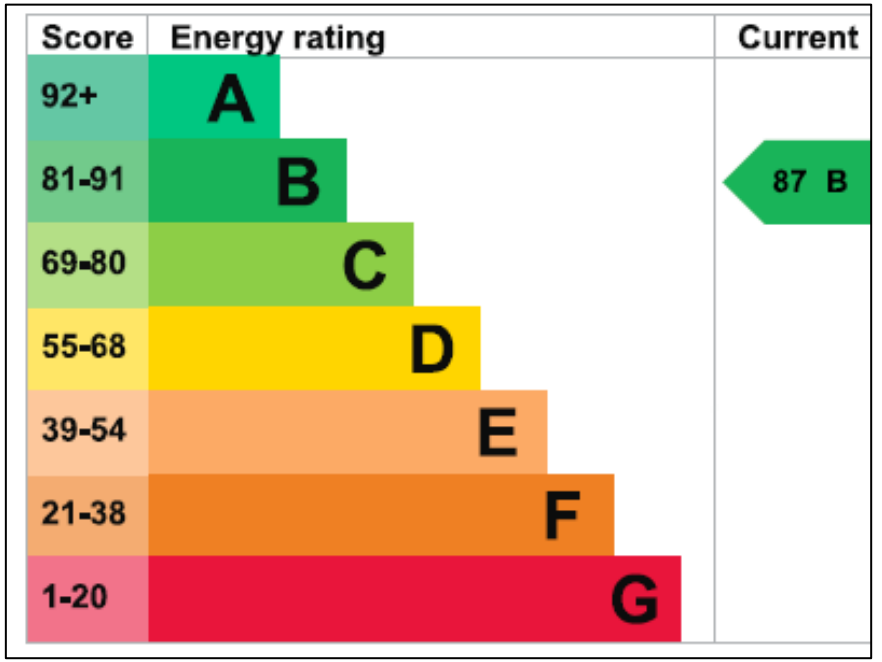
CASE STUDY: Before

Score	Energy rating	Current
92+	A	
81-91	B	
69-80	C	
55-68	D	
39-54	E	
21-38	F	
1-20	G	18 G

Project: Kirkley, Lowestoft

Heath and Housing Support Officer

CASE STUDY: After



Client Feedback:

"Great news – we have central heating! It's amazing. We'd like to thank you for all your help and support. This could not have happened without you."

Estimated annual bill savings are £1887,30

Project: Kirkley, Lowestoft

Heath and Housing Support Officer

Next steps & lessons learnt

Waveney & West Norfolk Keeping Warm and Well

1. **Evidencing impact**: planning to evidence how improving the energy efficiency of a home has direct impacts upon health outcomes, alongside social and welfare provsion.

2. '**Size of the prize**'. Home upgrade schemes for residents with health needs – Multimillion pounds of Central Government and Energy provider grants available. Yet, no other known example of this type of targeted collaboration. This groundbreaking project could be scaled across our local system. For example:
   - Warm homes Social Housing Fund – Wave 3 to be delivered 2025 – 2028. in excess of £30mil available in Norfolk and Waveney

3. **Process improvement**: it has been time consuming to navigate the processes required to obtain permission to deliver the projects. Lessons have been learned along the way that can help expedite future projects, but there are likely potential ways to streamline data sharing initiatives of this kind in future

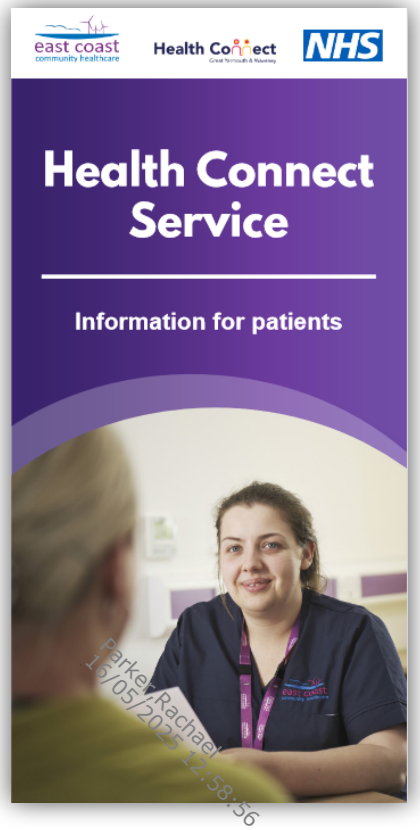
4. **Proof of concept**: this initiative has demonstrated the value that data sharing can bring where there are willing partners in place. But this is the tip of the iceberg; what other opportunities could there be to explore?

2. Health Connect

Great Yarmouth & Waveney

Health Connect Great Yarmouth & Waveney

Health Connect helps residents in Great Yarmouth and Waveney recover faster and avoid hospital admission by offering them practical and emotional support in their own homes, as well as connecting them to wider health, social and community services.



Health Connect is a collaborative programme of work developed and steered at Place by the NHS, local borough, district and county councils.

This is a targeted service created to support patients recently discharged from hospital, those who've used community health care, and residents accessing services whose health and wellbeing is affected by wider determinants of health.

The service is delivered by a team of trained connectors, hosted by East Coast Community Healthcare, who contact patients by phone shortly after referral and assess their needs and preferences.

This may include problem solving, basic health observations, equipment provision, condition specific assessments, or co-ordination with GP, community health or social care.

A key outcome of the Health Connect service is to match the resident with suitable services and opportunities in their area, such as social groups, clubs, classes, events, volunteering, or counselling.

Activity

Over 5,500 referrals for welfare calls → 1 in 5 welfare calls resulted in information, advice or support being provided → Over 1,300 residents supported 1:1 in the community → Referrals made to 150+ unique organisations or services for longer term support

Lead & key contact: **Daniel Schaffer** – Community Transformation Change Manager

Case study –

Health Connect
Great Yarmouth & Waveney

Background
David, a retired individual living with his wife, was referred for a welfare call following a fall that led to his admission to the James Paget University Hospital (JPUH). Although this was not his first fall, it was the first time he required acute care. Upon discharge, he was assessed as independent with personal care needs and discharged on Pathway 0. David also has a diagnosis of dementia.

Assessment
•**Support Network:** David has no recognisable support network outside of the home and is becoming increasingly isolated.
•**Mobility:** He has a walking frame for stability but does not use it (dementia related), posing multiple fall risks. A bed lever had been installed but was removed by David, making it difficult for him to get in and out of bed.
•**Financial Concerns:** David's wife is worried about winter fuel bills and the cost of care. She is also undergoing regular treatment for cancer.

Output
•**Observations:** A full set of observations was taken and recorded.
•**Therapy:** Discussed the potential benefits of therapy and agreed to explore this further at PCH.
•**Financial Support:** Referred to DIAL for assistance with claims for Attendance Allowance (AA) and Carer's Allowance.
•**Dementia Support:** Referred to the Alzheimer's Society for long-term support.
•**Care Arrangements:** Although resistant to formal care, David agreed to consider gradually introducing support.
•**Cancer Support:** Accompanied David's wife to the Louise Hamilton Centre for cancer support.
•**Winter Fuel Payments:** Referred to Great Yarmouth Borough Council (GYBC) to explore winter fuel payment options.
•**Access to Services:** Supported in accessing services through Centre 81.
•**Carer Support:** Linked to Carers Matter Norfolk and Suffolk Family Carers for additional support.

Outcomes
Over the past two months, David's situation has significantly improved. Through shared decision-making, it was determined that mobility equipment might increase fall risks at this time, so the focus has shifted to strength, balance, and nutrition. Benefits have been applied for, and David's wife feels more prepared to handle immediate future challenges. The improved financial situation has allowed for the introduction of a small amount of care from a trusted professional. Coordinated support has enabled David to recover comfortably at home, reducing the risk of hospital readmission.

"I've been told there's support, but I've not been offered any. You'll be just like the rest of them. "

David's wife

North Norfolk Frailty Workstream Case Study

Overview

Developed in response to the North Norfolk Place Board priority of frailty, with the aim to prevent, reduce and delay frailty. The model is data-led, starting with Emergency Department (ED) and Minor Injuries Unit (MIU – Cromer) attendance data for people aged 50+ who have fallen but not been admitted (people residing in care homes or those with a Rockwood score of 7-9 are out of scope). Once a person consents, their details are shared with the respective district council (North Norfolk or Broadland) who make initial contact, who can offer a range of support, as appropriate, and if needed can facilitate a discussion at the GP practice's Multi-Disciplinary Team.

Background

Elderly gentleman, who is a frequent faller, and lives with his wife. Both have multiple long-term conditions and care for one another, with no formal support links in place. They are worried about being dependant on family members, such as having to take time off work to take them to appointments. The couple have called emergency services when unable to support each other and leave the door unlocked to enable access.

Initial Contact

Community connector undertook a home visit, due to both of them being hard of hearing. Established that both were in receipt of the state and a small private pension but neither were claiming Attendance Allowance. Identified needs relating to aids and adaptations with damaged stair rail and bed and chair not being suitable. The husband tries to do some exercises by copying someone he sees exercise in the field opposite their home.

Referrals and interventions secured

Assistive Technology to support linking their hearing aids to their telephone and care alarms.
Tech skills for Life to provide the husband with knowledge to use a smart phone and his wife to learn about online banking and access online exercise classes for both.
Financial inclusion to support both of them with Attendance Allowance applications and then pension credit once received.
Integrated Housing Adaptations Team (IHAT) for Disabled Facilities Grant (DGF) for a wet room.
Cromer Carers for information about the household support fund to help towards energy bills.
Norfolk County Council for aids and adaptations and Occupational Therapy (OT) assessment.

Follow Up

During a follow up visit, it was identified that there had been some confusion regarding IHAT and the OT being separate services. The couple hadn't returned their financial assessment for the DFG, resulting in case closure and they had started considering self-funding options, which would have cost them their entire savings. This was put back on track and NNDC's IHAT and Financial Inclusion team agreed to work together to support the couple to complete the process.

Outcomes

Enabled to maintain independence in own home: Provision of recliner chair, grab rails and orthopaedic bed. Wet room pending. Awaiting Assistive Technology input at point of closure. Hoped that this will enable the gentleman to communicate more independently without requiring his wife to talk for him on the phone.
Improved financial situation: In receipt of Attendance Allowance and Pension Credit with the latter enabling Disabled Facilities Grant for wet room to be provided without financial assessment. Cromer Carers provided £100 to go towards energy bills and cover transport fees for doctors' appointments. Gained back winter fuel payment. Awarded a free TV licence.

Case Study – Winter Warm: Norwich City Council & Integrated Care Coordinators

Overview

Integrated Care Coordinators (ICCs) are system roles that support in facilitating multidisciplinary meetings (MDMs), gathering data, accessing various systems (social care and health systems) and making onward referrals to connect people to the right service, at the right time. The ICC roles and Norwich City Council worked collaboratively to establish a pathway that enabled ICCs to refer individuals who would benefit from financial support, in the form of the Household Support Fund (HSF), which District Council colleagues can facilitate. A targeted approach was taken and focused on those people with respiratory related conditions and whose housing, income and other factors may exacerbate their health condition. This integrated and holistic offer of support was prioritised for those living in areas of high deprivation – known as RITA (Reducing Inequality Target Areas) areas in the Norwich District Council area.

Background

73-year-old lady who lives alone. Referred to the ICC by a Community Matron. Mould present in the property. Lady had a chest infection and a diagnosis of emphysema.

Referrals

Norfolk First Support for short term care package whilst unwell with chest infection.
Norwich City Council for support with one-off deep clean to remove mould.
INTERACT for support around possible move to sheltered housing (more appropriate housing solution).
Groundworks East for support with preventing future issues around damp and mould.
Norwich City Council (HSF) for one-off financial support.
Linked with social group for Christmas lunch.

Outcomes

Happy to remain in current home: Provided with dehumidifier and support in how to use. Further advice by Groundworks East to prevent return of damp and mould. She felt happier in her own home and was less inclined to move.

Improved financial situation: £200 Tesco voucher was granted. She was able to use this to offset the energy charges incurred through needing to have the heating on for longer periods than usual when experiencing the chest infection.

Improved physical health: Provision of dehumidifier reduced the impact that the cold and damp in home was having on her condition; emphysema.

Reduced social isolation: Attended Christmas Lunch rather than spending it on her own as originally intended.

Breckland Community Health & Wellbeing Workers Case Study

Project overview

Developed in Brazil, brought to the UK by Public Health and Westminster Council, the model is based on household cohorts, between 80-120 per Community Health & Wellbeing Workers (CHWW). Engagement once per month to build trust in the community. Focusing on deprived areas to improve health and wellbeing outcomes for residents

Background

Six Afghan families, in the settlement scheme move into Watton. They were attending the Medical Practice daily to receive medical care, the CHWW's were asked to work with them to understand what they needed, the barriers the families had and help them integrate into the UK culture.

Initial Contact

Through door knocking initial contact was made, providing monthly visits built up trust and engagement with the families to understand their needs.

Referrals, assistance provided

The families had no understanding of UK healthcare, system literacy was provided, referrals for food vouchers, financial support and awards, explained and helped the families to gain dental care provision, liaised with the people from abroad team, help the families access English for Speakers of Other Languages (ESOL) classes and all of the families had medical treatment for an infectious disease. Referrals to working well to get family members jobs. Health inclusion and vaccinations were administered, the NHS App was installed on their phones.

Outcomes

Empowered and Sustainable Family: No longer high engagers, prevented the wider community from getting infected, children in the family enrolled in education.

Improve Financial situation: The parents obtained jobs due to working well and ESOL classes, were able to navigate the UC claims with support from the CHWW team therefore, no more financial support was required.

Breckland Community Health & Wellbeing Workers Case Study

Background

Gentleman in his 60's sent a letter to the medical practice, stating that he was eating dog biscuits and being emotionally abused as he had no telecommunications and wasn't allowed out of the house. He was neglected, had no bed, or place to wash and had to go to the toilet in the garden.

Initial contact

Door knocked, wasn't allowed entry, but spoke on the doorstep, then set up a safe place to talk at the local food bank, issued a food voucher, delivered the food the next day and got consent to take his case to Breckland Collaboration meeting.

Referrals, assistance provided

Various processes to remove the gentleman from the unsafe home, poor literacy, had no bank account and UC claim was going into the perpetrators bank account, therefore a police report was made for the financial abuse. Environment health report made due to the 12 unsafe dogs at the property, all being looked after by the gentleman, his UC claim was paying the rent, bills and he had no money.

Weekly meetings with the housing team and social worker to get an appropriate property, this all had to completed at the food bank as his perpetrator could not know, as he was also subject to physical abuse, and the property had cctv.

Outcomes

" These girls saved my life. I am forever grateful for their continued support"

The gentleman was supported into supportive accommodation, as he was vulnerable, without the perpetrator's knowledge, all abuse was reported to the police through a modern - day slavery, domestic servitude basis, he has his own money, his own space, he is safe, learning how to read and write, is clean, tidy and supported with friends.

INTERACT Team Case Study – AGE UK Ms. A

Overview

INTERACT provides support for people aged over 18 whose health and wellbeing are adversely affected by their housing/home environment and have health conditions, frailty or frequently use health and care provisions. Managed by Norwich City Council and supported by Voluntary Norfolk, Age UK Norwich and Citizens advice Bureau, working together to assist service users to achieve their housing goals, and agreed outcomes set. All referrals for Interact are made via an organisation or a health professional

Background

Ms A had accrued arrears and shared that she was not managing in her first floor flat due to poor mobility. She wore a knee brace, had very few ligaments left, struggled getting in and out of the bath and could only walk a few steps without crutches. Already experiencing anxiety, her worries about falling were increasing her fears about going out, which was impacting on her wellbeing. Ms. A was in receipt of Employment and Support Allowance, Housing Benefit and her Personal Independence Payment (PiP) was due to be reviewed. Ms.A was referred to INTERACT by an income officer at Norwich City Council.

Interventions via INTERACT

The Social Prescriber built up a rapport with Ms A. and worked together to capture her goals in a personalised care and support plan. Which lead to the following support:

- Implementing handrails in the existing bathroom to use the bath safely and more easily.
- Completion of a Medical Assessment Form to apply for a disability rating. Ms. A would then have priority on any adapted and ground floor properties
- Registration to join the housing register, calls to Home Options and information on how to bid.
- The support with her Personal Independence Payment (PiP) review application via Age UK.
- Referral to Better Together Norfolk (mental health and wellbeing) and 1:1 support from a Life Connector.
- Support from an Enhanced Recovery Worker (ERW) for short-term talking therapy.
- 10 sessions of personalised strength and balance training from a health coach
- Eligibility for a grocery voucher to help offset some of the costs from an upcoming move.
- Grant applications to apply for a mobility scooter.
- Viewing properties, updating records to reflect the new address, understanding energy provider requirements and other admin related to the new home.
- Physical support to move to a sheltered property.

Outcomes

- The Medical Assessment resulted in Ms. A being eligible for early access to a sheltered property that was on the ground floor.
- A successful grant application has resulted in securing a mobility scooter and Ms A is now able to enjoy getting out.
- Joint visits from the SPX, Life Connector and ERW have increased Ms A. in engaging with services.
- The support has improved her confidence in the community.
- Ms. A was pleased the income officer had taken the time to refer her as she had been listened to and achieve her goals. In the past she had not had a worker that had changed so many things for her.

INTERACT Case Study - Mr T

Overview

INTERACT provides support for people aged over 18 whose health and wellbeing are adversely affected by their housing/home environment and have health conditions, frailty or frequently use health and care provisions. Managed by Norwich City Council and supported by Voluntary Norfolk, Age UK Norwich and Citizens advice Bureau, working together to assist service users to achieve their housing goals, and agreed outcomes set. All referrals for Interact are made via an organisation or a health professional

Background

Mr T - A 34-year-old man with learning difficulties, and a functional neurological disorder that resulted in left leg monoplegia. He lived with his mother and relied on her support, until she went into residential care. This situation left Mr T in a p property without a formal tenancy agreement, but with the owner's implied or express permission, known as 'Use & Occupation'.

Mr T's family were advised that the property would be given it back to the Council. Mr T was made an occupant under the Norwich City Council policy and the Tenancy Management Team referred Mr T to INTERACT. When INTERACT first met Mr T, he was in an empty (no furniture or white goods) three-bedroom property, with just his belongings and his bed.

Interventions via INTERACT

Mr T was entitled to a one-bedroom property, which would be his first tenancy. It was important to him that he could continue to live in the neighbourhood he was familiar with, would need help with resettlement, getting money to buy furniture and white goods, and financial support. The support Mr T received from INTERACT included:

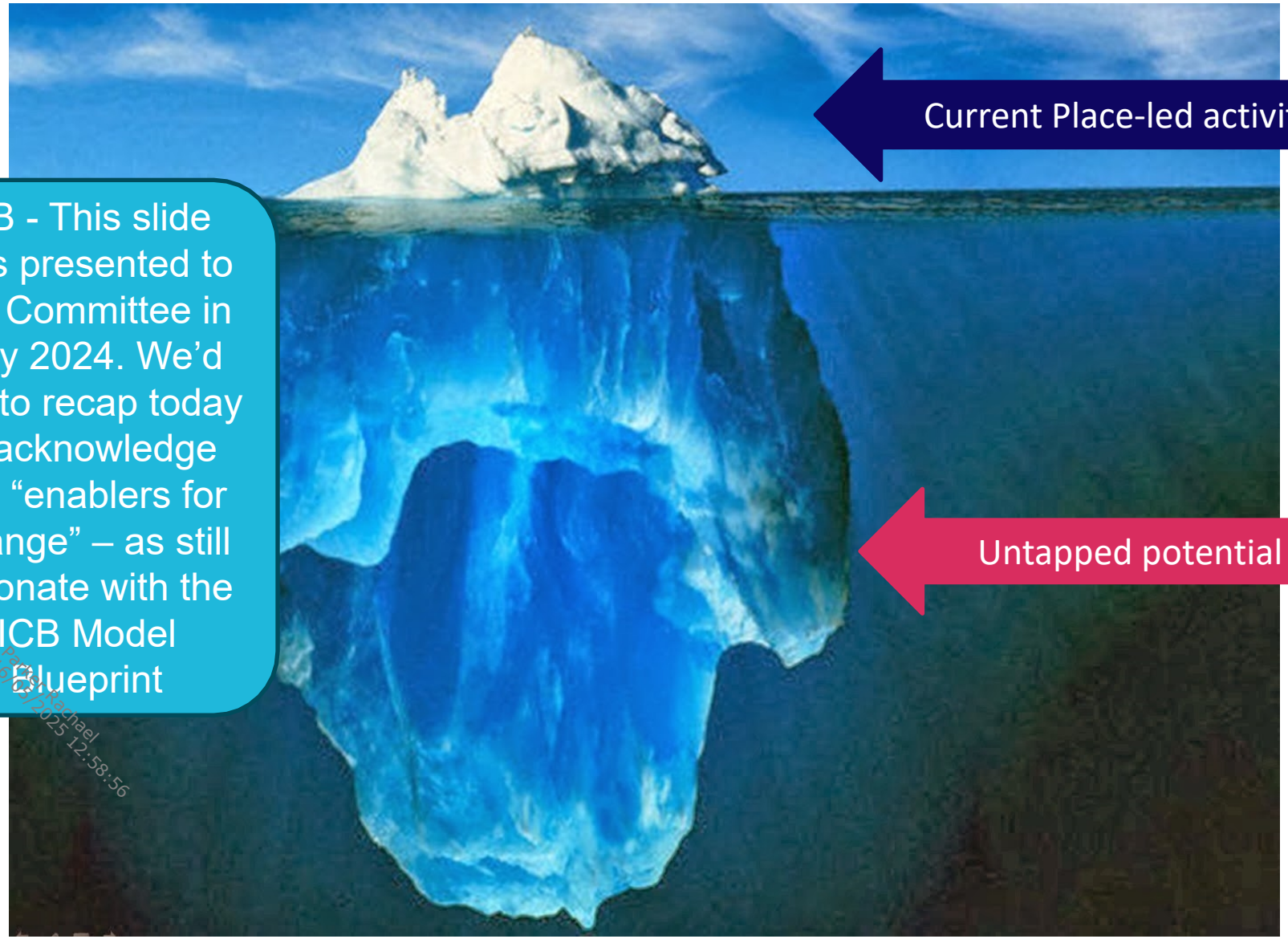
- Applying for the Housing Register and liaison with Norwich City Council's Housing Options Team on his behalf
- Signed up to the property newsletter, and assisted bidding list as this would ensure a smoother process for Mr T to understand.
- Mr T was struggling with his finances (only receiving £280 per month for Universal Credit, and it was a priority to have Mr T apply for the benefits he was entitled to.
- Submitted applications to Client Hardship Fund, BESOM, and Baseline for white goods, decorating, and starter packs for Mr T's property
- Applying for Personal Independence Payments, Council Tax Reduction and Housing Benefit.
- Mr T moved into his new property and INTERACT attended appointments with the Housing Officer as Mr T built a rapport with the INTERACT caseworker and had asked for him to be at the visits
- Resettlement assistance
- Attendance at community centre to become familiar and confident with access to support in the future.
- A volunteer to decorate his kitchen and living room

Outcomes

- Mr T is now in his new property which is just 10mins walk from the house he grew up in and this enables him to see his close friend.
- His financial situation has improved following a successful Housing Benefit application and council tax reduction. He was awarded a backdated Personal Independence Payment, which has helped to clear his debt and future payments are now in place until January 2031.
- Grants have enabled Mr T to obtain a washing machine, oven, fridge, toaster, kettle, sofa.

INTERACT worked with Mr T for nine months. He was thankful for the support that he received. He doesn't usually trust people but felt comfortable with INTERACT and all the support that he received.

Tip of the ‘place’ iceberg of opportunity



Current Place-led activity

Examples described are just the start of what Place can achieve, if enabled

NB - This slide was presented to the Committee in July 2024. We’d like to recap today & acknowledge the “enablers for change” – as still resonate with the ICB Model Blueprint

Untapped potential

Enablers for change:

- Agreed delegation and accountability.
- Clarity of Place function within the ICB & ICS operating model
- Maximising the benefits of place as described with strategic plans, such as PHM & Health Inequalities Strategic Framework for Action; Primary care Strategy

Norfolk and Waveney
Integrated Care Board

Agenda item: 7ii

Subject:	**Complaints, Enquiries and MP Queries regarding Place**
Presented by:	**Mark Burgis, Executive Director of Patients and Communities**
Prepared by:	**Jon Punt, Senior Lead for Patient Experience, and Sarah Bedford, Patient Experience Manager**
Submitted to:	**Patient and Communities Committee**
Date:	**19 May 2025**

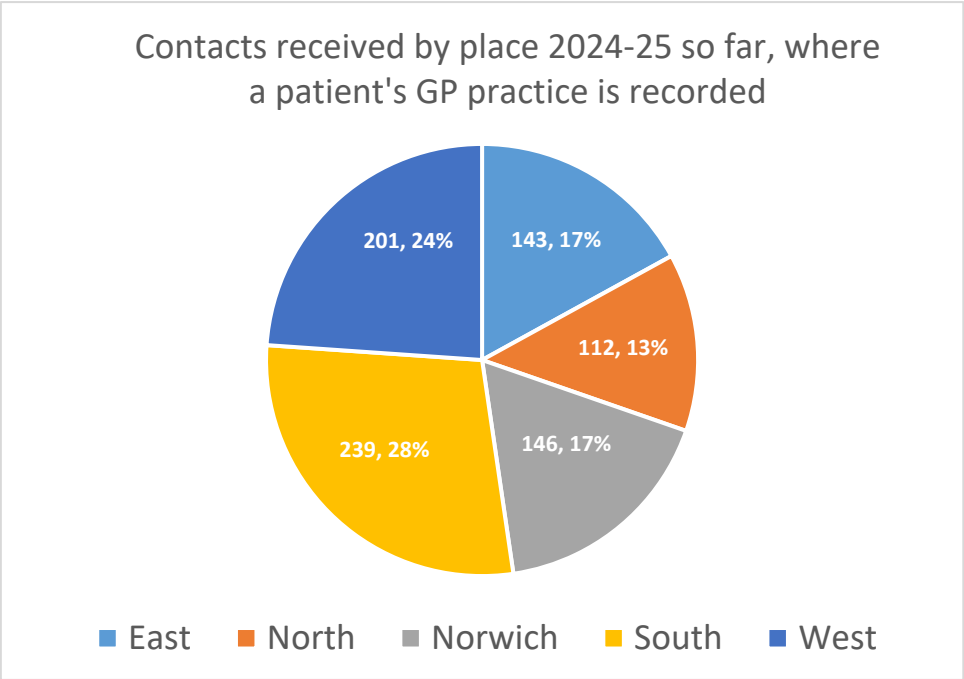
Introduction

This report aims to provide additional detail around where ICB queries are originating from in terms of location, and any trends noted from these contacts.

Executive Summary

The ICB's Patient Experience Team deals with many contacts from across the system, although the way these are logged does not allow for easy analysis of any place-based trends and themes, therefore this report is limited to reporting on volumes of contacts where a patient's GP practice has been recorded and some high level trends.

While the ICB does not capture the data that would allow us to anticipate trends in the desired way, for most primary care and vaccination queries a patient's GP practice will be recorded, thus allowing for us to understand the geographic spread of contacts across the financial year so far. This is detailed in the chart below:



Our analysis of the datasets on enquiries and concerns, complaints, and MP enquiries has not identified any overarching themes or trends.

However, working through the data has identified two regular concerns raised whereby the enquirers were highlighting an issue with local service provision. These were:

- A perceived lack of community rehabilitation beds in North Norfolk following the closure of services.
- A lack of a timely service for housebound patients receiving their COVID vaccinations in West Norfolk

While the current method of data capture may not be fully optimised for this type of analysis, there is an opportunity to explore enhancements that could provide additional insights. Furthermore, linking this work with our health inequalities team presents a potential avenue to better understand the data and identify areas that may benefit from further attention.

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)	

Improving lives **together**

Norfolk and Waveney Integrated Care System

West Norfolk Place Board

19th May, 2025

Background

West Norfolk Place Board

- The West Place Board was established in August 2022, with the following aim:

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

- Representation from the College of West Anglia, General Practice, Healthwatch Norfolk, Integrated Care Board, Local Authorities, NHS Trusts and the Voluntary, Community and Social Enterprise Sector

- Representation from King's Lynn and West Norfolk and Breckland Health and Wellbeing Partnerships

- Advisory remit, with oversight of Community Transformation schemes

West Place Priorities

West Norfolk Place Board

- Tackling Health Inequalities
  - *Shared priority with King's Lynn and West Norfolk Health and Wellbeing Partnership*
- Urgent and Emergency Care
- System Integration

Health Inequalities

West Norfolk Place Board

Marmot Programme:

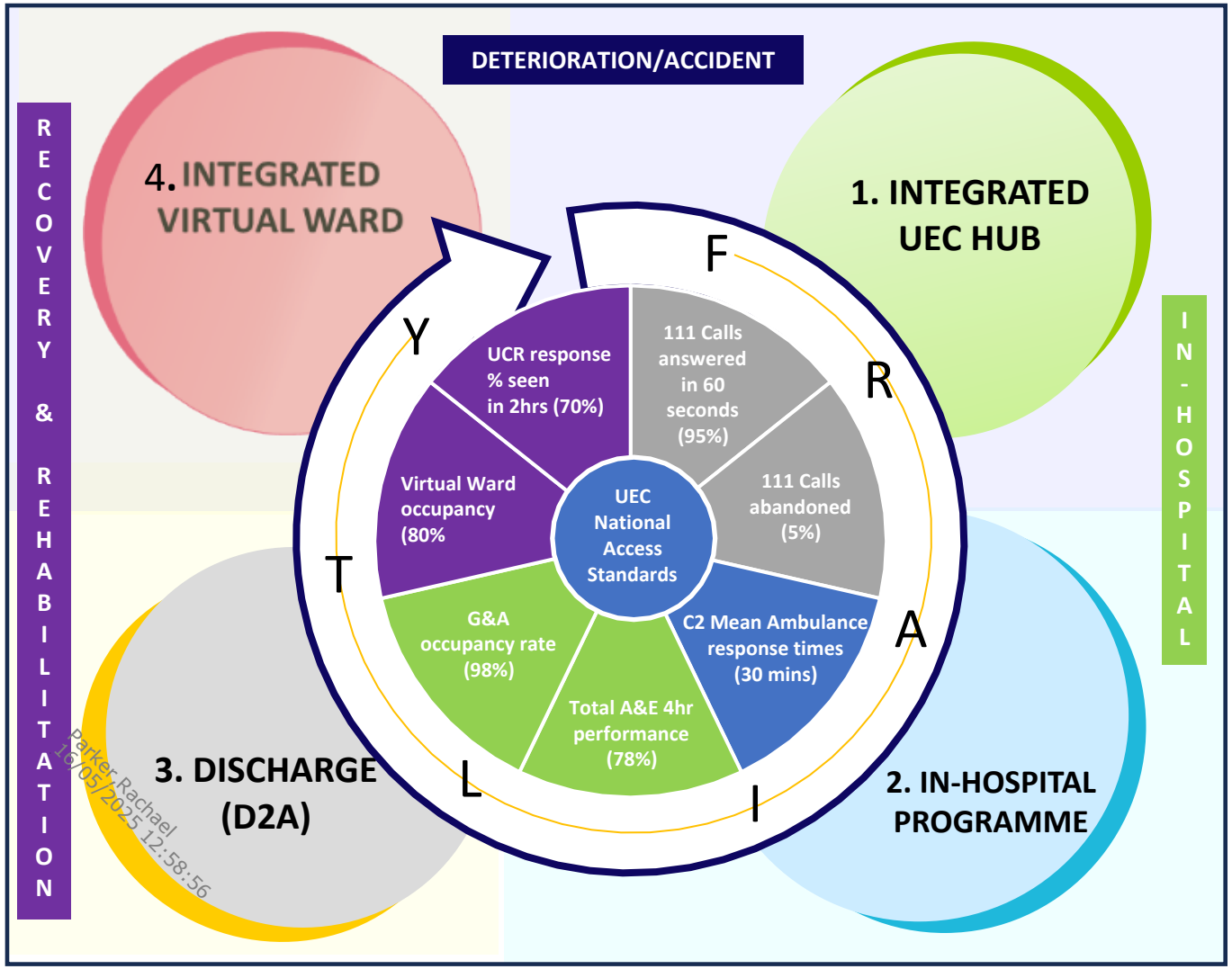
- 2 year initiative to galvanise West Norfolk's approach to tackling health inequalities
- Initial focus on 'Starting Well' with rural inequalities as a cross cutting theme

Healthcare Inequalities:

- 5 clinical conditions, and smoking, are known to have a strong link with inequalities
- Place Board developing options for partners to focus on during 2025/26

West UEC Alliance

Improving lives together
Norfolk and Waveney Integrated Care System



West UEC Alliance projects mapped against the **7 main UEC National Access Standards**

UEC Board focuses on 3 areas of improvement:

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

Urgent and Emergency Care (1)

West Norfolk Place Board

- Several projects have been delivered via the West UEC Alliance, with input from the Place Board. Examples include:
  - Integrated Virtual Ward
  - Integrated Urgent and Emergency Care Hub
  - Intermediate Care enhancements
  - Improvements in hospital discharge
  - Optimising Care project

Urgent and Emergency Care (2)

West Norfolk Place Board

- Optimising Care is a person-centred approach that seeks to increase an inpatient's mobility, through the use of equipment, to help minimise deconditioning.
- With improvements in mobility, it is anticipated that fewer double-up packages of care will need to be sourced, enabling more expedient discharges.
- QEHKL is now embedding Optimising Care with nursing and therapy staff completing an online ESR module and face-to-face moving and handling training.

West Norfolk: Falls Prevention Project

West Norfolk Place Board

AIM: To identify people who are 65 and over and are still relatively active, and provide an approach to proactively support them, hopefully prevent them having an injurious fall in the future

How do we do this?

1

Identifying at risk Cohorts

Using local intelligence, and data, we proactively identify groups of people who are at risk or in need of support.

2

Intervening to mitigate the risk

We contact people and make them aware of the support that is available to them, offering referrals where appropriate

3

Evaluation and learning

We will evaluate the success of the different cohorts and identify any learning to assist with future service development

Our Operating Model

West Norfolk Place Board

Core Elements:

Identify
our cohort, understanding key factors contributing to their risk of a fall

Contact
our cohort to understand how to support them

Intervention
tailored to the person

Follow-up
to understand what worked well

Principles:

Identify organisations who work with people in our cohort, and explore appropriate data sharing opportunities to identify people who might benefit from some assistance

People to be contacted via phone to discuss their current situation, and have an open, unscripted conversation about how we can help and what services we provide

Each person will be offered adaptations service and an exercise referral. Should other needs be identified during the conversation referrals will be made to other organisations

Follow up calls/surveys will be made to find out about their experiences of the services and the support offered

Primary Process

West Norfolk Place Board

Process:

Ivy has been identified at being at risk of a fall, via one of the projects identified cohorts, or via an external organisation

Ivy will receive a letter, and/or a direct phone call. A member of team will call her and have an unscripted conversation to identify any needs and offer her relevant, preventative support

Ivy is supported to access the preventative support on offer, tailored to her need and in doing so hopefully reduces the risk of her having a fall

Ivy will receive a follow up call once she has received the service, to identify her perceived impact of the service in relation to her confidence around falling

Services Available:

1. Adaptations within the home
2. Referral to falls prevention-based exercise
3. Referrals to other services if other needs identified

A set of questions will be asked at the initial call, and Ivy will be called again and asked some more questions once the services have been delivered

Cohorts/Organisations

West Norfolk Place Board

Primary Care/Community Health

- GP's/Social Prescribers
- NCHC Community teams and falls assessments team

Secondary Care

QEH Waiting lists:

- Orthopaedics
- Ophthalmology
- Rheumatology
- ED Fallers (in progress)

- Falls Clinic (QEH)
- Pain clinic (QEH)
- Rapid Assessment and Frailty Team (QEH)

VCSE / Other

- Careline Users
- Assisted bin users
- Fire Service - Homes Safety visits
- Private Care companies
- Age UK Norfolk /Norwich
- Vision Norfolk – Eye Clinic Liaison Officer
- Libraries
- NCC Tech support coaches
- NW Community Support service
- British Red Cross
- Private Chiropody services

Your Health Norfolk Testimonials (1:1)

89-year-old who is nearing the completion of her 1:1 visits.

Would you be willing to provide a brief testimonial about your experience with the service? If yes, please share your testimonial below:

Since the sessions have began I feel my confidence particularly in walking has improved, I don't need to use my stick as much around the house. I feel stronger in myself eg lifting boxes in the house. My mobility has also improved also, Im able to bend over and pick things up a lot easier

Parker Rachael
16/05/2025 12:58:56


Parker Rachael
16/05/2025 12:58:56

System Integration (1)

West Norfolk Place Board

- **New Hospital Programme**:
  - Enabling partner input into new delivery model: current focus on the Business Case for the NHP, including development of plans to support management of demand on a future hospital.

- **Neighbourhood Health**:
  - Scoping potential for new community based model of working, via a trial in one of our most deprived communities

- **Workforce Development**:
  - Focus on improving access into health and care roles, especially in relation to work experience

- **Voluntary Sector Partnership Working**:
  - West and North commissioned CAN to engage with the sector
  - Action plan to be developed in coming months

System Integration (2)

West Norfolk Place Board

Community Transformation Programme

- *A set of ICB funded projects that have been developed with partners*

- Learning Disability Health Checks
  - *GPs, Norfolk Community Health and Care and West Norfolk Mencap working together to improve quality and quantity of checks*

- Leg Ulcer Treatment
  - *PCN led initiative to improve treatment in Primary Care, and engagement with specialist services*

- Care Home Dentistry

- Palliative Care
  - *Provision of out of hours rapid response services and care home support (provided byTapping House)*

Improving lives together
Norfolk and Waveney Integrated Care System

NHS
Norfolk and Waveney

Norfolk and Waveney Learning from Deaths Forum Summary Annual Report 2024-2025

Patients and Communities Committee, May 2025

Lisa Read, Head of Place Quality, Norfolk and Waveney ICB
Evelyn Kelly, Senior Quality Governance & Delivery Manager, Norfolk and Waveney ICB

Learning from Deaths Forum

The Norfolk & Waveney Learning from Deaths Forum (LFDF) meets on a bimonthly basis, co-Chaired between NCC Director of Public Health and ICB Executive Medical Director.

The aim of the LFDF is to improve the health outcomes of our population, with a particular focus on those at most risk of health inequalities, by learning from deaths which have occurred across Norfolk and Waveney. The forum provides a system platform to bring together specific areas of oversight and assurance collectively, including:

- Roll out of Medical Examiner scrutiny of all community deaths;
- Learning from the deaths and mortality metrics of our NHS Provider partners;
- Oversight of Coronial Regulation 28 Reports and responses;
- Statutory mortality reviews, including safeguarding and community safety, child deaths, maternal deaths and LeDeR.

2024-2025 Population Mortality Data Headlines

- New Summary Level Population Mortality methodology was introduced nationally in 2024. The new model uses the previous 5 years as baseline data and adjusts for age, sex and deaths in the COVID-19 pandemic.

- Regionally we are seeing fewer deaths than are expected. This pattern is similar across the East of England, particularly in deaths from circulatory and heart disease, as well as lower respiratory and liver disease.

- Locally, 2023-2024 Winter deaths were 5% lower than expected according to the baseline, in line with Suffolk / Hertfordshire / East of England average.

Parker Rachael
16/05/2025 12:58:56

2024-2025 Suicide, drug and alcohol related deaths

- Unlike similar counties, Norfolk has not seen a rise in suicide rates in the last eight years and we are no longer a negative outlier. Variation and risk factors are in line with National picture.

- There has been an increase in drug related deaths, particularly in suspected suicides linked to drug use. There has also been a trend for people to use multiple different drugs simultaneously, leading to fatal outcomes. Work is ongoing across NHS providers to improve services for people who use Ketamine. Public Health is leading work to provide integrated mental health and substance use support services to address the complex needs of individuals at risk. Barriers to accessing this support are recognised include stigma. Inclusive and non judgmental treatment environments are vital to encourage people to seek help.

- Learning has been shared around the need for early intervention and referral to treatment services for people struggling with alcohol misuse to prevent the escalation of alcohol-related harm and potential fatalities. Alcohol teams in place in all providers now.

2024-2025 Child death reviews

- Child Death numbers remain low and stable
- The majority of child deaths are due to genetic or chromosomal conditions.
- However, there are modifiable risk factors implicated in some child deaths which are unchanged from previous years:
  - Parental smoking,
  - Parental obesity
  - Co-sleeping
- Links to wider public health work around smoking cessation and weight management support, plus specific work led by LMNS with ICB support in the pregnant community and their families.
- Concern remains on how to ensure messaging is heard by all – vulnerable and younger people. Links have been made to the health inequalities team to support at place level

Medical Examiner Service

- The Medical Examiner (ME) Service has now been rolled out to cover all Community deaths from September 2024
- This provides additional scrutiny of deaths across the system.
- There have been some capacity issues, and communications with primary care have helped to improve understanding of the process and to minimise delays for families. These delays are now much improved.
- Feedback from families has been positive with the service providing an opportunity to raise questions, raise worries or concerns, and receive support to navigate through unfamiliar processes. ME support provides an opportunity to start the grieving process with clarity of information about their loved one.
- Local and National feedback has highlighted that the ME process can help the family to feel listened to without having to go down a formal complaints process
- The NNUH ME Team are currently reviewing the outcome/impact of the support provided by their service.

2024-2025 Key Learning

Drug & Alcohol Related Deaths

Growing trend noted around mortality risk associated with poly-substance use and links with suspected suicide. Work is being undertaken to increase access to early intervention for alcohol misuse and to support primary care oversight of prescription medications. Stigma continues to be a barrier to support.

Healthcare Providers

NNUH is in the top ten highest SHMI nationally which is higher than expected. Robust plans in place to explore and address possible reasons. External review by Royal College of Physicians requested. ECCH making good progress embedding LFD process. Community provider themes around end of life and managing deterioration.

LeDeR (LD&A)

Opportunities for improvement around MCA and DOLS practice. Prevention and management of pneumonia and access to screening for Cervical and Breast Cancer. Compliance with statutory review timescales is a local challenge due to capacity, but the quality and depth of our reviews is good.

Coronial Reports

12 PFD Reports received for Norfolk healthcare provision and an additional 9 raised in Suffolk in relation to NSFT. There was one non-healthcare PFD related to a road traffic death. The site of the incident remains closed. National cases with an opportunity for local learning are highlighted via the new LFDF newsletter.

Norfolk and Waveney
Integrated Care Board

Agenda item: 10i

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:	**19 May 2025**

Purpose of paper:

Provide an update on the VCSE Assembly.

Executive Summary:

The VCSE Assembly has been developing a Risk Register to highlight the risks of the sector and how they impact the wider system. The register will indicate any risks to be put forward for discussion to the committee and potentially to the ICB board. The VCSE assembly will ask for support in how to mitigate these risks and ask the Patients and Communities Committee to help support a programme of work to reduce the risk to the VCSE sector, and wider system. In April, the VCSE Assembly Board met to pull together an action plan, which correlates to the Risk Register and is currently in a draft stage. The action plan will set out clear actions and programmes of work that will support the VCSE Assembly and ICB to mitigate risks.

This report also highlights the findings of the recent State of the Sector report published in February 2025 and ongoing discussions about how as a system, we can move forward to work more collaboratively.

The report makes recommendations to the Patient & Communities Committee:

- Patients and Communities Committee to oversee the VCSE Integration Risk Register.
- Support the ICB VCSE Partnering team to deliver an agreed action plan to address these risks, working alongside ICS colleagues and VCSE partners
- Take risk register to the ICB board for further ICB commitment to supporting mitigating these risks, accepting that risks to the VCSE sector, have a significant impact on the wider system

Report

The VCSE Assembly met for the second time in March, since a “refresh” in January 2025. The assembly is pushing forward with new governance structures, and the board meeting provided an oversight to all members about the direction of travel regarding reporting and communication to the wider VCSE sector.

As chair, I sent out an update letter to VCSE colleagues, which was shared across networks within the Assembly structure. This outlined recent updates and a direction of travel, highlighting continued communication to the sector about future engagement and actions.

A Research and Innovation Lead has been appointed and started in April 2025. This is a new post, working closely with the ICB’s Research and Innovation team and is an exciting new development within the assembly. This will help add a greater representation and voice from across the sector. The Assembly will also gain a new board member, representing the Children and Young Persons alliance. The new co-chairs have been announced and I am working on embedding them into the Assembly.

The assembly had a short verbal presentation from Anne Borrows, who is supporting the new hospitals programme for Kings Lynn and Great Yarmouth. Anne was keen to hear from VCSE colleagues about examples of practice that would support ongoing concerns about capacity for services whilst the new hospitals were being built, and potentially for an increase in demand over the next 15 years. The VCSE assembly board overwhelmingly felt that the VCSE sector had an important role to play within this work, however felt that further discussions regarding appropriate representation for the programme, at central and place level were needed. Although Anne was not in a position to support this request, she is going to make the relevant enquiries and link back with the VCSE Assembly board with information about how to move this forward. The VCSE Assembly will look to support the new hospitals programme, and awaits next steps to do this.

Members were provided with a State of the Sector report with papers, a collaborative piece of work, highlighting key themes across the VCSE sector. Undertaken by infrastructure colleagues, the work identified key concerns, similar to those raised in the previous assembly board meeting in January, matching many of the captured risks on the risk register. 92 individual organisations engaged with reporting which included a mix of charities, community groups and Social Enterprises. The key findings for the report were:

- Funding: 59% highlighted securing funding or commissioning is a main challenge.
- Increasing demand for services: 47% highlighted this as a key issue.
- Recruitment and/or retention of volunteers: 34% selected this issue.

The report indicates a sector that is concerned about the future, struggling to keep up with demand and 34% of organisations feel it will be a challenge to continue

current capacity, never mind increase it. The report also highlighted concerns regarding commissioned contracts, which are no longer covering the cost of delivery for services. External factors, such as an increase in national insurance contributions from April 2025, are causing increased concern and risk of a reduction in capacity and ability to deliver services.

The VCSE Assembly has created a risk register, highlighting sector risks, many which match with the state of the sector report.
The risks have been separated into two separate registers;
VCSE Integration Risks - those risks that require input by ICS statutory partners to help mitigate the risks. Those that without mitigation will lead to declining VCSE sector and impact the wider system in terms of increased demand on acture, primary and social care services, as well as a lack of a VCSE “marketplace” in which to deliver prevention and community services.
VCSE Assembly Operational Risks - Risks to providing meaningful representation and engagement from the wider VCSE sector. Action must be taken to make sure that the wider VCSE sector is engaged within the work of the VCSE assembly, and that we are getting accurate representation and managing conflict of interests with the assembly board.

There was much discussion during the board meeting about how we utilise resources to help mitigate actions, including the responsibilities for these risks but also how as a system, the ICS responds to the risks being raised. There was concern from assembly members, that risks had been highlighted previously but were tolerated, rather than mitigated, and this had led to increased instability and will have significant impacts on a number of individual organisations. Assembly members are keen to see more action and have a focus on how we change culture within the system to achieving meaningful impacts. Assembly board members also highlighted the need for greater understanding across the system, that sits with both the VCSE sector, and ICS partners, to improve ability to work together better.

The VCSE Assembly feels that the VCSE Integration Risks should be overseen by the Patient and Communities Committee, and should take responsibility to support ongoing mitigation to help reduce these risks and the wider impact on the system. The Assembly recognises that these risks do not sit alone within the Norfolk and Waveney ICB, so wish to empower the ICB VCSE Partnering team to continue to work with other ICS partners but also to work with the ICB Executive Management Team to deliver a programme of work to help mitigate these risks.

The VCSE Assembly is currently working on an action plan, which will highlight programmes of work to help support mitigating risks, improve understanding across the system and provide a framework for meaningful change and collaboration. Within this, is a communications plan to the wider VCSE sector, to help provide wider engagement, and continue to push forward with greater representation, communication and transparency.
The VCSE Assembly action plan is currently in a draft stage.

Please note that this report is being submitted on 8th May 2025, and the next VCSE Assembly Board meeting is Tuesday 13th May 2025. This means that I should be

able to provide updates on the risk registers mitigating factors, as well as key priorities for the VCSE Assembly Action Plan.

Recommendation to the Committee:

- Patients and Communities Committee to oversee the VCSE Integration Risk Register.
- Support the ICB VCSE Partnering team to deliver an agreed action plan to address these risks, working alongside ICS colleagues and VCSE partners
- Take risk register to the ICB board for further ICB commitment to supporting mitigating these risks, accepting that risks to the VCSE sector, have a significant impact on the wider system

NHS Norfolk and Waveney ICB – VCSE Assembly Operational Risks (2025-26)

Norfolk and Waveney ICB aim:

Principal risk: That people in Norfolk will experience poor health outcomes due to suboptimal care.

Norfolk and Waveney ICB aim:

The Norfolk & Waveney VCSE Assembly was established to 'support fair and equitable partnering and engagement as part of the ICS, embedding sector voice into planning & decision making processes'.

Achieving this purpose requires engagement across the VCSE sector and an understanding of the Assembly's vision and mission.

Principal risk:

Summary of risks relevant to VCSE Assembly Operational

Ref	Risk description	Month risk rating											
		1	2	3	4	5	6	7	8	9	10	11	12
VA01	Lack of understanding about Assembly role & function										12	12	12
VA02	Communications and engagement										12	12	12
VA03	Representation gaps										9	9	9
VA04	Managing conflicts of interest of members										6	6	6
VA05	Resources to further develop model										9	9	9
VA06													
VA07													

VCSE01	
Risk Title	Lack of understanding about Assembly role and function
Risk Description	The VCSE Assembly is relatively unknown across the ICS system. There is a lack of engagement from the wider VCSE sector and the forums and networks that feed into it are unaware of how the assembly influences wider system workstreams. ICS is relatively unaware of the VCSE Assembly, and how it can support the work programmes attached to them. Structures that currently have VCSE representation are often unaware that the individuals that provide the representation are linked directly to the assembly or that they have opportunity through that representation to develop closer working relationships with the wider sector via the assembly. There is a risk that without knowledge across the ICS of the assembly, either no VCSE engagement will happen, or it will be limited to existing relationships, which may or may not be the most appropriate or overly representative of the communities we wish to target. There is also a risk that we have lack of appropriate VCSE representation, and this could be considered to be “tokenistic” rather than meaningful.

Risk Owner	Responsible Committee	Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	PH&I Board	Tim Gardiner		

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	2	12	1	1	2	2	2	4

Controls	Assurances on controls
VCSE Assembly Development – further connectivity into VCSE forums Development of Communications plan, including a range of networks, forums and place-based networks that can be used to share the work of the VCSE Assembly. Health Inequalities & VCSE Partnering team within the ICB, to support integration and communication of the VCSE Assembly into workstreams and planning. Greater governance and process for the VCSE Assembly, including a process for ICS partners to “request” support from the VCSE Assembly.	- PHI Board - VCSE Strategy Group - VCSE Assembly - Empowering Communities infrastructure arrangements

Gaps in controls or assurances
Fully developed Communications strategy highlighting long term comms plan for VCSE Assembly. Mapping work to identify gaps in work streams for VCSE representation and engagement.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion

Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score										12	12	12
change										➔	➔	➔

VA02	
Risk Title	Lack of engagement across wider sector
Risk Description	VCSE Assembly has a lack of engagement from the wider VCSE sector. Although there is significant collaboration between the sector, much of this is not well linked, and work streams are often in silos. Lack of knowledge and understanding of the VCSE Assembly is a key part of this, including clear information on the aims, work and actions of the Assembly. There is a lack of understanding about how to engage with the VCSE Assembly, and how this fits in with wider ICS governance and decision making.

Risk Owner	Responsible Committee	Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	PH&I Board	Tim Gardiner		

Risk Scores								
Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	3	12	1	1	2	3	3	9

Controls	Assurances on controls
Continued development and alignment of VCSE Assembly with current networks and infrastructure Development of communications and engagement plan Increase the “portfolios” within the board members and recruit new voices from across the wider sector. Build on VCSE engagement work at Place level to develop engagement with smaller and more local organisations Clear and transparent communications regarding the VCSE Assembly Board in public, to build trust within the wider sector Development of Hubs/Sub-groups to help with engagement with wider sector	- PHI Board - VCSE Strategy Group - VCSE Assembly - Empowering Communities infrastructure arrangements

Gaps in controls or assurances

Communications Strategy Place development, lack of VCSE networks within places. Lack of VCSE Engagement sessions or forums.

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**

Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score										12	12	12
change										→	→	→

VA03	
Risk Title	Representation gaps
Risk Description	Lack of VCSE Representation across a range of work streams within the ICS. Not all ambitions within the 5year Joint Forward Plan have relevant VCSE leads or portfolio holders within the VCSE Assembly Board. Lack of VCSE representation will lead to not meeting ambitions set out when establishing the VCSE assembly, and potentially miss out on strong place based and community focused delivery in some areas.

Risk Owner	Responsible Committee	Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	PH&I Board	Tim Gardiner		

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
9	3	9	1	1	2	9	3	12

Controls	Assurances on controls
Mapping Exercise to highlight gaps within representation across ICS workstreams Map current VCSE representation within workstreams to make sure that we have suitable representation and capacity to support the ongoing work Development of VCSE Representatives as part of VCSE Assembly, that are recruited and support via the assembly board, but that do not sit on the board.	- PHI Board - VCSE Strategy Group - VCSE Assembly - Empowering Communities infrastructure arrangements

Gaps in controls or assurances

Lack of mapping exercise and understanding of current relationships between VCSE and ICS workstreams

Lack of funding to allow for expansion of Assembly Board Leads/Portfolio holders

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion

Visual Risk Score Tracker – 2024/25

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

VA04	
Risk Title	Managing conflicts of interest in Board
Risk Description	Risk that those Assembly Board members, who sit on the assembly to represent the VCSE sector have a conflict of interest due to the organisations they work for. Many of the organisation will already be commissioned by the ICS or have potential interest in doing so. This could lead to individuals benefiting from sitting on ICS workstreams, giving them unfair advantage within commissioning, or influencing decisions for their own organisations advantage.

Risk Owner	Responsible Committee	Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	PH&I Board	Tim Gardiner		

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
2	3	6	2	2	4	2	2	4

Controls	Assurances on controls
Clear role profiles and appointment agreements Terms of reference Conflicts of Interest form to be updated before each meeting, and sent out as part of meeting packs. Any conflicts arising within board meetings must be highlighted by members at time of meeting or at specific agenda item Reporting on all VCSE Assembly work to the board and to be shared transparently across the wider VCSE sector via comms Fair and transparent recruitment process of all new board members Memorandum of Understanding across VCSE Networks and Forums, to have a clear procedure on who is put forward to sit on VCSE Assembly Board 12 monthly review of VCSE Assembly with board, including ICS members to highlight any issues regarding conflicts of interest.	- PHI Board - VCSE Strategy Group - VCSE Assembly - Empowering Communities infrastructure arrangements

Gaps in controls or assurances

Updated Conflict of Interest Document

12 month review governance or process

Memorandum of understanding with relevant VCSE networks

VCSE Assembly Board member appointment agreements in place

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**

Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score										6	6	6
change										→	→	→

VA05	
Risk Title	Resources to further develop model
Risk Description	Lack of capacity and resources to successfully embed VCSE representation into all relevant ICS workstreams. Without the appropriate level of support there may be significant gaps in representation and a risk that the Assembly becomes seen as tokenistic rather than meaningful engagement. Key risks are funding to remunerate VCSE representatives who are funded via own organisations to sit within ICS workstreams. Lack of funding also means lack of development and maturity within the VCSE Assembly Board. As an ICS, we need to be conscious of the capacity of VCSE Assembly members, including: their ability to attend Programme Boards, committees and the ICB Board and complete required reading, as well as writing reports, alongside attending meetings.

Risk Owner	Responsible Committee	Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	PH&I Board	Tim Gardiner		

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
3	3	9	1	1	2	3	3	9

Controls	Assurances on controls
Grant for the VCSE Assembly Development of future strategy to align with the 5 year Joint Forward Plan Mapping of VCSE Representation and potential gaps Where appropriate work streams that require ICS support, budget can be used for remuneration costs.	- PHI Board - VCSE Strategy Group - VCSE Assembly - Empowering Communities infrastructure arrangements

Gaps in controls or assurances

Lack of clear development plan and budget

Mapping exercise

Process and governance arrangements regarding funding VCSE remuneration

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**

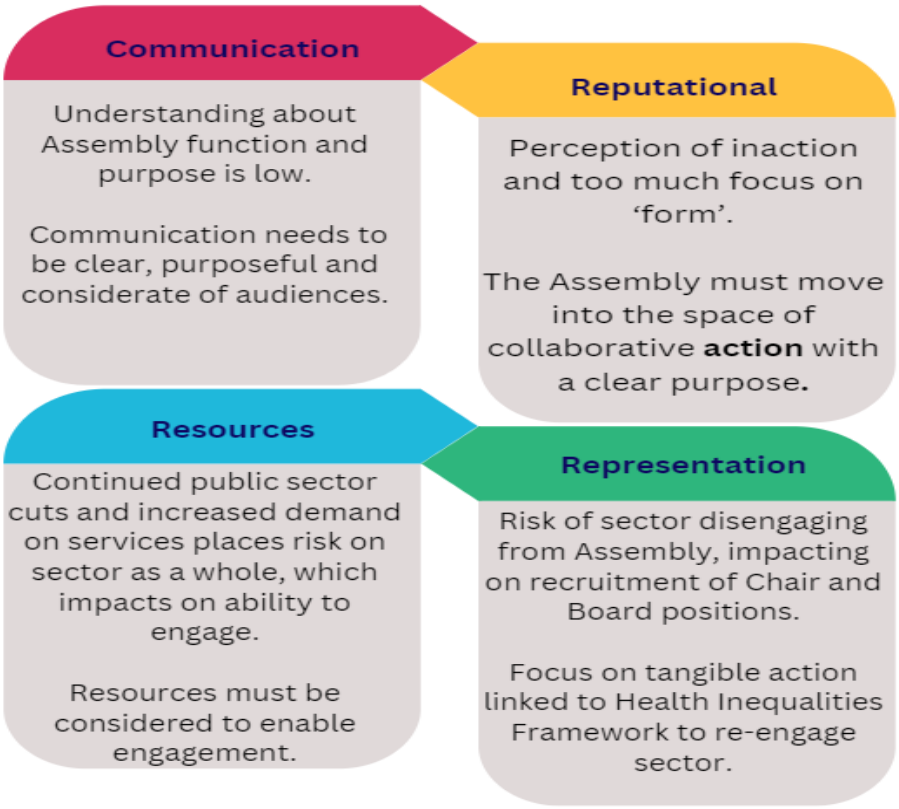
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score										9	9	9
change	□	□	□	□	□	□	□	□	□	→	→	→

Impact score	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Financial, including claims	Small loss Risk of claim remote	Loss of 0.1 - 0.25 percent of budget Claim < than £10,000	Loss of 0.25 - 0.5 percent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective Loss of 0.5 - 1 percent of budget Claim(s) between £100,000 and £1m Purchasers failing to pay on time	Non-delivery of key objective Loss of >1 percent of budget Failure to meet specification/slippage Loss of contract/payment by results Claim(s) >£1m

Table 3 Risk Scoring: Likelihood x Consequence (LXC)

Consequence		Likelihood				
		1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost certain
5	Catastrophic	5	10	15	20	25
4	Major	4	8	12	16	20
3	Moderate	3	6	9	12	15
2	Minor	2	4	6	8	10
1	Negligible	1	2	3	4	5

	1-3	Low risk
	4-6	Moderate risk
	8-12	High risk
	15-25	Very high risk



These are the risks identified in the development plan

NHS Norfolk and Waveney ICB – VCSE Integration Risks (2025-26)

Norfolk and Waveney ICB aim:

Principal risk: That people in Norfolk will experience poor health outcomes due to suboptimal care.

Norfolk and Waveney ICB aim: To make sure that people can live as healthy a life as possible

Ref	Risk description	Month risk rating											
		1	2	3	4	5	6	7	8	9	10	11	12
VCSE01	Sector stability										16	16	16
VCSE02	Parity of esteem										12	12	12
VCSE03	Understanding of sector impacts										8	8	8
VCSE04	Commissioning strategies										12	12	12
VCSE05	Lack of social value framework in ICS										12	12	12

Principal risk:

Summary of risks relevant to VCSE Integration

VCSE01	
Risk Title	Sector stability
Risk Description	Current system financial pressures are having a significant impact on the VCSE sector, compounded by loss of statutory contracts, cost of living impact on fundraising, reductions in volunteering and an increase to National Insurance Costs. These challenges have also been highlighted through a recent state of the sector report. Important to recognise that by nature VCSE sector support vulnerable 'Core20plus' communities and it is those communities most adversely affected. Recent reports highlight VCSE Organisations lacking appropriate reserves to sustain services without suitable funding. Many organisations are also making redundancies due to uncertainty around commissioning decisions/contracts. This risk is further exacerbated by the current financial climate in the statutory sector. Duplication of work and lack of understanding regarding the work at place and neighbourhood level. Look to larger or national organisations to deliver work across

	region, rather than local organisations, this leads to loss or reduction of local organisations and long-term stability of VCSE within the region.

Risk Owner	Responsible Committee	Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	PH&I Board	Shelley Ames	21.01.25	

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	3	9	4	3	12

Controls	Assurances on controls
HI & VCSE teams VCSE Assembly Board Partnership working with other statutory bodies State of the sector reports – building understanding of specific risks Assembly engagement forums and reporting	- PHI Board /Patient & Communities Committee - VCSE Strategy Group - VCSE Assembly - Empowering Communities infrastructure arrangements

Gaps in controls or assurances

Commissioning & investment strategies

Social Value Framework

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion

Visual Risk Score Tracker – 2024/25

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score										16	16	16
change										→	→	→

VCSE02	
Risk Title	Parity of Esteem
Risk Description	Risk that societal and more holistic approaches to health and wellbeing will not have similar parity regarding clinical and acute healthcare. Lack of equity in partnering and ability for the sector to have influence over strategic decision making.

	Focus on treatment rather than prevention and risk that without relevant funding or investment within prevention and community led workstreams, risk of declining provision to deliver this work effectively. May impact recognition within commissioning strategies and impact decommissioning or lack of commissioned services.

Risk Owner	Responsible Committee	Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	PH&I Board	Shelley Ames		

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	3	12	2	2	4	2	2	4

Controls	Assurances on controls
HI & VCSE team VCSE Assembly Board Partnership working with other statutory bodies State of the sector reports	- PHI Board - VCSE Strategy Group - VCSE Assembly - Empowering Communities infrastructure arrangements

Gaps in controls or assurances

Shared understanding around the impact of the sector and role it plays in supporting health and wellbeing outcomes

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion

Visual Risk Score Tracker – 2024/25

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

VCSE03	
Risk Title	Understanding of Sector Impacts
Risk Description	Failure to understand the importance and health impact the work of the VCSE sector offers, especially regarding prevention. Lack of understanding across the ICS about the cost and return on investment that the VCSE sector can provide.

	Lack of awareness of the potential for VCSE sector to help develop and deliver place-based community services that work towards overall health system. As well as impact of loss of services will have on population. Lack of awareness of how the work reduces the impact on ICS services, including acute care, mental health support, primary care and social care.

Risk Owner	Responsible Committee	Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	PH&I Board	Shelley Ames		

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	2	8	1	1	2	4	2	8

Controls	Assurances on controls
HI & VCSE team VCSE Assembly State of the sector reports Mapping work Understanding of the work at Place Level	- PHI Board - VCSE Strategy Group - VCSE Assembly - Empowering Communities infrastructure arrangements

Gaps in controls or assurances

Engagement with statutory workforce and leadership

Evidence/evaluation

Sustainable investment/commissioning strategies

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion

Visual Risk Score Tracker – 2024/25

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

VCSE04	
Risk Title	Commissioning Strategies
Risk Description	The way ICS statutory bodies commission services often overlooks key factors within the work of the VCSE sector. Commissioning practices often prioritise the

	cost of services, focusing on factors such as quantity of people support, rather than factors such as quality of engagement. Lack of significant long-term funding: services are commissioned for short period of time (often 12 - 24 months) which can lead to poor impact evaluations and rushed pilot schemes, as well as economic wastage and short term contracts for staff. Where grants are issued every 12 months but not commissioned long term, this can create unrealistic funding expectations and lack coordination of impact and quality management.

Risk Owner	Responsible Committee	Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	PH&I Board	Shelley Ames		

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	3	12	2	2	4	3	4	12

Controls	Assurances on controls
HI & VCSE team VCSE Assembly State of the sector reports	- PHI Board - VCSE Strategy Group - VCSE Assembly - Empowering Communities infrastructure arrangements

Gaps in controls or assurances

Commissioning principles document or compact

System wide (including VCSE) compact working group to assess commissioning decisions and work toward best practice

ICS commissioning guide for VCSE organisations

Data sharing relevant ICS Data for VCSE organisations

Joint understanding of Social Impact and Investment

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion

Visual Risk Score Tracker – 2024/25

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

VCSE05	
Risk Title	Lack of Social Value in Framework
Risk Description	Lack of understanding and knowledge on how the commissioned services have a larger scale impact regarding prevention and how, in the long term, this saves money on clinical, acute and primary care services. VCSE often does not understand the key drivers for commissioners, nor understand the true value in regard to return on investment for the ICS. Misunderstanding at system level and within VCSE of what is social value and how this can be used for quality and commissioning decisions.

Risk Owner	Responsible Committee	Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	PH&I Board	Shelley Ames		

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
3	4	12	1	2	2	3	2	9

Controls	Assurances on controls
HI & VCSE team VCSE Assembly State of the sector reports	- PHI Board - VCSE Strategy Group - VCSE Assembly - Empowering Communities infrastructure arrangements

Gaps in controls or assurances

Joint understanding of Social Impact and Investment

Commissioning framework

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion

Visual Risk Score Tracker – 2024/25

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

Ageing Well - Overview: Programme Workstreams

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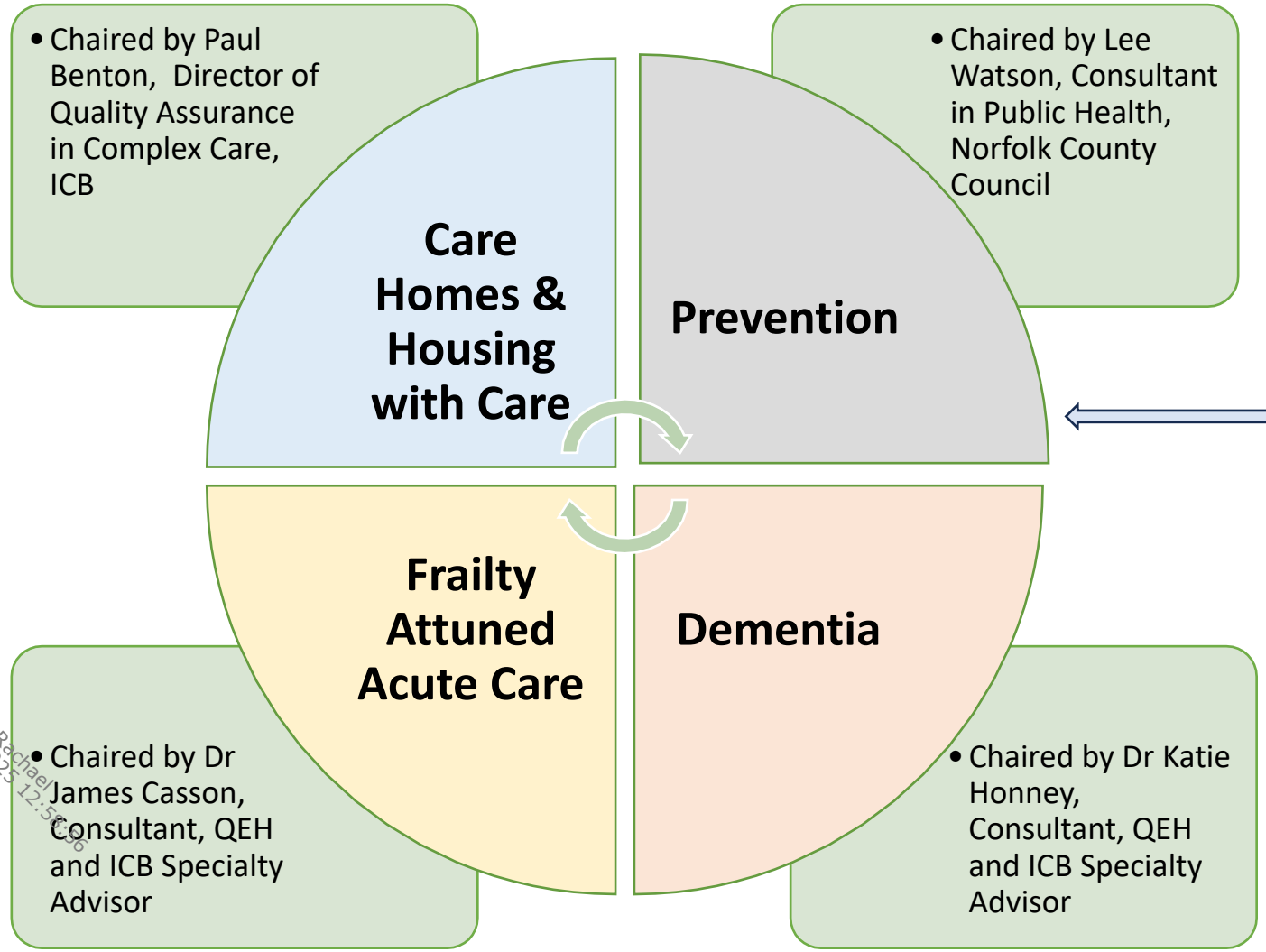
Norfolk and Waveney Integrated Care System



Senior Responsible Officer:
Dr Frankie Swords

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

N&W ICS Patients & Communities Committee

Ageing Well - Assurance/Escalation Update (1) - March 2025

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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	Board Decision
1	Ageing Well Programme Board	24/03/2025	Update on the JPUH/ GYW new model of care by PSC. The model includes a shift towards more preventative care models, with a focus on proactive identification and care for people with frailty. The work is fully aligned to the Ageing Well Strategic Framework, and in line with the ask to all our places to use the strategic framework matrix to identify and then address gaps in local service provision.	Public Health reps to link with PSC on the JPUH model of care. Already linked with QEH model	Aims to be cost-neutral/ cost saving	No	For assurance
2	Ageing Well Programme Board	24/03/2025	The Suffolk County Council and SNEE ICB reps provided an update on the Suffolk Dementia Strategy and Action plan. It was noted that connecting and supporting Waveney residents was a key priority. The team aim to share learning and good practice across the region. Operational colleagues from Waveney adult social care are connected to the wider team meetings. Agreement to provide an update report to the Board and to share good practice.	Agreement to provide an update report to the Board and to share good practice	No	No	For assurance and to note inclusion of Waveney.
3	Ageing Well Programme Board	24/03/2025	Work continues on the development of the Ageing Well dashboard and operational blueprint for 25/26 – further feedback requested from membership before workstream metrics can be finalised.	Will require support from the BI team once metrics confirmed	No	No	To note
4	Ageing Well Programme Board	24/03/2025	The frailty attuned acute care workstream has delivered the requirement for unified frailty screening tool, and this is now in place at QEH and NNUH (in planning stage at JPUH). It was agreed that the acute aspects of this workstream be passed over to the N&W acute hospitals specialty clinical network as business as usual from now on. There is now a need to focus on frailty identification and coding in primary care (including those identified by the acutes and using the same scoring system) and in particular on resultant actions once identified. Workstream will now evolve to cover care across the whole system including community and primary care, to enhance identification of people with or at risk of frailty, and the proactive management of individuals coded with frailty. This will build on the delivery of a successful frailty education programme with 200+ attendees to date.	Workstream will now evolve to cover frailty attuned care across the whole system including community and primary care.	No	No	For assurance
5	Ageing Well Programme Board	24/03/2025	JPUH and NCC have signed the Dementia Charter. This means that all statutory organisations have provided executive level support for the Charter.	To note	No	No	For assurance

N&W ICS Patients & Communities Committee

Ageing Well - Assurance/Escalation Update (2) - March 2025

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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	Board Decision
6	Ageing Well Programme Board	24/03/2025	Confirmation that falls prevention and management will not be a separate workstream but incorporated into existing streams: the prevention stream will cover arrangements for falls prevention in the community through maintaining physical activity and independence, falls prevention in care homes will be led through the care home workstream, and falls prevention within acute hospitals and fracture liaison services for people admitted with falls will be picked up though the acute clinical specialty network.	Decision to incorporate into existing workstreams made	No	No	For assurance
7	Ageing Well Programme Board	24/03/2025	Place now represented on the Ageing Well Board. All Places working on their plans for 25/26 and looking into how they can improve support to care homes. Proposal that each place team will report back to board on their progress on a rolling basis.	Each Place team will report back to the board on a rolling basis.	No	No	To note
8	Ageing Well Programme Board	24/03/2025	Ageing Well Programme Board Terms of Reference revised (v1.8).	To approve the attached document in this report.	No	No	To approve

N&W ICS Patients & Communities Committee

Ageing Well - Existing Risks Update - March 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	Board Decision
9 - BAF05	Ageing Well Programme Board	20/06/24	**Risk:** Increasing numbers of older people with complex health needs in Norfolk and Waveney which could cause; • Growing ill health among older people and strain services and financial resources • Declining quality of care if demand exceeds capacity **RAG Rating** **Pre-Mitigation:** Critical (5 x 4 = 20) **Post-Mitigation:** Critical (5 x 3 = 15) **Progress and Actions** **Mitigation** • Increased focus on early intervention and upstream prevention via Ageing Well Board • Ageing Well Programme with substantive programme support and specialty advisors in post • Workstreams for Dementia, Frailty, Care Homes and Prevention established to facilitate change and improvement needed **Update** • Programme Blueprint developed and approved to support coordination of change and improvement work • Social Isolation and Loneliness needs assessment published to support understanding of vulnerable groups when implementing changes • Further prevention priorities identified for workstream to support healthy Ageing objectives • Letter sent to HWP requesting focus in 25/26 onwards to improve age friendly practices and increase age friendly status across N&W • Overarching BAF risk discussion added to each Ageing Well Board agenda • Risks evaluated at each workstream; further risks considered • Reporting now integrated with InHealth risk system	To Note	Yes	Yes	For assurance

Norfolk and Waveney
Integrated Care Board

Agenda item: 11ii

Subject:	Update on the Prevention Workstream
Presented by:	Lee Watson, Consultant in Public Health Janice Shirley, Head of System Clinical Transformation Programmes James Allen, Senior Clinical Programmes Manager William Lee, Clinical Programmes Manager
Prepared by:	Lee Watson, Consultant in Public Health
Submitted to:	N&W ICB Patients and Communities Committee
Date:	19 May 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 Prevention workstream.

Executive Summary:

Prevention 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.

It is generally recognised that there are three types of prevention that are central to addressing poor outcomes. Primary prevention is action that tries to stop problems happening. This can be either through actions at a population level that reduce risks or those that address the cause of the problem. Secondary prevention is action which focuses on early detection of a problem to support early intervention and treatment and/or reduce the level of harm from a disease or exposure. Tertiary prevention is action that attempts to minimise the harm of a problem through careful management.

All partners across the ICP have a role to play with regards to Prevention, the Prevention workstream within the Ageing Well Programme consists of mainly primary and secondary prevention efforts.

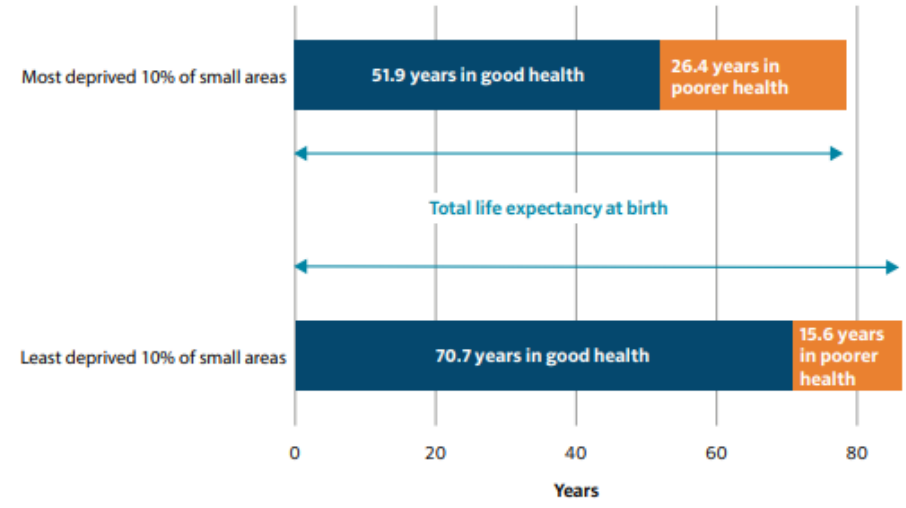
Report - Update on the work of the Prevention workstream in the Norfolk and Waveney Ageing Well Programme

Background

Norfolk and Waveney have an older population compared to the rest of England, and this population is projected to increase at a greater rate than the rest of England. Age is not evenly distributed across the area, for example in North Norfolk 34% of the population are aged 65 and over, the highest percentage in any district in England (1).

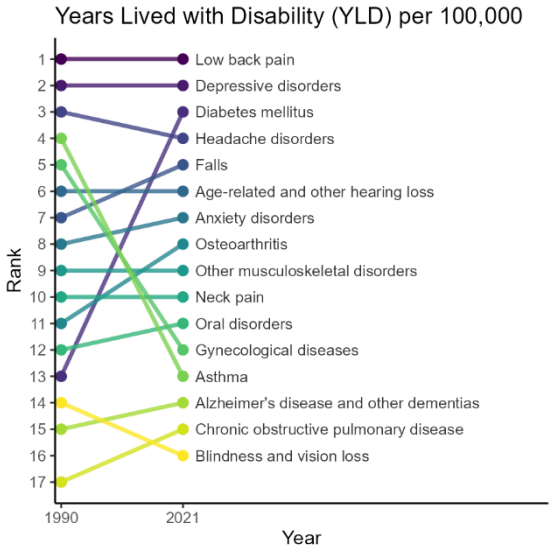
Although Norfolk and Waveney has above average Life Expectancy our healthy life expectancy (ie. How long someone can expect to live in good health) is no better than the England average. National data illustrates the significant gap in healthy life expectancy between the most deprived and the most affluent.

Figure 3: Inequality in life expectancy and healthy life expectancy at birth for females in the most and least deprived areas in England, 2018 to 2020



Source data: Office for National Statistics (ONS), Health state life expectancies by national deprivation deciles, England: 2018 to 2020[6]

The Global Burden of Disease study provides ranked estimates of conditions that contribute to the most years lived with disability. These are the conditions that have the highest impact on healthy life expectancy.



In 2024 the NCC Public Health team completed a strategic review for Healthy Ageing, whilst also engaging with Suffolk colleagues to understand action and ambitions for the Waveney population.

As a result of this work NCC's public health team developed the below vision and ambitions.

Vision:
We will help people stay healthy, active and connected with others in their communities and help older people maintain their independence and experience the best possible quality of life. This approach aims to increase healthy life expectancy in Norfolk and reduce inequalities in health outcomes.

Ambitions:

- Older people and people approaching older age (50+) have an awareness and understanding of what factors support healthy ageing and have easy access to appropriate health and wellbeing support
- Services & interventions are tailored to older people such that age does not impact accessibility or outcomes
- System partners are supported to understand and maximise the role that they can play in tackling inequalities through supporting healthy ageing
- Communities and organisations are encouraged and supported to become more Age Friendly

Simultaneously this work aligned with the development of the Ageing Well Strategic Framework and therefore provided a context and mechanism to drive improvements in work that contributes to prevention of ill health in older adults.

Prevention Workstream objectives:

1. Understand the health and wellbeing of our 50+ population and inequalities in health outcomes in this cohort (JSNA)
2. Improve residents understanding of positive activities available to improve and protect their health and wellbeing (Communications and Engagement)

3. Improve and optimise preventative services and associated pathways for the 50+ population
4. Encourage Age Friendly Practices across organisations and support the development of Age Friendly Communities
5. Implement Proactive Interventions Programme to prevent, reduce and delay Adult Social Care demand

Progress update- what we have achieved to date:

Published a Social Isolation and Loneliness JSNA: https://www.norfolkinsight.org.uk/jsna/social-isolation-and-loneliness-needs-assessment/2025/01/27/

Key findings include:

- Loneliness and social isolation can often overlap but they are not the same, loneliness is a subjective feeling whereas isolation is an objective state. Data on isolation is not well collected in England.
- Around 188,000 (22%) of adults experience loneliness some of the time, often or always in Norfolk
- Risk factors include:
    - Age
    - LGBTQ+
    - Living in a deprived area
    - Living alone
    - Lower income
    - Carer
    - Disabled
    - Not in work
    - Lack of Transport

Ageing Well Suffolk DPH annual report: Suffolk Annual Public Health Report 2024 - Ageing Well

Recommendations:

- Make Healthy Ageing a Shared Priority
- Co-produce a Menu of Interventions
- Embed Findings in Public Health and Community Strategies
- Shift the Narrative Around Ageing
- Develop a Research Programme on Healthy
- Implement a Targeted Population Health Management
- Identify Economic Opportunities for Healthy Ageing

A falls prevention needs assessment will be published in the next 4 weeks.

Public Health Commissioned Services
An initial review of inequalities in access and outcome with regards to age has been completed, this is leading to quality improvement work and further deep dives into topics such as NHS Health Checks and Sexual and Reproductive Health services.

Norfolk County Council Services:
The emerging needs assessment documents have been used to inform the approach to Countywide roll out of the Proactive Intervention programme, previously piloted in South Norfolk and Broadland geography.

Wider system approaches:
Norwich City made commitments to become an Age Friendly Community in October 2024, following in North Norfolk's footsteps taking a series of actions aiming to make Norwich a better place to age.

A winter communications and engagement campaign was delivered as a partnership between NCC and the ICB in 2024/25, the learning from this work is feeding into the planning and development of a multi-year programme approach from 2025 co-produced with system partners and residents.

There are several preventative projects co-ordinated by Place Boards including the West Place Falls pilot and the North Norfolk frailty pilot. In addition each of the 6 Health and Wellbeing Partnerships have delivered projects reflecting older peoples needs and those that are refreshing their strategies for 25/26 are aligning to Ageing Well principles where appropriate. In Kings Lynn and West Norfolk the ICB, Public Health and the District Council have launched a significant programme of work to create a "Marmot Place" with the aim of tackling the social determinants of health inequality, which in the long term has potential to greatly reduce the gap in life expectancy and healthy life expectancy for residents.

Next steps:

Over the coming months the Falls Prevention JSNA document will be published, as will an overarching Healthy Ageing JSNA document, aligned to the 8 domains of Age Friendly Communities.

We will establish a community of practice for areas already engaged with Age Friendly Communities and those who have an interest in getting involved with the aim of sharing best practice and advocating for Age Friendly practices.

We will continue our programme of continuous improvement of NCC Public Health Services.

In response to the emerging findings from the Falls prevention needs assessment the workstream will seek to improve the system-wide approach to falls prevention in collaboration with other workstreams and wider system partners. A key element of this work will be the implementation of the county-wide proactive intervention programme.

Using the learning from the winter 24/25 communications campaign we are building a multi-year campaign. Working with system partners and residents to co-design this approach the campaign will covering three key pillars:

- Keeping active (physical activity)
- Keeping connected (social connectedness)
- Taking positive action (NHS Health Check, screening, immunisations)

This work is in early development and we are currently planning stakeholder and resident engagement to build this approach.

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):	
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

Prevention Workstream

Presented by:

Lee Watson, Consultant in Public Health

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

Prevention Workstream Vision & Ambitions

In 2024 the NCC Public Health team completed a strategic review for Healthy Ageing, whilst also engaging with Suffolk colleagues to understand action and ambitions for the Waveney population. As a result of this work NCC's public health team developed the below vision and ambitions.

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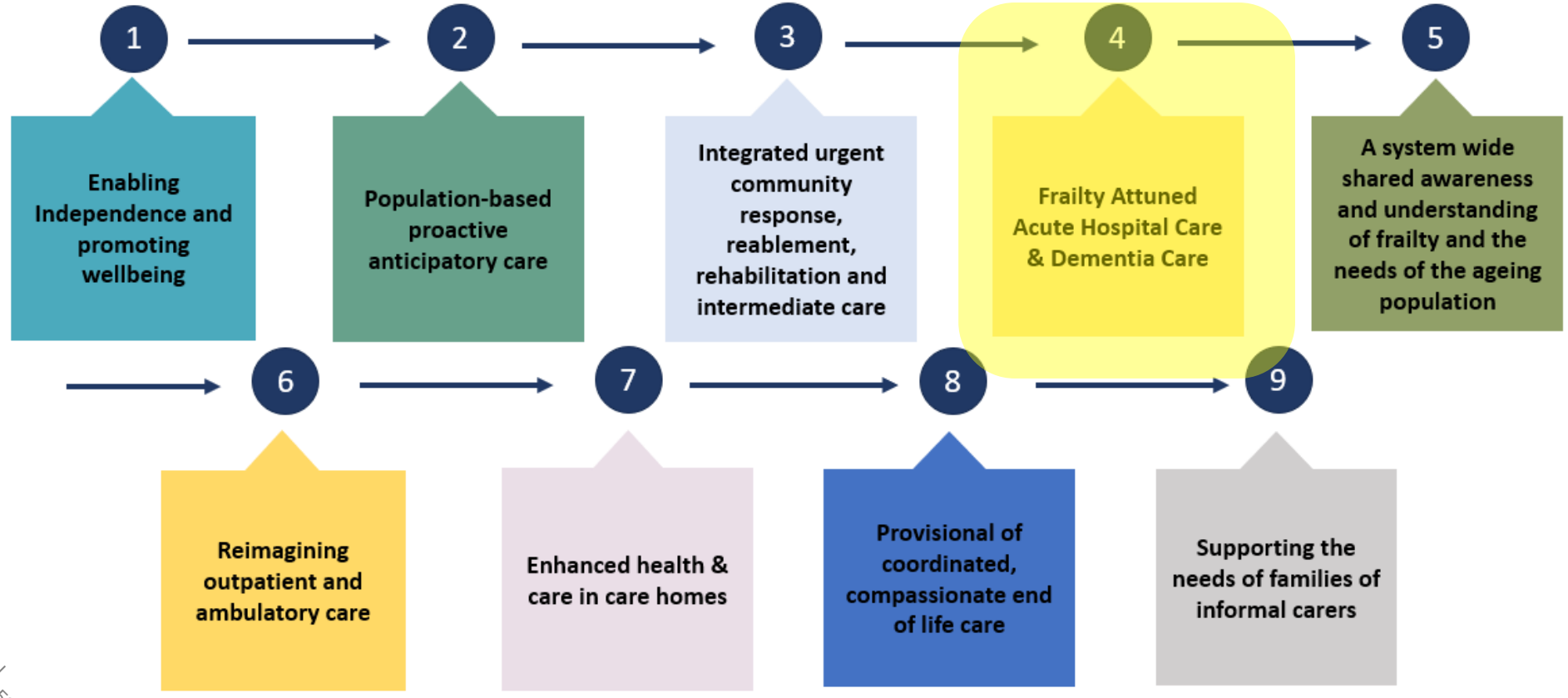
- Services & interventions are tailored to older people such that age does not impact accessibility or outcomes
- System partners are supported to understand and maximise the role that they can play in tackling inequalities through supporting healthy ageing
- Communities and organisations are encouraged and supported to become more Age Friendly

Ageing Well Overview - Strategic Framework

Nine Goals under the Strategic Framework



Parker Rachael
16/05/2025 12:58:56

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

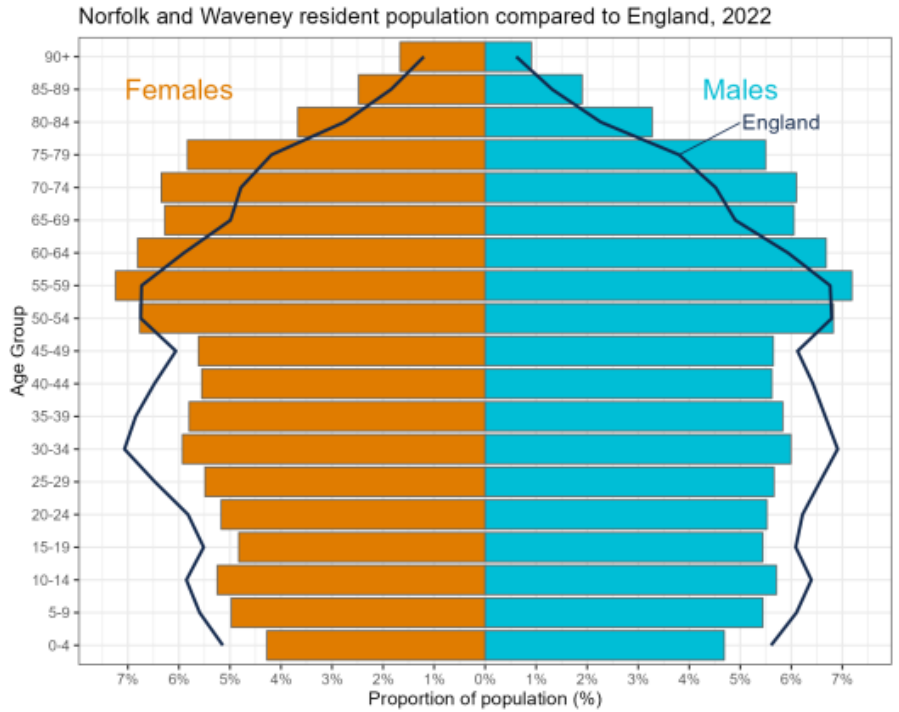
Background & Context

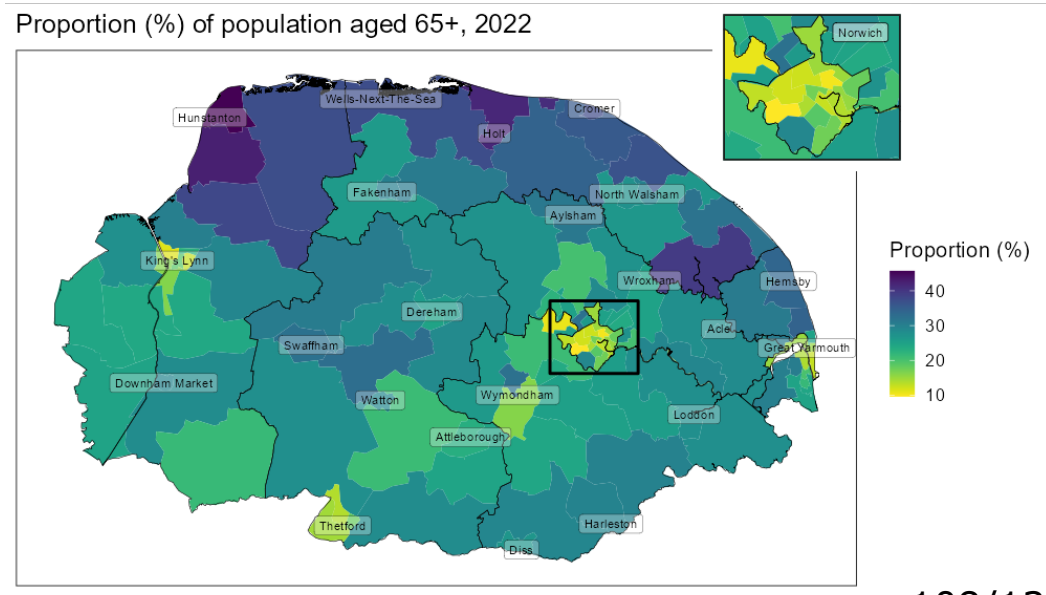
Population Context

- Norfolk & Waveney has a rapidly growing older population
- 34% of North Norfolk residents are 65+, the highest in England
- Life expectancy is relatively high compared to the England average
- Healthy Life expectancy is no higher than the England average
- Old age dependency ratio projected to increase in every district except Norwich

Current Challenges

- Preventable health conditions (frailty, falls, long-term conditions) are increasing
- Multi-morbidity increasing
- Social determinants of ill-health leading to stronger inequity
- Aligning resources to shift towards prevention





Objectives & Core Priorities

Workstream Objectives

1. Understand the health and wellbeing of our 50+ population and inequalities in health outcomes in this cohort (JSNA)
2. Improve residents understanding of positive activities available to improve and protect their health and wellbeing (Communications and Engagement)
3. Improve and optimise preventative services and associated pathways for the 50+ population
4. Encourage Age Friendly Practices across organisations and support the development of Age Friendly Communities
5. Implement Proactive Interventions Programme to prevent, reduce and delay Adult Social Care demand

Progress Update (1)

Data and insight:

- Social Isolation and Loneliness JSNA
- Falls Prevention JSNA
- Healthy Ageing JSNA
- Ageing Well Suffolk DPH annual report

Public Health Commissioned Services (NCC):

- Inequalities in Access and Outcome
- Quality improvement work e.g. NHS Health Checks
- Public Health data dashboards

Progress Update (2)

Norfolk County Council Services:

- Proactive intervention programme, informed by Falls and Social Isolation and Loneliness JSNA and Health and Wellbeing Partnership engagement to design

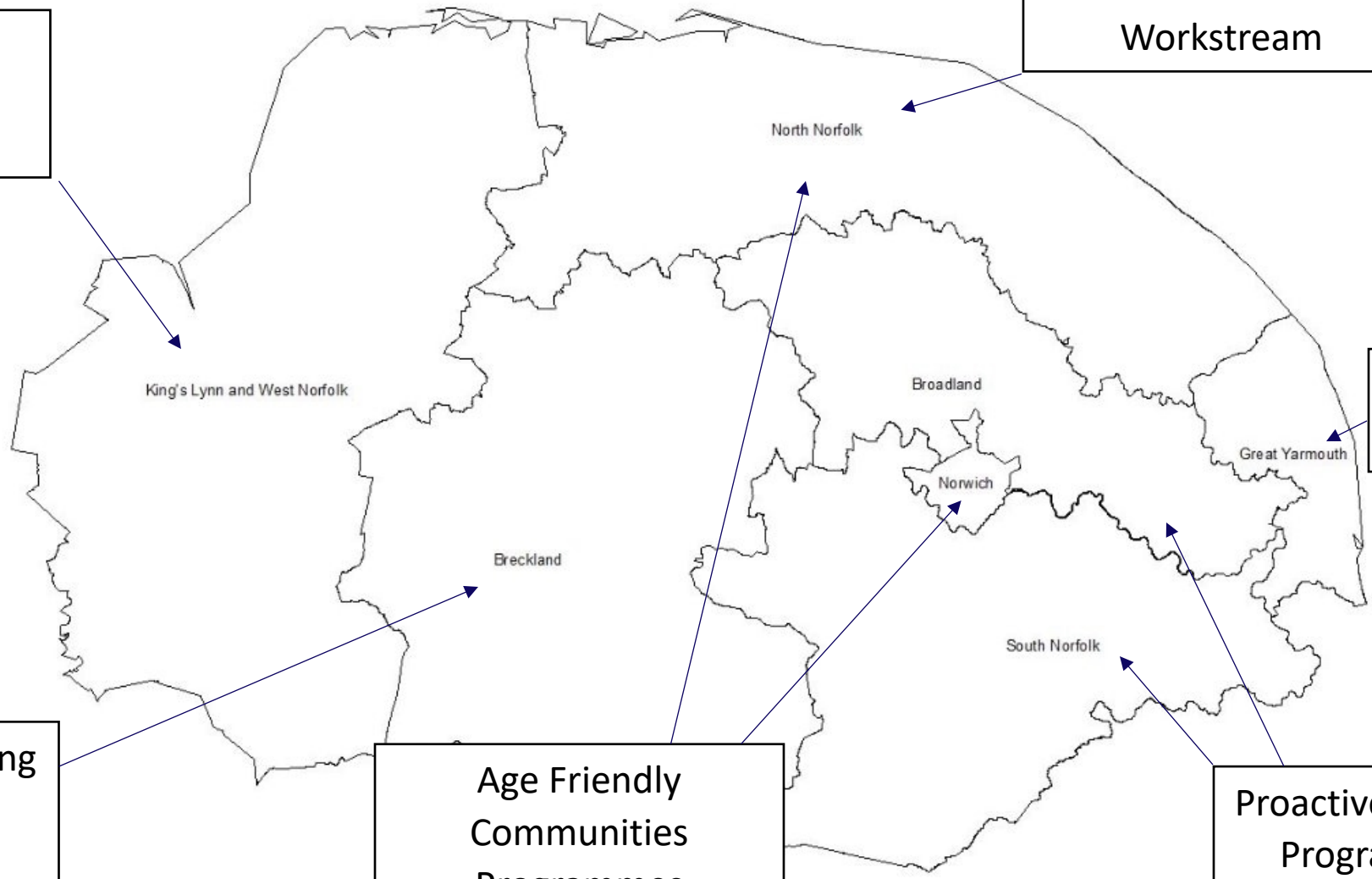
Wider system approaches:

- Age Friendly Communities- North Norfolk and Norwich- support, other areas interested in 25/26
- Communications and engagement- winter campaign 24/25, Ready2Change 2025 campaign. Planning 2-year approach for 25-27 co-produced with system partners and residents
- Place Boards- several preventative projects including West Falls pilot, NN frailty pilot
- Health and Wellbeing Partnerships- projects and strategy reflecting older peoples needs.

Place based Prevention Examples

Marmot Place-tackling health inequalities

North Norfolk Frailty Workstream



Your Health iBCF Falls Prevention

Private sector housing and health post

Age Friendly Communities Programmes

Proactive Intervention Programme Pilot

Prevention Programme Road Map- the next 5 years

Year 1 - 2025/26

- Overarching Healthy Ageing Needs Assessment complete to understand the current landscape and associated needs assessment reports for Social Isolation, Loneliness and Falls completed with recommendations (PRE-001)
- Developed a mechanism of whole system engagement and co-developed an approach to falls prevention responding to the findings from the Falls Prevention JSNA (PRE-002)
- Supported existing areas that have made commitments to Age Friendly and encourage other geographies to engage with the Centre for Better Ageing to develop commitments (PRE-005)
- Continued improvement of relevant NCC Public Health commissioned services in relation to access and outcomes for those 50+ (PRE-007)

Year 2 – 2026/27

- Developed bespoke, co-designed campaigns each year for patients, public and carers with a focus on: Keeping Active, Staying Connected and Taking Positive Action and supporting workstream preventative communications (PRE-003)
- Supported existing areas that have made commitments to Age Friendly and encourage other geographies to engage with the Centre for Better Ageing to develop commitments (PRE-005)
- Continued improvement of relevant NCC Public Health commissioned services in relation to access and outcomes for those 50+ (PRE-007)

Year 3 - 2027/28

- Developed bespoke, co-designed campaigns each year for patients, public and carers with a focus on: Keeping Active, Staying Connected and Taking Positive Action and supporting workstream preventative communications (PRE-003)
- Place teams and HWB's successfully developed Age Friendly communities that enable people of all ages, particularly older adults, to live healthy, active, and fulfilling lives, promoting environments that support people to age with dignity, purpose, and security (PRE-004)
- Supported existing areas that have made commitments to Age Friendly and encourage other geographies to engage with the Centre for Better Ageing to develop commitments (PRE-005)
- Continued improvement of relevant NCC Public Health commissioned services in relation to access and outcomes for those 50+ (PRE-007)

Year 4 -5 2028-30

- Developed and delivered a place-based offer to residents identified to be at risk of falls, initially via Adult Social Care and District Council data (PRE-007)
- Continued improvement of relevant NCC Public Health commissioned services in relation to access and outcomes for those 50+ (PRE-007)

Conclusion & Any Questions?

The prevention workstream is focussed on:

Improving Awareness & Access:

- System partners understanding of our population through needs assessment
- Residents aged 50+ supported to understand key ingredients to age well
- Residents understand where they can access appropriate health & wellbeing support in their community

Tackling Inequalities:

- Age should not impact accessibility or outcomes of public health services
- System partners optimise their role in reducing unfair differences in health outcomes

Delivering Age-Friendly Communities:

- Support and encourage organisations and places to become more age-friendly, whilst reducing age discrimination

Norfolk and Waveney
Integrated Care Board

Agenda item: 12

Subject:	**Population Health & Inequalities (PH&I) Board – 15/04/2025 – Assurance & Escalation Report**
Presented by:	**Dr Frankie Swords**
Prepared by:	**Dr Frankie Swords**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**19 May 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 15 April 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:	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 [15/04/2025]

Improving lives together
Norfolk and Waveney Integrated Care System

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
78.	PH&I Board	15/04/2025	PHM Software Provider – Regional Procurement Hub announcement	Procurement documentation finalised. Regional Procurement Hub to announce Prescribing Services Limited (PSL), eclipse software, as the successful provider	N/A	N/A	For assurance	
79.	PH&I Board	15/04/2025	High impact and areas of opportunity analysis	Report produced by PSL, with input from PHM to demonstrate areas where intervention could have greatest impact in reducing unplanned admissions. To be presented to PHM & HI executive leads, to consider next steps	N/A	N/A	For assurance	
80.	PH&I Board	15/04/2025	PHM Phase 2 Projects – Live	NHS Digital Weight Management Programme (DWMP) and the National Diabetes Prevention Programme (NDPP) phase 2 projects now live	N/A	N/A	For assurance	
81.	PH&I Board	15/04/2025	HI Board maturity assessments (NWICB, JPUH, NNUH, ECCH, and QEH)	NHS Anchors Group assessments completed, being approved for consolidation into a Norfolk and Waveney system improvement plan	N/A	N/A	For assurance	
82.	PH&I Board	15/04/2025	Inclusion Health Locally Enhanced Service (LES) for General Practice	LES has been approved, and Primary Care health inequalities training sessions are ongoing	N/A	N/A	For assurance	
83.	PH&I Board	15/04/2025	Plus Group Workshop – planned for May 2025	This workshop includes a focus session on learning disabilities, autism and get Norfolk working	N/A	N/A	For assurance	
84.	PH&I Board	15/04/2025	VCSE Assembly Board – 16 April 2025	In person VCSE Assembly Board scheduled to discuss the voluntary sector's action plan, influence, and support for the wider system and priorities	N/A	N/A	For assurance	
85.	PH&I Board	15/04/2025	£540,000 Volunteering for Health grant	Volunteering development officer post to now be hosted by the voluntary sector due to NHS national changes	N/A	N/A	For assurance	

Population Health & Inequalities (PH&I) Board - Points of Assurance / Escalation [15/04/2025]

Improving lives together
Norfolk and Waveney Integrated Care System

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
86.	PH&I Board	15/04/2025	PHM, HI & VCSE Risk Registers – Refresh	Refresh of documentation continues in line with the new inphase platform. It was agreed that risks would also be reviewed in line with NHS national changes	N/A	N/A	For assurance	
87.	PH&I Board	15/04/2025	VCSE Risk Register – New Register	Assembly Operational and Integration risk registers to be presented and agreed at Patient & Communities Committee	N/A	N/A	For escalation	
88.	PH&I Board	15/04/2025	NWICB Health Inequalities Improvement Plan Final	Overview of plan provided. This was supported by the PH&I Board.	N/A	N/A	For assurance	

PH&I Board - New Risks [15/04/2025]

Improving lives together
Norfolk and Waveney Integrated Care System

Programme Risks as of 15/04/2025 – 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 in line with the new in phase platform.

The PHM team reported 1 risk. No new risks were added, the risk scoring remained the same (as previously reported) and below 15.

1 risk remained the same:
- 'PHMI19 PHM team resources to respond to system demand' risk score 9.

The HI team reported 4 risks. No new risks were added, 1 risk scored above 15 & all risk scorings remained the same (as previously reported).

1 risk scored above 15:
- 'HI05 Financial restrictions impacting on investment into health inequalities' remains at a risk score of 16. This was previously escalated to the Patient & Communities Committee. Risk continuing to be escalated.

3 risk scores 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 9.
- 'HI07 Lack of Place resources to support HI strategy development & implementation' risk score 12.

Norfolk and Waveney ICB Patients and Communities Committee Forward Plan

Agenda Item / Issue	Lead	Jul	Sept	Nov	Jan 2025	Mar	May	July	Sept	Nov	Jan 2026	Notes
Standing agenda items												
Introductions, Apologies, Declaration of Interest	Chair	X	X	X	X	X	X	X	X	X	X	
Minutes, Matters Arising, Actions Update	Chair	X	X	X	X	X	X	X	X	X	X	
Risk Register	MB	X	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	X	
Ageing Well Programme Board Update	FS	X	X	X	X (*Frailty update)	X	X (*Preventio n 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)	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)	X (V)	AR=Annual Report, V=Verbal
Any Other Business	All	X	X	X	X	X	X	X	X	X	X	
'Spotlight' On Item(s)	MB	X	X	X	X	X	X	X	X	X	X	
Complaints Report (quarterly)	JP	X			X			X	X		X	
VCSE Assembly Updates (monthly)	TG		X		X	X	X	X	X	X	X	
People and Communities Approach (twice yearly)	CW			X				X		X		
Community Voices (quarterly)	MB			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	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	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 mtg)
Place deep dive (Agenda May 25)
Waiting times - revisit September 25 (raised 27.1.25)

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

NHS 10-Year Health Plan:
'Change NHS' Norfolk and Waveney Insight Report

1. Introduction

This report has been created to share feedback gathered in Norfolk and Waveney as part of the Government's Change NHS engagement activity, which aims to shape a new 10-Year Health Plan for England.

For over 76 years, the NHS has been a cornerstone of public health in the UK. However, to ensure it remains sustainable for future generations, the Government has launched Change NHS to gather views, experiences, and ideas from people across the country. The insights collected will help develop a modern health service that meets the evolving needs of the population.

The 10-Year Health Plan focuses on three key shifts that the Government, health services, and experts agree need to happen:

1. Moving care from hospitals to communities – ensuring more care is provided closer to home.
2. Making better use of technology – integrating digital advancements to improve patient experiences and outcomes.
3. Focusing on preventing sickness, not just treating it – prioritising prevention to reduce the demand on healthcare services.

This report summarises the collective feedback from patients, NHS staff, and partner organisations across Norfolk and Waveney. It provides a local perspective on the future of healthcare and will be used to support decision-making in our region while also being shared with stakeholders who contributed to the discussions.

1.2. Engagement Approach

Hearing from people about their experiences and priorities for health and care services is essential. As an NHS Integrated Care Board (ICB), we were asked by the Government to facilitate conversations with a broad range of stakeholders to ensure local voices contribute to shaping the future of health and care in England.

To gather feedback, we used a combination of workshops and existing engagement insights from recent consultations and community discussions. Participants were invited to share their views on key aspects of the 10-Year Health Plan, with structured discussions based on the following questions:

The NHS in 10 Years (Workshop Warm-up Activity)

- If the 10-Year Health Plan is a success, what three words will describe how using the NHS will feel in the future?
- What will be the same and what will be different?

Shift 1 – Making Better Use of Technology

- What are your hopes and fears for how technology could be used in the NHS?

- What technologies should the NHS prioritise and why?
- What technologies are you worried about and why?

Shift 2 – Moving More Care from Hospitals to Communities
- What difference – good or bad – would this make to you?
- Thinking about virtual wards, what sounds good? What concerns do you have?
- Thinking about community diagnostic centres, what sounds good? What concerns do you have?
- Thinking about ambulance triage, what sounds good? What concerns do you have?

Shift 3 – Preventing Sickness, Not Just Treating It
- What difference – good or bad – would this make to you?
- What forms of prevention should the NHS prioritise and why?

Any Other Feedback
- Is there anything else you want to share that was raised in your workshop but hasn't been covered above?

1.3. Engagement Sources and Audiences
Feedback was drawn from two key sources:

Existing Feedback from Engagement Activities	**Workshops**
Community Voices Insight Bank	Norfolk Homelessness Solutions Forum
Deaf Connexions Engagement	Community Voices Network Meeting
Dental Plan Engagement	Health and Wellbeing Partnership meeting
JFP Engagement	Norfolk Youth Parliament
SOS Bus Engagement	South Norfolk and Broadland Health and Wellbeing Partnership meeting
Talking Therapies Engagement	NNUH Patient Panel
Walk-in Centre, Norwich Engagement	QEH Public Event
Flourish - CYP Engagement	

This engagement approach ensured that feedback reflected a broad range of perspectives, including patients, young people, vulnerable groups, community organisations, and NHS staff.

2. Summary of Key Themes

Key themes for the future of the NHS include improving accessibility, efficiency, and inclusivity while maintaining its core values of free, high-quality, and patient-centred care. Digital innovation, such as enhanced appointment systems and AI-driven support, is seen to streamline services, though concerns about digital exclusion and maintaining human interaction remain. Shifting care from hospitals to communities could improve access and reduce pressure on hospitals, but funding and coordination challenges must be addressed. A prevention-first approach, focusing on education, early intervention, and community-based support, is essential to improving long-term health outcomes and reducing costs. Effective implementation of these changes requires sustainable investment, workforce development, and seamless integration across services.

3. Feedback by Question

3.1 Warm-up Activity: Vision for the NHS in 10 Years

What 3 words will describe how using the NHS will feel in the future?
Stakeholders expressed a shared vision for the future of the NHS, emphasising accessibility, inclusivity, and efficiency. Responses such as *"joined-up care," "inclusive and accessible,"* and *"universal access for all"* highlight the expectation of a more connected and equitable healthcare system. Words like *"proactive," "progressive thinking,"* and *"effective"* suggest a desire for innovative, patient-centred care that focuses on preventative approaches and seamless service delivery. Maintaining the NHS as a free, non-private service was also seen as essential to its future identity.

What Will Stay the Same?
Many people felt that core NHS values—particularly staff dedication, professionalism, and commitment to patient care—will remain unchanged. Passionate and hardworking healthcare professionals, high-quality care, and specialist expertise were all highlighted as enduring strengths. There was also a recognition of the NHS's free-at-the-point-of-use model, with responses reaffirming that accessibility should continue to be a fundamental principle. Additionally, practical aspects such as hospital food provision, children's play areas, and union representation were acknowledged as aspects that contribute positively to the patient and staff experience.

What Will Be Different?
People anticipate significant improvements in access to timely care, with fewer barriers preventing patients from getting the treatment they need. A more seamless and efficient system could enhance the overall patient experience, making healthcare feel more connected to local communities. Education and research are expected to play a greater role, ensuring that both patients and healthcare professionals have a better understanding of how the NHS operates and the true costs of delivering care.

Digital innovation is seen as a key driver of change, with more self-service options such as online appointment booking and enhanced NHS app functionality. These advancements would empower patients to take greater control of their healthcare while reducing administrative burdens on staff. Greater use of technology could also improve accessibility, for example, by ensuring better locations and parking for both staff and patients.

A more equitable system is envisioned, with the elimination of the so-called "postcode lottery" that currently results in inconsistent service availability depending on location. Long waiting times for diagnostics and specialist care could become a thing of the past, with faster referrals and improved coordination across the NHS. Enhanced integration and communication within the NHS and between partner organisations would contribute to more joined-up care, reducing inefficiencies and delays.

Hospital discharge processes are expected to be smoother, with better handovers ensuring a seamless transition from hospital to community-based care. Similarly, social care bottlenecks, which currently cause delays in hospital discharges, could be significantly reduced through better coordination.

A shift in workforce skills is also anticipated, with NHS staff—particularly in secondary care—becoming more generalist. This would allow them to take a more holistic approach, treating patients as whole individuals rather than focusing solely on specific conditions. By improving collaboration across different healthcare services and increasing flexibility in roles, the NHS could provide more comprehensive and personalised care.

3.2 Shift 1 – Making Better Use of Technology

Hopes for Technology in the NHS
There is a strong sense of optimism that technology can transform the NHS, making healthcare more accessible, efficient, and patient-centred. Many people hope that digital solutions will improve access and convenience, particularly through better appointment booking systems, self-service options, and expanded telephone or video consultations outside the traditional 9-5 model. A more user-friendly NHS app, with features such as prescription refills, hospital navigation tools, appointment reminders, and self-care resources, was seen as essential in reducing stress and making healthcare more efficient. Virtual wards were also highlighted to allow patients to receive care at home while staying connected to NHS services.

A key priority is the creation of a single, centralised system for patient records that would ensure seamless coordination between NHS services, social care, and voluntary organisations. Many feel that reducing the need for patients to repeatedly share their medical history would streamline treatment and improve outcomes. There is also enthusiasm for AI-driven insights that could summarise clinical reports, identify potential risks such as frailty in older adults, and assist in clinical decision-making while still maintaining human oversight.

Inclusivity and accessibility were recurring themes, with people keen to see technology remove barriers to healthcare. Digital translation tools, easy-read formats, and plain English communication could make services more accessible for non-English speakers and those with cognitive challenges. Some suggested alternative ways to access care, such as allowing repeat prescriptions to be ordered over the phone rather than requiring in-person visits. Ensuring that both staff and patients have the necessary digital skills and tools was also seen as vital.

Trust and transparency were identified as key factors in the successful adoption of new technologies. Participants stressed the importance of explaining how algorithms make decisions to avoid bias and ensure fairness. Allowing patients to track who has accessed their medical records would help build confidence in digital systems. While AI and automation could improve efficiency, there was broad agreement that human oversight should remain central to care delivery.

Many people also saw technology to relieve pressure on NHS services. Automating administrative tasks and using AI to assist decision-making could reduce human error and free up resources for frontline care. Digital triage tools and walk-in hubs could help manage emergency care more effectively, while online health resources could support self-care and preventative measures. Cost savings from reducing inefficiencies could then be redirected to clinical services.

Looking ahead, there is hope that technology will support the expansion of mobile and virtual healthcare services, making it easier for patients in remote or underserved areas to access care. Improved communication about waiting times and service availability via text or email was seen as a simple but impactful improvement. Greater opportunities for self-referral could empower patients to take a more active role in managing their own health. However, ensuring that both NHS staff and the public receive proper training and support to navigate these digital changes will be critical to their success.

Fears About Technology in the NHS

Many fear that increased reliance on technology could lead to digital exclusion, particularly for vulnerable groups such as the elderly, homeless individuals, and those without internet access or digital literacy. Concerns were raised about accessibility barriers, including language differences, reliance on telephone or online services, and the lack of alternative options for those struggling with technology.

Privacy and security risks were another major concern, with worries about data breaches, hacking, and the misuse of sensitive patient information. Participants also feared the potential for errors, such as incorrect data input, accidental deletions, and system crashes, which could impact patient safety.

There was also unease about the loss of human interaction in healthcare. While digital tools can improve efficiency, there is concern that they could replace face-to-face care, leading to impersonal and fragmented services. AI was viewed with some scepticism, particularly around its role in decision-making and its potential to replace professional judgment.

Finally, the ability of the NHS workforce to effectively implement and manage new technologies was questioned. Concerns included staff training, system integration issues, and whether technology could truly enhance, rather than complicate, healthcare delivery. While digital innovation is welcomed, there is a strong call for a balanced approach that maintains human oversight and ensures inclusivity for all patients.

Technologies the NHS should prioritise and why

A top priority is improving online booking systems, allowing patients to book and reschedule appointments easily instead of relying on early-morning phone calls to GP surgeries. There was also strong support for shared patient records, ensuring seamless access across different healthcare providers to prevent duplication and delays in care.

AI-driven diagnostics were seen to speed up treatment decisions and enhance early detection of health conditions. Similarly, remote monitoring technologies, such as wearable devices and virtual wards, were suggested to help manage complex needs at home, improving recovery while reducing hospital admissions.

Participants also emphasised improving communication tools, particularly for families and patients with additional needs. This includes multilingual support, digital self-referral options, and accessible appointment systems for non-digital users.

Other key recommendations included ensuring existing systems work effectively before introducing new ones, prioritising digital inclusion, and investing in tools that maintain the human element in healthcare, particularly for vulnerable groups.

Technologies people are worried about and why
People expressed worries about data security and privacy, fearing breaches, hacking, and unauthorised access to online health records. There was concern that AI-driven decision-making could lack human oversight, leading to misinterpretation or errors without professional judgment.
Another key issue was the over-reliance on digital systems, particularly for booking appointments, consultations, and receiving test results. This shift risks excluding non-digital users, especially those without smartphones or internet access. Additionally, there were concerns that face-to-face care is being deprioritised, making healthcare feel impersonal and inaccessible for some patients.
Overall, people emphasised the need for human backup systems, ensuring technology enhances, rather than replaces, personal and professional healthcare interactions.

3.3 Shift 2 – Moving More Care from Hospitals to Communities

General Impact (Positive and Negative)
The idea of moving more care from hospitals to community settings has sparked a range of responses, highlighting both potential benefits and significant challenges.

On the positive side, community-based care could significantly improve accessibility, particularly for those in rural areas who face long travel times to hospitals. By bringing services closer to people's homes, it would reduce transport-related problems and help eliminate the exposure to hospital-related infections. For many, staying out of the hospital could mean better health, avoiding unnecessary stays that sometimes cause more harm than good. It could also address health inequalities by making services more accessible, and integrating health and social care could create a holistic system of support. Community health hubs could link patients to various services, such as district nurses and social care, in one convenient location. Additionally, this shift could free up hospital beds, save time and money, and create more local jobs. By having core workers handle multiple tasks within the same space, care could become more streamlined and efficient.

Community-based care could also foster a sense of community and empowerment. It would offer better support for vulnerable groups, including those suffering from social isolation. Moreover, it could give healthcare professionals an opportunity to see patients in their home environment, which would allow them to better understand the context in which people live and offer more tailored care. Co-locating services like health centres with local councils and charities could create a more integrated care model.

However, there are significant challenges associated with this shift. One of the most prominent concerns is the difficulty in securing funding and resources for community-based services. Hospitals are often reluctant to release the funds necessary to move services into communities, and there are logistical issues related to staffing and ensuring quality care in these settings. Professional isolation could be a problem for healthcare workers who are used to working in team environments at hospitals. There are also worries about the variance in the quality of care between different areas and community services, with some regions potentially struggling to meet the demand for healthcare. Another concern is the risk of social isolation, neglect, and abuse, particularly for the most vulnerable individuals, if the shift isn't carefully managed.

Additionally, factors like weather, power outages, and poor signal coverage could hinder the accessibility of community-based care. There are also concerns about the workforce and whether there will be enough trained professionals to meet the increased demand for services. The reliance on charities and voluntary organisations to deliver these services without sustainable funding could further undermine the effectiveness of the model. Some people voiced frustration over the lack of continuity in care, noting issues such as not seeing the same GP or experiencing delays in follow-up care. In some cases, patients felt abandoned by their healthcare providers, particularly after the closure of more traditional GP services.

Despite these concerns, there are examples of community-based care that have been well-received, such as mobile healthcare services and local health hubs. These services have been appreciated for their convenience and quick access to care. Community-based care has also been seen as a potential solution to long A&E waiting times and could alleviate pressure on hospitals. Many people believe that the key to making this shift work lies in the integration of health and social care services, which would ensure a seamless system of support for patients.

For this model to succeed, several things need to happen. First, funding must be sustainable, with adequate resources allocated to community services and those provided by the voluntary sector. There also needs to be better training for community health workers to ensure they understand the broader needs of the individuals they are caring for. More community-based rehabilitation and reablement services are needed to support patients who are not quite ready to go home but do not require hospital-level care. Prevention and early intervention should also be a focus to help avoid hospital admissions and ensure care is provided in the community when possible.

Virtual Wards

Virtual wards were generally viewed positively, with many recognising the potential benefits for patient recovery and overall healthcare efficiency. One of the key advantages mentioned was the ability for patients to recover at home, where they could avoid the risks of hospital-acquired infections and be surrounded by family, friends, and pets. Many people highlighted that patients could sleep better without the disturbances typical of hospital wards and maintain control over their medications. Virtual wards were also seen to improve accessibility, particularly for vulnerable groups such as the homeless, who face barriers to accessing traditional healthcare. Some saw virtual wards to reduce health inequalities by providing services closer to central locations and allowing for flexible health interventions, such as pop-up screening units.

Additionally, virtual wards were seen as a resource-efficient option, freeing up hospital beds for critical cases and enabling better allocation of healthcare resources. Specific programmes, like virtual detox services, were viewed to expedite treatment for individuals who might otherwise avoid inpatient care. For some, the option to remain at home was seen as especially valuable for older people and those receiving palliative care, as it could provide a more dignified environment compared to being admitted to a hospital. Technology also emerged as an enabler, with digital tools viewed to manage the growing demands of healthcare delivery, particularly as the population continues to increase.

However, there were concerns about the virtual ward model. One key issue was the potential for patients to feel neglected or “out of sight, out of mind,” especially if home-based care lacks sufficient monitoring. Pain management was also raised as a concern, with some feeling that it might be less effective at home, particularly when access to controlled substances is limited. Staffing and training were highlighted as significant challenges, with some expressing concern over whether there would be enough trained professionals available to deliver care effectively, especially in rural areas like Norfolk.

Other concerns centred around the digital infrastructure required for virtual wards to function smoothly. Poor broadband coverage and digital literacy issues could exclude certain patients, particularly those living in rural areas or with conditions like early dementia. The effectiveness of monitoring systems was also questioned, with some wondering if the care would be continuous or intermittent, potentially compromising patient safety.

Additionally, there were worries about the pressure virtual wards might place on local support services. As providers like housing services and voluntary organisations are increasingly expected to fill gaps in care, there is a risk that these groups might become overstretched, leaving the NHS to shoulder less responsibility. Some people also feared that patients might be discharged too early, potentially delaying necessary treatments or creating challenges for those not yet ready to leave the hospital. Respite care for families and carers was another issue, as hospitals often provide this support, but virtual wards might not, requiring additional funding for alternative care services.

Community Diagnostic Centres

Community diagnostic centres were generally viewed positively for their potential to increase access to healthcare services and enhance the overall patient experience. People appreciated the use of advanced technology, which could streamline processes and improve efficiency. The centres were also seen as an attractive option for staff, as they could potentially offer a more appealing work environment compared to traditional hospital settings. The added capacity that these centres could provide, combined with the possibility of integrating other services such as social care and financial advice, was viewed as a major benefit.

Convenience was another key factor, as the centres could save patients time and transportation costs, while also offering quicker access to diagnostics. The idea of self-serve monitoring in waiting areas was suggested to enhance the patient experience and link directly to patient records. Some people felt that having a local hub for a variety of services would make healthcare more accessible and could increase appointment attendance.

However, there were concerns about the implementation and effectiveness of community diagnostic centres. One major point of contention was the location of these centres, as many were seen to be too closely linked to hospitals, thus not achieving the goal of making healthcare more community-based and accessible. There were also worries about the impact on hospital staff, particularly the strain of training new staff to operate these centres and the potential loss of skilled workers from the hospital system.

Some people questioned whether creating separate diagnostic centres speed up care or if it simply reduced wait times for scans without making a significant difference in the overall treatment process. Concerns were also raised about the time-sensitive nature of tests, particularly how quickly lab results would be processed after a scan. The potential for

consolidating services in one location was seen as a positive, but some questioned whether this would be effectively implemented in practice.

Finally, the cost of setting up these centres was highlighted as a significant concern, as well as the possible social stigma associated with attending certain tests in a community setting. Some worried that patients might feel embarrassed if others in their community saw them going for a test, particularly if it was something sensitive or private.

Ambulance Triage

Feedback on ambulance triage reveals both positive aspects and concerns regarding its effectiveness and future potential.

One of the main positive points highlighted was the expansion and integration of the ambulance triage system with GP services. Many people felt this improvement would lead to more efficient patient care by allowing non-urgent cases to be directed away from emergency departments, enabling quicker responses for those in critical need. Norfolk's efforts in this area were specifically praised, with people noting that the system is already functioning well and that there are plans to make further improvements. Another key advantage highlighted was the ability to prevent older patients, particularly those over 75, from being admitted to A&E unnecessarily. This approach would allow them to be directed to more appropriate care settings.

There was also support for providing basic interventions, such as offering walking frames or installing handrails in patients' homes, as these could be addressed quickly and help avoid unnecessary trips to the hospital, reducing both wait times and pressure on A&E departments. People also want quicker ambulance response times and timely treatment, not only during the ambulance journey but also once at the hospital. Furthermore, the collaborative approach between ambulance services, primary care, and emergency departments was viewed as essential to managing patient flow more efficiently and ensuring that each patient received the appropriate care for their needs.

However, concerns about the system were also raised. A significant issue highlighted was that ambulance services are often the first point of contact, but in some cases, patients' needs are more social than medical. For example, some people may need social care rather than urgent medical attention. This issue raises questions about how unscheduled care hubs can be improved and how the broader system can be better coordinated to support patients' non-medical needs. There was also a concern about how to manage the growing pressure on ambulance services without overburdening staff or stretching resources too thin.

Another concern was the expectations of patients and their families. Many people believe that calling an ambulance automatically means that the patient will be admitted to the hospital, which may not always be necessary. This mismatch of expectations can lead to confusion and frustration, particularly if patients are not discharged or redirected as expected. People also questioned who would manage the risks involved in making triage decisions and how the governance of the system would be structured.

The idea of ambulance staff referring patients directly to virtual wards was suggested as a time-saving measure, although this would require more research and planning to implement effectively. The need for proper funding for staff training and ensuring that paramedics can administer medication correctly was also raised as a priority.

Additionally, concerns about system coordination were common. Many people felt that different healthcare services, such as ambulance services, primary care, and emergency departments, are not communicating effectively with each other. This lack of integration can result in delays, inadequate treatment, and gaps in follow-up care after patients are discharged. Some patients reported feeling lost in the system, unsure about their treatment or what steps to take next.

The overburdened nature of ambulance services and A&E departments was also a recurring theme. Long waiting times, especially during peak periods, were a major issue. People expressed concern that ambulance services are often overwhelmed with patients who do not need urgent hospital care, leading to delays in treatment and increased pressure on resources. Addressing these concerns by improving primary care and social services to prevent unnecessary ambulance calls could help alleviate some of this pressure.

3.4 Shift 3 – Preventing Sickness, Not Just Treating It

General Impact (Positive and Negative)
The shift from treating illness to preventing sickness has generated a mixture of positive feedback and concerns, reflecting the complexity of this approach and its potential impact on individuals and the healthcare system.

Positive Aspects
Many people emphasised the importance of education as a key factor in prevention. Educating individuals early about healthy habits, such as good nutrition, mental health, and smoking cessation, can lead to healthier lives and help reduce long-term healthcare costs. There is support for integrating preventive services into schools and communities, where children and families can learn lifelong health habits. For instance, oral health education and encouraging dental hygiene in schools could reduce dental problems later in life, while mental health support and addressing issues like addiction early on could prevent more severe conditions.

The idea of community-based services was also highlighted, with a focus on providing support in the context of people's daily lives. This approach allows for tailored services that take cultural, social, and economic factors into account. Additionally, the whole-family and whole-community support approach, where services are provided not just to individuals but to entire families, was recognised as essential in breaking cycles of ill health and social disadvantage.

People also noted that early intervention through initiatives like vaccinations, smoking cessation programmes, and mental health support (such as Talking Therapies) would help avoid more severe health issues, reducing the need for hospital visits and improving individuals' overall well-being.

Concerns
Despite the promising potential of prevention, there are several concerns that need to be addressed. One major challenge is ensuring accessibility. Some populations, particularly vulnerable groups such as low-income families or those with disabilities, may struggle to access or engage with prevention services. Furthermore, cultural and language barriers, poverty, and lack of stability (like safe housing) can significantly impact individuals' ability to

engage in prevention programmes. These barriers may prevent the full benefits of preventive healthcare from being realised, particularly in underserved communities.

There are also concerns that certain preventive measures could have unintended negative consequences, such as shaming individuals who don't meet health targets or focusing too much on specific risk factors (e.g., obesity) without addressing other factors like malnutrition. Additionally, behavioural change is often slow and requires intrinsic motivation, making it difficult to achieve lasting results for many individuals.

Funding for preventive initiatives is another significant hurdle. Many people pointed out that it's difficult to prove the business case for preventive measures, especially since their benefits may only become clear over the long term. This means that a shift to prevention-first healthcare requires long-term planning and sustained investment, which may not always be prioritised in current systems.

The balance between prevention and immediate treatment remains a concern, with some people worried that an emphasis on prevention could divert resources away from those who urgently need treatment. Additionally, some people reported that mental health support and addiction services often fail to address the underlying issues (e.g., trauma or psychological triggers) and may not be accessible to those who need them most.

Potential for Prevention
The potential benefits of a prevention-first approach are significant. Early intervention, particularly in schools, can teach children lifelong health habits. A focus on addressing health and social issues in the community (such as domestic violence and addiction) can help prevent long-term health problems. By working together across sectors, including the NHS, schools, housing, and social care, the effectiveness of prevention efforts can be maximised.
Moreover, community-based solutions like the SOS Health Bus can play a positive role by addressing health issues early and fostering safer environments, particularly in high-risk settings such as nightlife venues. These kinds of initiatives help prevent minor incidents from escalating into major health crises.

Challenges
For this prevention-focused system to be effective, coordination between health services, social care, and other sectors is vital. There is a need for joined up thinking to ensure that prevention efforts are holistic and reach everyone, including those who are hard to reach due to cultural, social, or economic reasons.

Finally, there is a need to ensure that support is available when people are ready for it, not just when the system dictates. A "no wrong door" approach would help ensure that individuals don't get lost in the system and can access the support they need without delays.

The shift to prevention-first healthcare offers promising potential to reduce illness, improve health outcomes, and save costs in the long run. However, its success will depend on making preventive services accessible, inclusive, and tailored to the needs of different communities. By integrating prevention into schools, communities, and families, and ensuring collaboration across sectors, a more effective and equitable healthcare system can be achieved.

Prevention Priorities and Why

The NHS should focus on a multi-pronged approach to prevention that addresses both physical and mental health, alongside lifestyle factors, to reduce long-term health disparities and costs. Here are some suggested key areas for the NHS to prioritise:

- **Vaccination Uptake:** Combatting misinformation and improving access to vaccines, especially for flu, COVID-19, and other preventable diseases, through targeted awareness campaigns. Vaccination is a proven preventive measure that can significantly reduce long-term health burdens.
- **Healthy Eating and Physical Activity:** Promoting lifestyle changes such as healthy eating and regular physical activity is crucial to preventing chronic conditions like obesity, diabetes, and cardiovascular disease. This could be integrated into school curriculums, workplaces, and community outreach, with a focus on dispelling myths and offering practical support.
- **Weight Loss, Nutrition, and Medication:** Prioritising weight management and nutrition as key components of overall health could prevent numerous conditions. Offering support like free weight management programmes and exploring options for medication where necessary could have a positive impact.
- **Mental Wellbeing and Early Intervention in Schools:** Mental health should be woven into the fabric of school education, focusing on building resilience and teaching coping mechanisms for emotional challenges. Early intervention can prevent the escalation of mental health problems later in life.
- **Smoking and Vaping Cessation:** Supporting individuals in quitting smoking and vaping is critical for reducing the risk of long-term health issues. Tailored programmes addressing addiction and mental health, alongside outreach to families, could be more effective in changing behaviour and preventing young people from starting.
- **Substance Use Prevention and Support:** Focusing on early intervention for alcohol and drug misuse, especially for younger individuals, is essential. Comprehensive support systems that target underlying mental health issues can prevent escalation and reduce healthcare costs over time.
- **Community-Based Services and Mobile Units:** Expanding services like the SOS Health Bus and mobile units, especially in high-traffic or vulnerable areas, could provide accessible care and reduce the strain on NHS services by addressing problems early.
- **Access to Regular Health Check-ups and Screenings:** Preventative screening for conditions like cancer, cardiovascular disease, and diabetes is vital for early intervention. Making these screenings more accessible to underserved communities and encouraging regular health checks can save lives and reduce treatment costs.
- **Affordable Dental Care:** Improving access to affordable dental care, especially for low-income and vulnerable populations, can prevent costly and complex dental issues in the future.
- **Social Care Integration:** Fostering collaboration between health and social care services to support individuals with stable housing, social support, and community-based resources can help people manage their health proactively.
- **Mental Health Support Services:** Expanding access to mental health services, including outreach and integration into community care, is vital. This should include culturally appropriate campaigns to reduce stigma and increase awareness of mental health issues.

3.5 Other Feedback

This question offered an opportunity for people to highlight issues that the NHS should address in Norfolk and Waveney to improve healthcare accessibility, effectiveness, and inclusivity across the region. These points were:

- **Funding for Preventative Care**:
    - The concern regarding the gap between the ambition for preventative care and the available funding is valid. While preventative measures are widely supported, without adequate funding, they cannot be implemented effectively. It's important to push for sustainable investment in this area, especially given the long-term savings that could be achieved by reducing the burden of preventable conditions.
    - Consider advocating for long-term funding commitments in preventative services, demonstrating the potential for improved outcomes and cost savings through early intervention.
- **Accessibility and Equity**:
    - There is a strong emphasis on ensuring that health services are accessible to everyone, especially marginalised and vulnerable groups. Tailoring strategies to address rural isolation, digital exclusion, language barriers, and the needs of people with disabilities is vital.
    - It's also important to address the "postcode lottery" in service access, particularly for primary care. This could involve advocating for more equitable distribution of healthcare services and resources to ensure that underserved areas are supported adequately.
- **Digital Health**:
    - The concerns about digital health services, particularly in rural areas with poor internet access, need to be addressed. Ensuring that digital health solutions are designed with accessibility in mind—such as providing support for people unfamiliar with digital tools and ensuring that services can be accessed through multiple platforms—will help alleviate these concerns.
    - Consider focusing on a blended model of care, combining both digital and in-person services to ensure wider access.
- **Mental Health and Dual Diagnosis**:
    - The need for better integration of mental health services and dual diagnosis pathways is clear. Simplifying the navigation of mental health services, especially for those with co-occurring conditions like substance misuse, can make a huge difference in both outcomes and patient satisfaction.
    - Streamlining care pathways for these individuals and ensuring they receive timely and compassionate support can build trust in the system.
- **Youth Engagement**:
    - There is a clear call for more engagement with young people, particularly regarding mental health, substance use (vaping and alcohol), and access to activities outside school. Developing age-appropriate outreach programmes and increasing youth representation in healthcare decision-making would give young people a voice in the process and encourage healthier choices.
    - Schools and community organisations should play a greater role in health promotion, as they are well-placed to reach young people early.
- **Social Care Integration**:
    - The integration of social care and healthcare cannot be overstated. Social care is vital for addressing the long-term needs of many patients and

preventing unnecessary hospital admissions. The NHS cannot function effectively without a well-supported social care system that ensures people can transition smoothly from hospital to home.
    - Advocacy for a more comprehensive, well-funded social care system should be a priority, with a focus on recruitment, retention, fair pay, and better training for social care workers.
- **Improving Services for Vulnerable Populations**:
    - The feedback highlights significant concerns about the underfunding of services for women with ADHD, as well as the lack of support for the neurodiverse community. Developing more targeted support services and peer support networks, especially in rural and coastal areas, could address these gaps.
    - Improving dementia and Alsheimer's care pathways and addressing the healthcare needs of the elderly are essential for improving outcomes, particularly given the aging population in the area.
- **Healthcare for People with Disabilities**:
    - The challenges faced by people with disabilities, including communication barriers, are unacceptable. Ensuring that individuals with disabilities are given equal access to healthcare and that their needs are considered in service planning is crucial.
    - Focusing on training healthcare professionals to provide accessible services, offering more flexible appointment systems, and ensuring that communication barriers (e.g., BSL interpreters) are addressed will help improve the experience for these patients.

4. Conclusion and Next Steps

Conclusion
In conclusion, the feedback provided is a strong call for a more integrated, accessible, and inclusive healthcare system. Key priorities highlighted include securing adequate funding for both preventative care and social care, improving digital and physical access for underserved populations, simplifying mental health and dual diagnosis pathways, and ensuring healthcare is inclusive for all, including those with disabilities and marginalised communities.

How the Feedback Will Be Used in Local Healthcare Planning
This valuable feedback will directly influence the planning and development of both national and local healthcare services. On a national level, the feedback will contribute to shaping the government's 10-year plan. In alignment with national findings, public input from the Change NHS engagement has emphasised the need for quicker access to appointments, better coordination between healthcare services, and greater investment in staffing. These insights will be incorporated into the government's strategy to address existing challenges within the NHS.

Locally, the feedback will inform the development of Norfolk and Waveney's health and care services, particularly when determining how funding will be allocated. This will help guide the Joint Forward Plan refresh, ensuring that local services are responsive to the needs and concerns raised by communities.

Next Steps
In Spring 2025, the Department of Health and Social Care will hold a National Summit, bringing together a selection of the public and workforce who participated in regional deliberative events. The goal of this summit is to finalise the national plan, which will be published later in 2025 and will shape the future of the NHS.

Locally, the feedback gathered will be shared back with participants through various channels. We will ensure that all those who took part in the engagement process are informed about how their input is being used to shape both local and national healthcare planning.

Acknowledgment and Thanks
We would like to extend our heartfelt thanks to everyone who shared their time, insights, and experiences during the engagement events. Your contributions are invaluable, and your feedback will play a crucial role in shaping the future of healthcare in Norfolk and Waveney.