Patients and Communities Committee

Thu 28 August 2025, 14:00 - 16:30

Virtual via MS Teams

Agenda

14:00 - 14:00 0 min

Meeting Agenda

- 00. P&C Committee - Agenda 28.8.25 - Draft.pdf (2 pages)

14:00 - 14:00 0 min

1. Chairs welcome and apologies for absence

14:00 - 14:00 0 min

2. Declarations of Interest

- 02 Register of Interests - P&CC.pdf (3 pages)

14:00 - 14:00 0 min

3. Minutes from the previous meeting (19.6.25) and matters arising

- 03 NW ICB PC Committee Minutes 19.5.25 Part One - DRAFT.pdf (13 pages)

14:00 - 14:00 0 min

4. Action Log

- Action log - 28.8.25.pdf (1 pages)

14:00 - 14:00 0 min

5. Risk Register

- 05i Risk Register cover sheet August 2025.pdf (3 pages)
- 05ii Risk Register 21.08.25 Patient and Communities Committee.pdf (1 pages)

14:00 - 14:00 0 min

6. Spotlight on: NHS Changes

- 06 WHWP presentation Sept 2025.pdf (7 pages)

14:00 - 14:00 0 min

7. Waiting for Hospital Care Report

14:00 - 14:00 0 min

8. Place Board Reports

- 07 Place Board Updates.pdf (5 pages)
- 07i Kirkley Retrofit Case Study July 25.pdf (11 pages)

14:00 - 14:00 0 min

9. All Age Carers Strategy for Norfolk and Waveney

- 09 All Age Carers Strategy 2024-29.pdf (29 pages)

14:00 - 14:00 0 min

10. Healthwatch Norfolk Update

14:00 - 14:00 0 min

11. VCSE Assembly Update

- 11 VCSE Assembly report_P&CC August 2025 (1).pdf (3 pages)

14:00 - 14:00
0 min

12. Ageing Well Programme Board Update

- 12i NW Ageing Well Progress Update ICB Patients and Communities Committee 28.08.2025 v3.pdf (4 pages)
- 12ii 2025.08.28 - Ageing Well Highlight Report v1.1 - PC Committee v1.pdf (4 pages)
- 12iii NW Ageing Well Programme Care Homes Progress Reports - August 2025.pdf (15 pages)

14:00 - 14:00
0 min

13. Population Health and Inequalities Board Update

- 13i 2025.08.19_inc 17.06.2025_PHI Board Report Cover Sheetv1.pdf (2 pages)
- 13ii 2025.08.19_inc17.06.2025_PHI Board Assurance-Escalations- v2.pdf (6 pages)

14:00 - 14:00
0 min

14. Complaints Report

- 14 2024-25 P & C Committee report v3.pdf (8 pages)

14:00 - 14:00
0 min

15. Policies for Review

15.1. Complaints Handling Policy and Procedure

- 15i ICB P&CC Front Page for Policy Ratification - Complaints Handling Policy and Procedure.pdf (2 pages)
- 15ia ICB-Complaints Handling Policy Procedure-V4-Jul25-Jul26.pdf (16 pages)

15.2. Media Policy and Our approach to working with people and communities

- 15ii ICB PCC Front Page for Media Policy Ratification.pdf (2 pages)
- 15ii ICB-Media Policy V3 Jun 25-Jun 27.pdf (12 pages)

14:00 - 14:00
0 min

16. Items for Escalation to the ICB Board

14:00 - 14:00
0 min

17. Any Other Business

14:00 - 14:00
0 min

18. Meeting Close

14:00 - 14:00
0 min

19.

NHS
Norfolk and Waveney
Integrated Care Board

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

Thursday 28 August 2025, 14:00-16:30hrs

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	14:00-14:15	**Chair's welcome and apologies for absence**	V	Chair
2		**Declarations of Interest**	P	Chair
3		**Minutes from previous meeting (19.5.25) and matters arising**	P	Chair
4		**Action log**	P	Chair
5	14:15	**Risk Register**	P	Mark Burgis
6	14:20	**Spotlight on: NHS Changes**	Pr	Rebekah Collett
7	14:40	**Waiting for Hospital Care Report**	V	Susan Balaam
8	14:55	**Place Board Reports**	Pr	Rebekah Collett Mark Burgis
9	15:10	**All Age Carers Strategy for Norfolk and Waveney**	Pr	Bethany Small
		Standing Items		
10	15:20	**Healthwatch Norfolk Update**	V	Judith Sharpe
	15:30	**BREAK (5 mins)**		
11	15:35	**VCSE Assembly Update**	P	Tim Gardiner
12	15:45	**Ageing Well Programme Board Update**	P	Dr Frankie Swords

13	15:55	**Population Health and Inequalities Board Update**	P	Dr Frankie Swords
14	16:05	**Complaints Report**	P	Jon Punt
15	16:15	**Policies for Review** i. Complaints Handling Policy and Procedure ii. Media Policy and Our approach to working with people and communities	P	 Jon Punt Chris Williams
16	16:20	**Items for Escalation to ICB Board**	V	Chair
17	16:25	**Any Other Business**	V	Chair
18	16:30	Close		
Date, time and venue of next meeting: TBC – future meeting dates are under review				
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			Indirect	Husband is a mental health counsellor and undertakes work independently and with the private provider Better Help, and VCSE provider: St Martin's Housing Trust	2022	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of counselling services by St Martin's Housing Trust or Better Help
Tracy Williams	Clinical Steward Health Inequalities and Central Place	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	30/04/2025	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 19 May 2025

Meeting in Public

Committee members present:

- 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
- Tim Gardner (TG), VCSE Assembly Chair, representing Emma Ratzer as 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
- Judith Sharpe (JS), Deputy Chief Executive, Healthwatch Norfolk
- Rebekah Collett, Associate Director of West Place, NHS Norfolk and Waveney Integrated Care Board (RC) for items 6 and 7
- Rachel Hunt (RH), Head of Place Development, Partnerships and Planning – Great Yarmouth and Waveney Locality, NHS Norfolk and Waveney Integrated Care Board for item 6
- Emma Bugg (EB), Acting Associate Director of North, Norwich & South Norfolk Place, NHS Norfolk and Waveney Integrated Care Board for item for item 6
- Jon Punt (JP), Senior Lead, Patient Experience, NHS Norfolk and Waveney Integrated Care Board for item 6
- Lee Watson (LW), Consultant in Public Health, Norfolk County Council, for item 11

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**	
	Cathy Armor (CA) began by welcoming everyone to the Patients and Communities Committee. Apologies for absence had been received from the following committee members: • Emma Ratzer, Norfolk and Waveney Voluntary Community and Social Enterprise Assembly (VCSE) Chair, and Chief Executive Officer of Access Community Trust, VCSE Board Member	
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 with the following correction: **Item 3 Waiting Times** - para 2, should read: *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 descent had slowed because of industrial action.*	
4.	**Action Log**	
	The action log was reviewed and updated accordingly.	
	Before progressing further with the agenda, CA highlighted the importance of addressing the ongoing changes and requested Mark Burgis (MB) to share an update on the changes taking place within the NHS and Integrated Care Boards (ICBs). MB advised a significant shift is underway, with the current 42 ICBs being reduced by approximately half by 2026. Additionally, ICBs will see their running costs cut by 50%, with revised budgets of between £18-£19 per head of population. In the East of England, Norfolk and Suffolk are expected to merge into a single ICB, potentially by April 2026. Ed Garrett, who is the Chief Executive of Suffolk and North East Essex ICB, has been appointed as Interim Chief Executive of Norfolk and Waveney ICB (N&WICB) following the departure of Tracey Bleakley. Ed Garrett brings prior experience in Norfolk and Waveney ICB and serves as a strong connection between Norfolk and Suffolk. Despite the challenges caused by organisational restructuring, MB acknowledged the dedication of staff who continue to serve patients and communities, even amid uncertain times. MB also introduced the recently released ICB blueprint, which outlines the core responsibilities and future roles of ICBs. MB highlighted the decision to end Norwich Walk-in Centre (WIC) and Vulnerable Adults Service consultation. Healthwatch Norfolk played a vital role, gathering approximately 3,500 public responses for the WIC consultation and 200 for the vulnerable adult's consultation. MB emphasised that the collected data will be instrumental in shaping future services. Judith Sharpe (JS) added that Healthwatch Norfolk's engagement team continues to gather feedback from vulnerable adult service users for a subsequent report, ensuring comprehensive input from the community. CA thanked MB for the update.	
5.	**Risk Register**	
	Mark Burgis (MB) introduced the item and updated that the two key risks remain. The first around health inequalities and population health management remains the same level.	

	MB reported that, regarding the second risk concerning the rising number of older individuals with complex healthcare needs in Norfolk and Suffolk, it is proposed that the score be reduced from 15 to 12 as a result of work carried out by the team. This adjustment is attributed to efforts from the Ageing Well Programme Board and the planned development of a system dashboard. Comments and questions from members of the committee: FS noted the report included in today's meeting papers indicated in relation to the health inequalities risk that it was behind target, but FS was certain all actions had been completed. MB acknowledged FS comments and will follow up on these. Regarding the second risk—more older people with complex health needs in Norfolk & Waveney— FS noted that most of the work is actually undertaken at place level, with leadership for 2 of the 4 board workstreams also led by the public health, and complex care teams, and significant input and overlapping projects also from other teams eg UEC, provider and locality teams, while the ageing well programme board provides strategic guidance and coordination of these projects. The update was noted. **Action 35:** MB to confirm the actions in relation to BAF08 had been completed.	
6.	**Committee Terms of Reference**	
	Mark Burgis (MB) introduced the item, taking the papers as read. MB explained a risk management audit earlier in the year highlighted the Terms of Reference for the Patients and Communities Committee did not make reference to risk management, therefore the committee ToR had been updated as per the appendix attached to the paper, which is seeking approval from this committee to those changes, ahead of the forthcoming ICB board meeting (21.5.25). Comments and questions from member of the committee: Tim Gardner (TG) queried whether VCSE Assembly representation should be included under committee attendees. MB acknowledged TG question and said as long as the VCSE is represented either by Emma Ratzer as VCSE Board member or by TG that is fine. **Approved:** The Patients and Communities Committee approved the revised Terms of Reference.	
6.	**Spotlight on: The Future of Place**	
	i. Patient Experiences Emma Bugg (EB) highlighted the strategic emphasis on shifting healthcare from treatment to prevention through personalised care and collaborative working. Key factors include fostering relationships among provider organisations, using the ICB as a convener to overcome hurdles, and enhancing enablers like information governance, workforce mobility, and data utilisation. Several case studies illustrate these principles, and scaling up efforts could accelerate progress. EB introduced Rachel Hunt (RH) to explore in more detail the 'Keeping Warm and Well	

initiative in West Norfolk and Waveney, highlighting the following:

- The project uses population health management data to proactively target vulnerable households for government and energy supplier grants.
- Data shared includes housing stock, financial vulnerability, deprivation, and clinical data to identify households negatively affected by cold conditions.
- Partnership with local government enabled targeted non-clinical interventions for household upgrades, such as new heating systems and solar panels, worth over £30,000 for some homes.
- The project achieved a 33% uptake compared to the usual 1-2% for traditional outreach methods.
- Next steps include assessing the long-term health outcomes and harnessing the approach as standard practice.
- Plans to engage more communities include building ambassador programmes and improving outreach to increase engagement further.

Comments and questions from members of the committee:

- FS emphasised the importance of data sharing in facilitating targeted interventions and proactive approaches, lauding its effectiveness in projects like the Keeping Warm and Well initiative.
- SM highlighted the challenges and necessity of streamlined information governance (IG) processes for innovative projects, praising the Population Health Management (PHM) approach and its broader applications across integrated care systems (ICS).
- TW underscored the significance of collaborative relationships with communities, safe housing, and strategic frameworks for addressing health inequalities, while promoting sharing of best practices across different areas.
- MB commended the case study for showcasing positive impacts on health outcomes and raised questions about scaling efforts and committee support to maximize change.
- AY praised the project for its integrated approach to care, which has been a goal for nearly a decade. He suggested exploring collaboration with councils on disability access funds, which are often underspent, to improve property safety and accessibility. This could reduce service pressures and achieve similar positive outcomes.
- TG highlighted the importance of innovative approaches and collaboration, particularly involving the voluntary sector. He emphasied the role of data sharing and embedding voluntary sector data into decision-making processes to improve initiatives like healthy homes. He also stressed building strong relationships and fostering best practices across sectors to achieve better outcomes.
- RH discussed lessons learned from the "Keeping Warm and Well" initiative and emphasised the importance of early engagement, local partnerships, and efficient utilisation of funding, including the £30 million Home Upgrade grant. She highlighted the need for targeting vulnerable households and leveraging government and energy supplier funding.
- EB added that smaller funding amounts can foster collaborative partnerships, maximising outcomes through personalised and integrated approaches.
- TD highlighted the need to review funding allocations, including the Disability Access Fund, to ensure they are being spent effectively. She

suggested leveraging unused housing stock to provide better homes for individuals facing substantial health challenges. TD further emphasised maintaining the progress made in Population Health Management (PHM) despite potential political shifts, stressing its importance in improving outcomes.

ii. Complaints, Feedback and Concerns

- Jon Punt (JP) discussed the challenges in logging data related to complaints and concerns, noting that the current system makes it difficult to align data with specific locations or practices, limiting the ability to draw actionable insights.
- He mentioned ongoing efforts to improve the data logging process and align it with best practices from Suffolk and North East Essex, where a stronger alliance model is in place.
- South Norfolk and West Norfolk were identified as areas with higher complaints, primarily due to known capacity issues at certain practices and discrepancies in the vaccination delivery model for housebound patients.
- In South Norfolk, specific practices were reported to receive more complaints due to capacity-related challenges, which are currently being addressed.
- In West Norfolk, the delayed delivery of housebound vaccinations caused dissatisfaction, as the local Primary Care Network (PCN) did not opt into a unified delivery approach, redirecting patients between GP practices and the National Booking System, leading to frustration.
- North Norfolk also expressed dissatisfaction, particularly regarding access to community rehabilitation beds, which remains a known concern for the area.
- Punt acknowledged that the limitations in the current data logging system prevent detailed extrapolation.

Comments and questions from members of the committee.

- MB thanked Jon Punt and his team for their efforts in highlighting challenges and aligning complaints and feedback data with specific locations. He acknowledged JP closer collaboration with Suffolk, which operates under a strong alliance model.
- FS suggested exploring oversight of complaints at the practice level and raised the importance of triangulating data to ensure better understanding, particularly with the delegated commissioning now in place.
- JP highlighted efforts to tag complaints by postcode where possible and discussed avoiding unnecessary burden on practices while improving processes. Mentioned ongoing discussions with the ICBs Head of Primary Care Commissioning Community Pharmacy and Optometry about replicating processes used in pharmacy across other areas like dental and general practice.
- TF shared past experiences with NHS England providing themes and trends reports on complaints data, stressing the importance of triangulating data across different geographical models and service providers.
- EB emphasised the importance of proactive measures, such as using intelligence from sources like Healthwatch and patient surveys, to prevent issues from escalating.

iii. Healthwatch Perspective

Healthwatch Norfolk

Judith Sharpe (JS) highlighted the following:

- The importance of proactive measures to address healthcare issues before they escalate. JS noted public concerns about GP and dental service access and stressed maintaining existing services when introducing new ones.
- JS also referenced a King's Fund study, which identified variations in governance models and delegation levels among place boards, emphasising the need for robust accountability and clear expectations.
- Partners at the place level show a strong motivation to address health inequities, demonstrating local passion for improving communities.
- There is a call for more protected time, resources, and support for place-based partnerships to enable effective action.
- JS emphasised the need to streamline processes, reduce governance constraints, and ensure collective focus on better-coordinated care.

Comments and questions from members of the committee:

- EB stressed the importance of fostering creativity and collaboration in healthcare systems, beyond rigid governance structures. She highlighted the success of initiatives born from shared vision and commitment to better outcomes.
- MB agreed with EB observations, emphasising the dedication and enthusiasm of place-based teams. He emphasised the importance of partnerships and collaborative efforts, referencing successes like the Marmot initiative.
- SM reflected on resource challenges and partner alignment, particularly in public health. She suggested leveraging public health consultants on place boards to provide more targeted support in localised health efforts.

Healthwatch Suffolk

Andy Yacoub highlighted the following:

- Health and community service access is the major barrier to ageing well, followed closely by transportation challenges.
- Loss of local services such as pharmacies, GP practices, and post offices is a significant concern, particularly in rural areas.
- Long travel times for hospital visits pose difficulties, especially in rural or transport-limited settings.
- Professionals emphasise the need for more localised pulmonary rehabilitation services and community-based support networks in addressing COPD.
- Virtual wards have been welcomed by patients and family carers, improving recovery and reducing stress by minimising hospital visits.
- Some patients and families advocate for retaining or expanding virtual ward services, highlighting benefits for palliative care.
- Older and disabled individuals express higher concerns about difficulties in long-distance travel, especially at night.
- Localised healthcare services are crucial for managing chronic conditions and improving accessibility for vulnerable populations.

	Comments and questions from members of the committee: • TD highlighted the importance of refining conversations and consultations to better reflect public concerns regarding healthcare proposals. • MB emphasised the value of localised and accessible healthcare, sharing a strong message about preserving effective place-based initiatives amid changes and uncertainties. • RC stressed that long-standing, trusting relationships across health, local authorities, and other organisations are crucial for effective collaboration and problem-solving in resource-limited areas. • EB discussed integrating neighbourhood teams and highlighted challenges, such as digital infrastructure issues, in achieving seamless cross-organisational collaboration. She also pointed out the repetitive processes required for each new project, which could be streamlined for better efficiency. CA acknowledged and thanked all contributors for this item. The updates were noted.	
7.	**West Place Board Report**	
	Rebekah Collett (RC) introduced the item, taking the papers as read. RC highlighted the following: • The West Place Board comprises a range of stakeholders, including representatives from general practice, local education providers, Healthwatch, NHS trusts, and local authorities. This diversity ensures that decisions and programmes reflect various perspectives and areas of expertise. • The Board's three main priorities are: - Tackling health inequalities: This priority aligns with the King's Lynn and West Norfolk Health and Well-being Partnership, focusing on addressing disparities in health outcomes across different communities. - Urgent and emergency care: Enhancing the efficiency and accessibility of services for patients requiring immediate medical attention. - System integration: Streamlining collaboration across healthcare services and stakeholders to improve overall system functionality. • The Marmot programme collaboration concentrates on reducing inequalities, with particular emphasis on improving outcomes for children and young people and addressing challenges unique to rural communities. • Several healthcare projects have been successful in addressing specific issues: - Hospital discharges have improved significantly, reducing delays from 140 patients to 35-40 patients. - Fewer escalation beds are now required at Queen Elizabeth Hospital (QEH), reflecting better patient flow management. - The Optimising Care project has reduced the dependency on double-up care packages through equipment and training improvements. - The Falls Prevention project targets individuals aged 65 and older with interventions like home safety adaptations, tailored exercises, and referrals to support networks. - The Community Transformation Programme includes:	

	- Palliative care: Enhancing out-of-hours rapid response services and care home support. - Leg ulcer care: Improving the quality and quantity of care within the community. - Care home services: Demonstrating success in service delivery and patient satisfaction. • The Place Board is actively involved in developing the business case for the new QE hospital. This includes creating strategies to manage future hospital demand effectively and planning for neighbourhood health workforce development. Collaboration with public health and other stakeholders ensures that measures are sustainable and impactful. Comments and questions from members of the committee: • CA noted the low participation of men in one group which raises questions about broader trends and outreach challenges. RC agreed and said the presence of men in certain community exercise groups varies depending on the area and engagement strategies. The update was noted.	
8.	**Learning from Deaths Report Summary**	
	Dr Frankie Swords (FS) presented this item, taking the papers as read. FS highlighted some of the key findings as follows: • Norfolk saw fewer deaths than expected last winter, possibly due to COVID or changes in reporting. • Norfolk has not experienced a rise in suicide rates for eight years, attributed to the county's suicide prevention strategy. • Efforts are underway to address ketamine and multiple substance use, integrating mental health and substance use support. • Alcohol teams are now in place at all providers to manage early identification and referral for alcohol-related issues. • Child deaths remain stable with modifiable risk factors such as parental smoking, obesity, and co-sleeping being addressed through education and outreach. • The medical examiner service enhances communication with next of kin regarding death certificates and aids the grieving process. • Norfolk and Norwich University Hospital commissioned an external review to address above-expected deaths, focusing on coding accuracy, sepsis care, and electronic observation systems. Mortality rates at the Norfolk and Norwich University Hospital are reducing gradually but remain flagged as high. Comments and questions from members of the committee. • TW commented about the increase in drug and alcohol-related deaths in Norfolk, particularly in Norwich, despite previous improvements. It emphasises the importance of sharing learnings across panels and sectors to address these issues. Linking drug and alcohol-related deaths to health inequalities and core inclusion health groups is seen as vital, with place-based partnerships playing a key role in tackling these challenges. • SM echoed TW comments about the significance of addressing health inequalities and linking them to inclusion health groups. Furthermore, the	

	Learning from Deaths Forum is a vital platform for consolidating information, identifying learning opportunities, and addressing key themes collaboratively. The update was noted.	
9.	**Healthwatch Updates**	
	i. Feedback on the Learning from Deaths Report <u>Healthwatch Suffolk</u> Andy Yacoub (AY) highlighted the lack of data on specialist information regarding drug and alcohol addiction recovery and shared insights from his experience working with an alcohol-based recovery charity, emphasising the importance of drug and alcohol addiction specialist nurses. AY raised concerns about the reduction in investment in alcohol-based recovery programs compared to the past adding some recovery programs often require out-of-county travel. **ii. General Updates / Escalations** <u>Healthwatch Norfolk</u> Judith Sharpe (JS) provided a verbal update, highlighting the following: • Healthwatch Norfolk is awaiting confirmation for its main contract tender, which has been delayed since September. • The consultation on the Walking Centre and engagement activities for vulnerable adult services are ongoing. • The engagement team has been busy visiting care homes, as well as participating in initiatives like the Crucial Crew program to engage with younger audiences. • A follow-up on the Hearing Loss Charter for primary care is being conducted, with a report expected in the next month. • Current projects include: - Experiences of hospital discharge among the older population. - A three-year study with carers of individuals with serious mental illness. - Examining the use of digital tools in primary care, such as the NHS app. • Ongoing concerns include issues with NHS dentistry and long waiting times for the pain clinic, with some patients waiting up to 18 months. Comments and questions from members of the committee: • TD highlighted the prolonged waiting times for pain clinics is historically due to the complexity of cases. TD requested JS formally escalate via email so TD can address the issue through proper forums and contractual processes. **Action 36: JS to formally escalate via email so TD can address the issues regarding long waiting times for pain clinics through proper forums and contractual processes.** The update was noted.	

	Healthwatch Suffolk Andy Yacoub provided a verbal update, highlighting the following: • A comprehensive report on waiting for elective care is set to be published this week. It focuses on identifying ways to support patients while they wait, rather than accelerating appointment schedules. The report acknowledges the challenges of living with pain for these patients and aims to propose actionable solutions. This report is based on approximately 1,400 survey responses collected collaboratively with West Suffolk and the James Paget hospitals. It includes multiple recommendations targeting improvement areas in elective care. • In January, a national report was submitted to the All-Party Parliamentary Group on Pharmacy. This submission was part of a broader initiative to influence policy and develop pharmacy services across the UK. • Ongoing work addressing cancer is focused on the Suffolk and North East Essex area. Insights gained from this initiative contributed to Healthwatch England's publication on national eye care. Specifically, 33 responses from Suffolk were included, adding substantial local data to the broader analysis. • A collaborative effort with Healthwatch Essex is exploring the experiences of individuals affected by recent changes to ADHD medication prescribing practices. A survey is being co-created to gather these insights, aiming to improve system-wide understanding and response to these changes. • Engagement and community outreach teams are consistently active in the Waveney area. They regularly engage with local groups and communities, collecting valuable feedback. AY is happy to share details of these engagements upon request. The update was noted.	
10.	**VCSE Assembly Update**	
	Tim Gardiner (TG) presented this item taking the papers as read. TG began by reflecting on the interesting conversations during today's meeting around relationships and integrated working, and TGs report is around the VCSE assembly presenting a risk register to highlight the assembly's aspiration to move forward in terms of working as a system. The risk register highlights some significant risks to the VCSE sector. The sector is quite unique with a collective of approximately 12,000 organisations across Norfolk and Waveney which makes it at times quite complex to engage and work with. Much of the risk register is about how do we pull some of that together and work in a slightly more integrated way. TG said it was important to note that as a voluntary sector, all those 12,000 organisations provide an important safety net around supporting statutory services within our communities: without it there would be an enormous increase in demand for statutory services. The risk register outlines how the ICB and the whole ICS recognise the risks and support to mitigate them. It was noted the VCSC Assembly Board, at its recent meeting, discussed a draft action plan which will sit alongside the risk register. TG will bring the action plan to the next meeting	

	Action 37: Present VCSE Assembly Board action plan at the next meeting. The update was noted.	
11.	**Ageing Well Programme Board Update including Prevention Workstream Update**	
	Dr Frankie Swords (FS) presented the update for the Ageing Well Programme Board, taking the papers as read. FS highlighted the following: • The assurance report highlights the prevention workstream, which includes place-based teams focused on proactive engagement, such as in Great Yarmouth and Waveney, to identify people with frailty. The Ageing Well programme aligns with these efforts, ensuring a concerted approach to addressing frailty and supporting healthier ageing. • Updates on the Suffolk Dementia Strategy and Action Plan were received, which fully align with our programme objectives. • Two additional statutory partners have signed the Dementia Charter. • The frailty-focused workstream has embedded comprehensive geriatric assessments and uniform frailty scoring tools across three acute trusts, improving care for older individuals. • A frailty same-day emergency care unit has been successfully established in the Queen Elizabeth Hospital, enhancing immediate care for older populations. • Efforts are underway to extend the integration of frailty scores across the community, enabling primary care and other partners to act on these assessments effectively. Lee Watson (LW) provided an update on the Prevention workstream, highlighting the following: • Norfolk's population is aging faster than the national average, with uneven distribution across the region, creating significant system challenges and opportunities to improve health and well-being in older age. • The focus is on promoting healthy aging to enhance quality of life, leverage the potential of older adults as assets (e.g., in volunteering and the economy), and reduce age discrimination, which remains a widespread issue. • A public health review in 2024 aligned Norfolk's ageing well strategy with preventive measures, setting clear objectives and ambitions for improving healthy life expectancy. • Key actions include conducting social isolation and loneliness needs assessments (already published) and falls prevention needs assessments (soon to be published), both of which guide targeted interventions. • Efforts to create age-friendly communities, based on the WHO's whole systems approach, include North Norfolk's ongoing journey (initiated a year ago) and Norwich's official participation starting October 2024, with public health teams supporting these efforts across the region. • The first community of practice all age-friendly initiatives, scheduled for this week, aims to bring together existing participants and newcomers, offering practical steps to start and sustain such efforts, including engaging with employers, improving public spaces, and enhancing transport accessibility.	

	• A multi-year communications and engagement strategy is under development to address health and well-being in collaboration with stakeholders and residents, structured around three main pillars: - Physical activity: Encouraging people to stay or become active to gain substantial health benefits. - Social connections: Promoting ways to stay connected or combat isolation, based on findings from the needs assessments. - Positive health actions: Highlighting the importance of screenings, immunisations, NHS health checks, and other health measures within an aligned and co-designed framework. • Initial communications focusing on physical activity are expected by summer, followed by campaigns addressing winter vaccinations and other critical health actions. This strategy is intended to be adaptable and enduring, outlasting organisational changes and maintaining a consistent "golden thread" across years of engagement efforts. Comments and questions from members of the committee: • TD expressed appreciation for LW refreshing presentation, highlighting the importance of embracing ageing with positivity rather than viewing it as a decline. TD advocated for encouraging active lifestyles and promoting safe, clean environments for older individuals, suggesting that this approach could energise Place boards and foster collaborative efforts. • CA highlighted the challenges of engaging employers in initiatives focused on ageing well, contrasting this with the enthusiasm for general workplace health programs. She reflected on the need to shift workplace perceptions and foster a positive outlook toward ageing. • TW highlighted the importance of addressing premature ageing, particularly in deprived communities where individuals may begin ageing earlier than expected. She emphasised the need for community-driven approaches, close engagement, and initiatives like exercise programs in care homes to promote active and healthier ageing while respecting the preferences of those aged 50 and above. • TG reflected on the importance of approaching ageing with a positive mindset and avoiding a sense of pessimism. He mentioned the Get Britain Working initiative related to supporting individuals aged 50 and above in maintaining their health and productivity at work. The update was noted.	
12.	**Population Health and Inequalities Board Update**	
	Dr Frankie Swords (FS) presented this item taking the papers as read. FS highlighted the following: The PHM software provider procurement is now complete; Prescribing Services Limited (PSL) were the successful provider, and the Eclipse software is now live. Current live projects – the Keeping Warm and Well project that had been presented earlier in the meeting and the National Diabetes Prevention Programme (NDPP) and the NHS Digital Weight Management Programme (DWMP). FS also reported new projects were being scoped and using data to identify cohorts of where we can	

	achieve the best impact in terms of identifying high risk cohorts and earlier intervention. The NHS Anchors Group have now all completed their Board Maturity Assessments. An example of this work in action is the Inclusion Health Locally Enhanced Service (LES) for GP surgeries is now approved meaning every single GP surgery can be incentivised to take local action using the health inequalities tools available to them. The revitalised VCSE Assembly Board, under its new invigorated leadership has had its first in person meeting and as TG alluded to earlier in the meeting, an action plan will be formulated to address the risks as the assembly sees them across the VCSE sector. NWICB had been awarded £540,000 Volunteering for Health funding which is being shared across partner organisations. The updated was noted.	
13	**Items for Escalation to ICB Board**	
	The committee agreed the following items should be escalated to ICB Board: - Emphasise the two identified BAF risks and recommendations for reducing their scoring. - Highlight Information Governance and its associated challenges. - Note Healthwatch Norfolk's concerns about extended waiting times for pain clinic appointments. - Recognise the publication of the new VCSE Risk Register.	
14.	**Any Other Business**	
	No items were raised.	
Date, time, and venue of next meeting: Monday 28 July 2025, 14:30-17:00hrs via MS Teams		

Minutes agreed as accurate record of meeting:

Signed: …… Date: ……...
Chair

Parker Rachael
27/08/2025 13:12:42

				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
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. **Update 19.5.25: TD to ask MH team to prepare a briefing on the referral process to share with committee members.**	28.7.25 ~~19.5.25~~ ~~24.3.25~~ ~~27.1.25~~		
35	19.5.25	Risk Register	MB	Confirm the actions in relation to BAF08 had been completed.		28.7.25		
36	19.5.26	Long waiting times for pain clinics	JS / TD	JS to formally escalate via email so TD can address the issues regarding long waiting times for pain clinics through proper forums and contractual processes.		28.7.25		
37	19.5.25	VCSE Assembly Board Action Plan	TG	Action plan to be shared at the next meeting.		28.7.25		

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:	**28 August 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 board assurance framework, these are linked to our system ambitions in the joint forward plan:

Risk 08 – 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.

Risk 31 – 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.

Since the last meeting in May two new risks have been added and assigned to the committee:

Risk 84 – Hospice Sustainability: There is a significant risk with the current approach to hospice funding for both adults, children and young people. Recent examples, such as the NHS-wide pay increases for staff, did not result in further funding for hospices to mitigate this. These organisations support a large patient group within the PEoLC space and, without this funding feeding through charitable organisations, they will become increasingly more challenged in delivering care for these vulnerable patient groups. These organisations have continued to provide excellent value for money for the services that they provide, but with a growing ageing population across the country and even more so in N&W, funding via grants needs to be agreed for a longer period than every 12 months and consideration needs to be made to account for growth in service for hospices. The implication of this risk could result in withdrawal of services offered by hospice organisations due to the lack of sustainable and adequate funding. and the significant risk with the current approach to hospice funding for both

Risk 105 – Central Alliance Risk – NW Community Support Service: (NWCSS)
The NWCSS contract is due to end on 30.09.25. The service provides a single point of access across NW for those individuals requiring informal support to enable a sustainable discharge via P0 or to support admission avoidance. The service was jointly funded by the ICB, NCC and SCC (ICB 59% NCC 38% and SCC 3%). However, NCC have taken a decision to direct their contribution to a new Proactive Intervention and Prevention (PIP) service which will initially provide a proactive upstream response to those identified to be at risk of falls. It is currently not an urgent response service to enable early discharge/admission avoidance activity, and the scheme is not in a place of development to adopt this function. NWCSS supports c2600 individuals across N&W annually with a broadly 50:50 split of activity between discharge and admission avoidance. Over half of the service activity is generated by CN residents. NWCSS is predominantly accessed by those aged 70 years and over, (with the highest referral rates for 80–90-year-olds), those that live alone, have a long-term condition and are from our core 20 populations. Thus, cessation of NWCSS without an alternative offer in place is likely to have the greatest impact on this cohort and present a risk to increased admissions and delayed discharges.

Recommendation to the Committee:

The committee is asked to: • Note the update. • Decide whether to accept the two new risks identified. • Consider whether any additional actions should be identified.

Key Risks	
Clinical and Quality:	Potential for poorer outcomes for patients.
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)	

NWICB Patients and Communities Committee

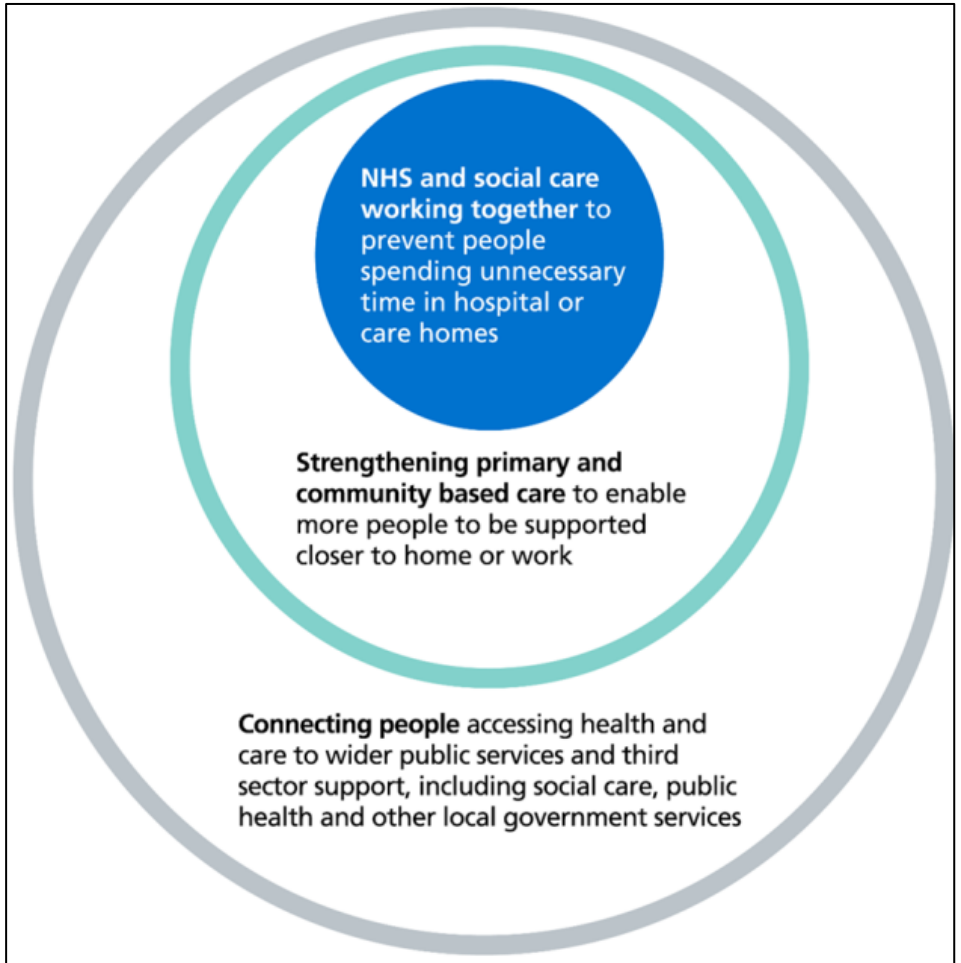
Risk Id	Risk Title	Description	Risk Owner	Risk Committee	Operational Lead	Date Risk Identified	Target Delivery Date	Unmitigated Score	Mitigated Score	Target Score	Controls	Actions	Action Owner	Action Start Date	Action Due Date
8	Health inequalities and Population Health Management	There is a risk that 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	Frankie Swords	Patients and Communities Committee	Shelley Ames	01-Jul-22	31-Mar-26	16	12	8	Community Voices gathering insights into HI and connecting with local communities to help address.	Ageing Well Programme Blueprint developed to establish priorities and align workstreams and agreed at Programme Board	William Lee	04/11/2024	31/03/2026
											Datahub Population Health dashboards in place to support reporting and population health management approaches.	Develop appropriate system Dashboard with all core workstream metrics	William Lee	04/11/2024	31/10/2025
											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				
31	Increasing numbers of older people with complex health needs in Norfolk & Waveney	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	Frankie Swords	Patients and Communities Committee	Olga Emmerson	20-Jun-24	31-Mar-28	20	12	12	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				
84	Hospice Sustainability	There is a significant risk with the current approach to hospice funding for both adults, children and young people. Recent examples, such as the NHS-wide pay increases for staff , did not result in further funding for hospices to mitigate this. These organisations support a large patient group within the PEoLC space and, without this funding feeding through to charitable organisations, they will become increasingly more challenged in delivering care for these vulnerable patient groups. These organisations have continued to provide excellent value for money for the services that they provide, but with a growing ageing population across the country and even more so in N&W, funding via grants needs to be agreed for a longer period than every 12 months and consideration needs to be made to account for growth in service for hospices. The implication of this risk could result in withdrawal of services offered by hospice organisations due to the lack of sustainable and adequate funding.	Olga Emmerson	Patients and Communities Committee	William Lee	20-Sep-24	31-Mar-26	12		8					
105	Central Alliance Risk 015 NW Community Support Service (NWCSS)	The NWCSS contract is due to end on 30.09.25. The service provides a single point of access across NW for those individuals requiring informal support to enable a sustainable discharge via PO or to support admission avoidance. The service was jointly funded by the ICB, NCC and SCC (ICB 59% NCC 38% and SCC 3%). However, NCC have taken a decision to direct their contribution to a new Proactive Intervention and Prevention (PIP) service which will initially provide a proactive upstream response to those identified to be at risk of falls. It is currently not an urgent response service to enable early discharge/admission avoidance activity and the scheme is not in a place of development to adopt this function. NWCSS supports c2600 individuals across N&W annually with a broadly 50:50 split of activity between discharge and admission avoidance. Over half of the service activity is generated by CN residents. NWCSS is predominantly accessed by those aged 70 years and over, (with the highest referral rates for 80-90 year-olds), those that live alone, have a long-term condition and are from our core 20 populations. Thus, cessation of NWCSS without an alternative offer in place is likely to have the greatest impact on this cohort and present a risk to increased admissions and delayed discharges.	Mark Burgis	Patients and Communities Committee	Rebecca Richards	17-Jul-25	07-Jul-25	16	12	12	The current service contract was extended until the end of September 2025, to enable review and proposal of next steps for the service. Triple lock approval has been granted to enable the service to be delivered for 12 months starting the 1.10.2025 to allow sufficient time to re-procure the service with the intention of awarding a 2 plus 1 year contract. Due to the reduced budget and thus capacity, the service will focus on rapid response short term low level interventions only to support discharge and hospital front door admission avoidance activity. Wider admission avoidance referral routes will be considered if capacity allows. Individuals requiring non-urgent support will be referred where able to relevant community services.				

Improving lives **together**

Norfolk and Waveney Integrated Care System

NHSE Neighbourhood Health Guidelines –

An overview of Neighbourhood Health in the 10Year Health Plan & what this means for local communities



National diagram showing the aims for all neighbourhoods over the next 5 to 10 years

Introduction

- The newly published 10year Health Plan commitment is Neighbourhood health "***will bring care into local communities; convene professionals into patient-centred teams; end fragmentation and abolish the NHS default of 'one size fits all' care. It will transform access to general practice and prevent unnecessary hospital admissions. It will help reintegrate healthcare into the social fabric of places***".

- The Health Plan recognises the **urgent** need to transform the health and care system. Moving towards a neighbourhood health service will deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery.

- However, achieving this will require an **integrated response** from all parts of the health and care system, and with wider partners. Neighbourhood health reinforces a new way of working for the NHS, local government, social care and their partners, where integrated working is the norm and not the exception.

- The full vision for the health system is set out in the 10 Year Health Plan.

NHS England's ambition

Neighbourhood health aims to create healthier communities, helping people of all ages live healthy, active and independent lives. Furthermore, the new model of care aims to improve experience of health and social care as services are provided within communities and increase an individual's agency in managing their own care.

This ambition will be achieved through **3 key shifts** :

From hospital to community

- Providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care

From treatment to prevention –

- Promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health

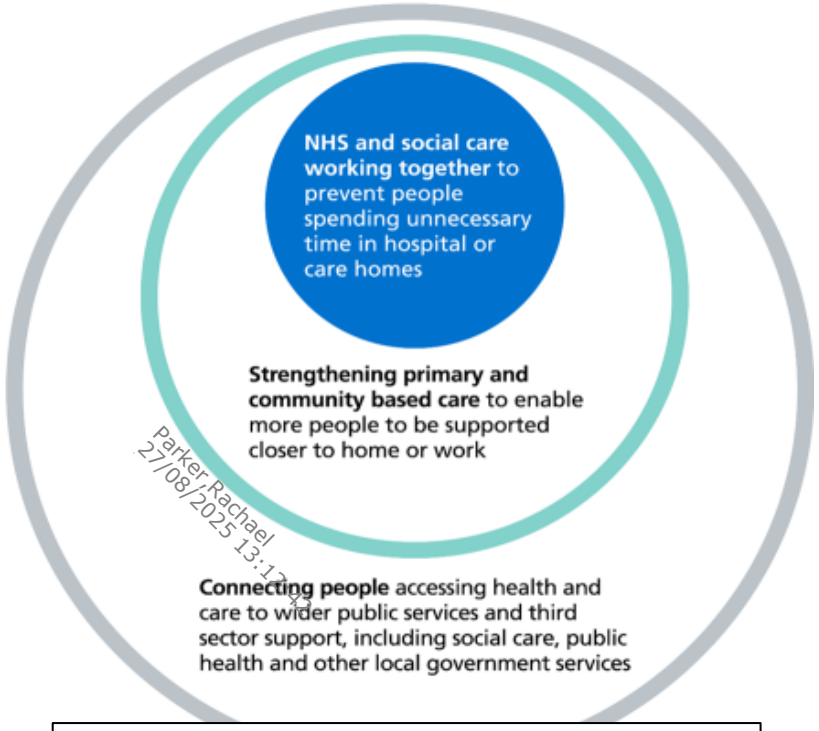
From analogue to digital –

- Greater use of digital infrastructure and solutions to improve care

NHS England » Neighbourhood health guidelines 2025/26

Requirements for 25/26 & beyond…

- NHSE guidance is the focus in 2025/26 should be to support adults, children and young people with complex health and social care needs, who require support from multiple services and organisations. Estimated as 7% of the population this cohort is linked to 46% of hospital costs. **As a minimum**, systems are asked to focus on the **inner circle in 2025/26**. As relationships strengthen, systems are expected to focus on the outer circles.
- Neighbourhood health is an important part of wider public sector reform. Previous estimates suggest around 1 in 5 GP appointments are taken up for non-medical reasons, such as loneliness or to seek advice on housing or debts.



National diagram showing the aims for all neighbourhoods over the next 5 to 10 years

Focusing on the inner blue circle will

1. Improve timely access to general practice and urgent & emergency care
2. Prevent long and costly admissions to hospital
3. Prevent avoidable long-term admissions to residential or nursing care homes

Transforming together over time, moving towards the outer circle will

1. Free up NHS capacity by addressing non-medical issues like loneliness and housing through local neighbourhood services.
2. Offer joined-up support meaning quicker help, better results, and smarter use of public resources.
3. Harness stronger local partnerships beyond traditional health & care pathways to create clear, local access and support for non-clinical care.

Benefits for local communities

How will local services be different?

Care closer to home

- Services will increasingly be delivered in people's homes or local neighbourhood centres, reducing the need for hospital visits.

Improved access

- Neighbourhood Health Centres will operate 12 hours a day, 6 days a week, offering diagnostics, rehab, and even social support services like debt advice and employment help.

Integrated, person-centred care

- Multidisciplinary teams—including GPs, nurses, social workers, pharmacists, and voluntary sector partners—will work together to support individuals holistically.

Prevention & early detection

- Greater emphasis on health literacy, screening, and proactive care will help prevent illness and reduce long-term conditions.

Health inequalities

- Rollout prioritises areas with the lowest healthy life expectancy, ensuring that deprived communities benefit first.

Digital-first

- Expansion of virtual consultations, remote monitoring, risk stratification and digital health tools will make care more accessible and efficient.

Examples of N&W progress towards Neighbourhood

Place-led collaboration

- Gt Yarmouth & Waveney Place applied to NHSE as an early implementor for Neighbourhood Health, as part of the **National Neighbourhood Health Implementation Programme (NNHIP).** Outcome of application due 8th Sept 2025
- Application harnessed commitment of all Place & system partners – LA, VCSE, Health & Social Care as a joint bid.
- GY&W Place Partnership motivated by NNHIP and regardless of application outcome, time is now to build on momentum for Neighbourhood Health

Health Inequalities & Prevention

- A Place Prospectus link here – has been drafted to showcase some work underway and future opportunities.
- The Prospectus describes a range of Place, PCN and Neighbourhood programmes of work with emphasis on addressing health inequalities, prevention and early detection and piloting innovative new ways of working at Place.
- Marmot Place Programmes – underway in West Norfolk, and due to launch Autumn 2025 in East Suffolk.

Population Health Management

- A digital first approach is being tested, by using PHM & risk stratification to support strategic resource allocation
- Pioneering scheme in West Norfolk & Waveney, East Suffolk, has linked data around clinical vulnerability with housing data to ensure sizable housing grants target the most vulnerable households. Case study: local family received £30k home upgrade grant via ECOflex because of our innovative, targeted programme.

NNHIP – application made by GY&W Place

What is the National Neighbourhood Implementation Programme (NNHIP)?

- In support of the NHS 10-Year Health Plan, on 15th July NHSE invited applications for a national programme to enable neighbourhood health development. Described as 'Wave 1', the programme will initially see 42 Places selected to participate. (Its estimated there are in excess +200 Places nationally eligible to apply).

- The NNHIP aims to develop neighbourhood health systems, **initially focused on supporting people with multiple long-term conditions and rising health risks.** The programme priorities include shifting care closer to home, reducing pressure on hospitals, and improving outcomes for people and communities.

- Places accepted onto the programme will receive:- 1) A dedicated national coach; 2) Access to regional learning networks and workshops; 3) Tools, resources, and examples of best practice; 4) A chance to influence future national policy. No funding is awarded to participate in the programme and local systems are expected to facilitate engagement and identify dedicate programme resources.

- Programme application required evidencing the extent of for the following:-
    - *Devolved funding, Place governance and any existing Neighbourhoods arrangements;*
    - *Evidence of risk stratification tools to identify adults with multiple long-term conditions;*
    - *Evidence of data sharing arrangements in place between constituted statutory organisations in Place;*
    - *Evidence of existing examples of integrated working in each Place or Neighbourhood and the impact achieved.*
- An application was submitted by GY&W Place on 7th August and was co-signed by 19 CEO's and Executive officers from N&W NHS provider organisations, LPC, County & local councils, PCN Clinical Directors in GY&W, ICB.

- GY&W Place was the only N&W ICB application

- Outcome of the application process is expected on 8th September

Improving lives **together**

Norfolk and Waveney Integrated Care System

Place Board Updates

Patients and Communities Committee

28 August 2025

North, Norwich & South Norfolk Update

June 2025 – ICS EMT agreed to following recommendations:

- Commit to supporting Norfolk & Suffolk in working towards an agreed and consistent definition, role and implementation of "Place" and "Neighbourhood“, via a clear strategy with shared coordinated outcomes that will support Place to implement the objectives outlined in the NHSE Neighbourhood Health Guidelines 2025.
- Support the establishment of shared **accountability for resourcing, integration and system transformation** at all levels – equitable to the arrangements in Suffolk
- Support the establishment of a system-wide **framework for investing in Place and Neighbourhood Health**, ensuring resources are allocated equitably based on evidenced need to reduce inequalities
- Note that if the impending reform agenda is deliverable, it’s paramount we understand, harness and safeguard the mechanism for ICS partners to work most effectively together as a system, in Places and neighbourhoods.

- In addition, ICS EMT were asked to support:
- The proposed structure of Place – 5 Places across Norfolk & Suffolk
- The role and relationship of Place in relation to Neighbourhoods – A tiered structure around System, Place and Neighbourhoods
- The measures needed to support governance arrangements – Formalised accountability and interfaces defined
- The focus areas that Place and Neighbourhoods offer our local system – The scope

North, Norwich & South Norfolk Update cont/d

- This means that North Norfolk, Norwich and South Norfolk Place Boards have ceased and work is now underway to develop a Central Norfolk partnership Group that begin forming arrangements to undertake more formalised partnership arrangements.

- The NNUH has offered a SRO to support the development phase in Central Norfolk. This provides the opportunity for the partnership formation, appetite and vision to be provider-led in line with the needs of the local population (population health), and offers potential for future governance arrangements that involve PHM insight into more localised decision making. This supports the direction of travel as set out in the NHSE Blue Print for ICBs and Neighbourhood Health, 10 year plan.

- Early engagement has been undertaken with Suffolk Alliance Associate Directors to begin understanding how place-based, partnership arrangements work within the local architecture. This work will need to continue to evolve over the forthcoming months and as the new ICB structure emerges.

- Projects which were being delivered as a result of discussions with Place Boards (North Norfolk, Norwich & South Norfolk) continue. There is a risk that delivery could be impacted by the forthcoming ICB changes but this is something that we will need to undertake as an ICB on a wider scale and is not directly attributed to the change of formation in the Board arrangements

West Update

The Place Board has three priorities, and some of the key activities are set out below:

- **Tackling Health Inequalities**
- This is a shared priority with the King's Lynn and West Norfolk Health and Wellbeing Partnership. The current focus is on the Marmot Review, which is reaching the end of its first year. There have been a series of engagement events, with more planned, to help the Marmot Team produce its interim report, with a focus on starting well: giving every child the best start in life. More details here: https://www.instituteofhealthequity.org/resources-reports/kings-lynn-and-west-norfolk The report recommendations are scheduled to be presented to the ICS Conference in November.
- In addition, the Board has been working on its contribution to reducing *healthcare* inequalities. A key part of this will be adaptation and promotion of Making Every Contact Count training to support frontline workers with putting healthcare inequalities changes into practice. This will be supported by a community of practice to facilitate and sustain working across partners.
- **System Integration**
- This priority aims to bring partners together in relation to common issues and opportunities. Key workstreams include the New QEH Programme, bringing together partners in the development of a business case to maximise the benefits of the new build and adopt new ways of working with community partners.
- This priority also includes activities in relation to neighbourhood health; there is pilot work in the King's Lynn PCN to bring together community and primary care partners in relation to developing trust and communications, and improving ways of working. This is at an early stage, but it is hoped that the learning can be extended across West Norfolk.
- Another programme of activity is in relation to workforce development. A review found that there is scope to improve the work experience offer in West Norfolk, and the Place Board has supported a new project to develop a work experience partnership to develop new entry routes into work experience for health and care roles. This will be procured over the coming months.
- The Board continues to oversee a range of community transformation initiatives spanning support to care homes, palliative care and learning disability health checks support.

West Update cont/d

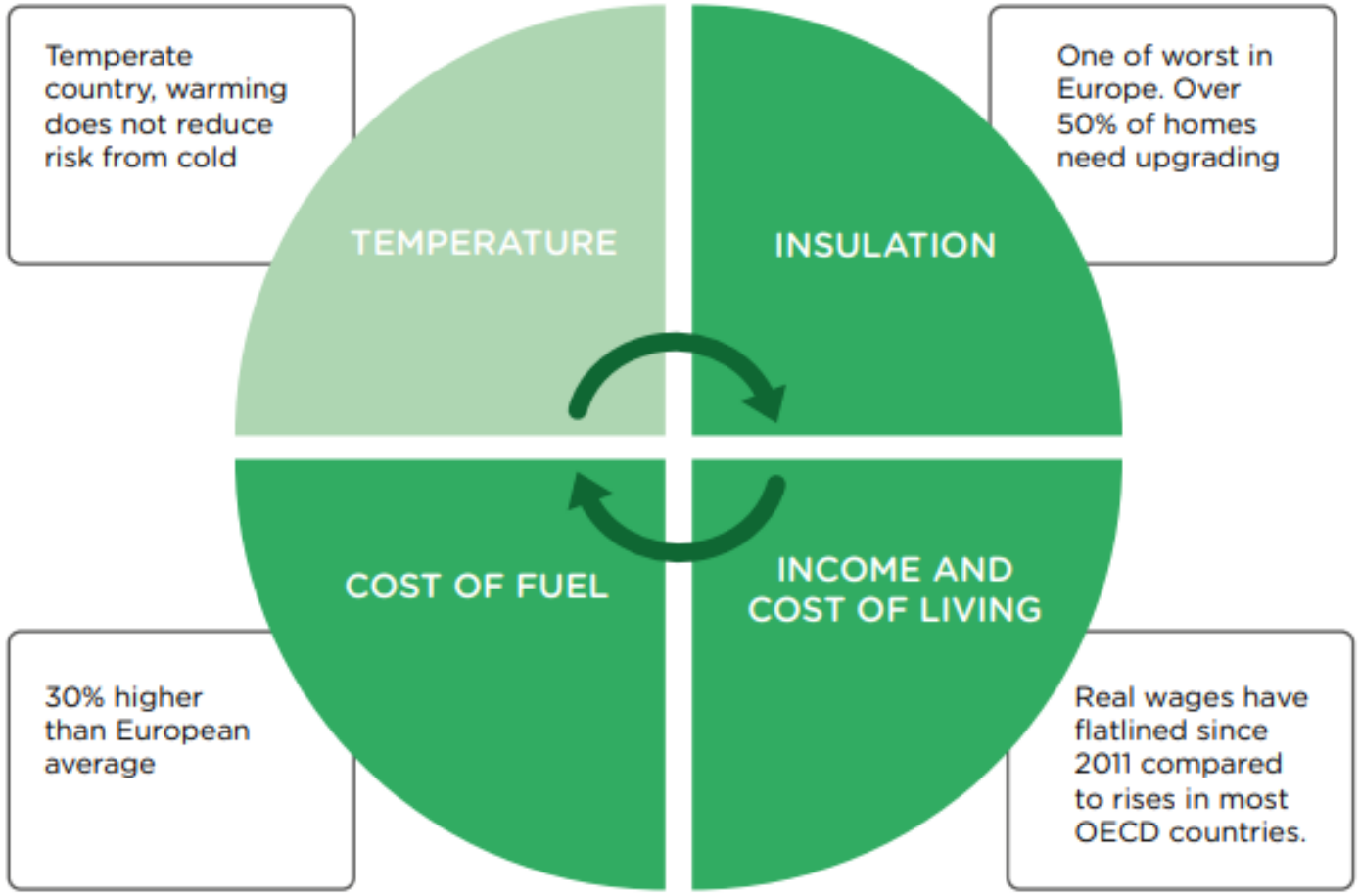
- **Urgent and Emergency Care**
- The Board oversees a falls prevention project which identifies individuals most likely to be at risk of falls, and proactively offering them home adaptations and exercise support, to reduce their risk. This has proven to be really successful, with good uptake and positive feedback from service users.
- The Board works with the West UEC Alliance in relation to a Programme of activities encompassing changes at the Front Door (such as in relation to a new Urgent Treatment Centre), in Hospital changes and Intermediate Care Service changes (for instance in relation to the Virtual Ward service).

Great Yarmouth and Waveney Place Board

Improving lives together
Norfolk and Waveney Integrated Care System

Waveney & West Norfolk Energy Efficiency Projects – *Keeping warm and well*

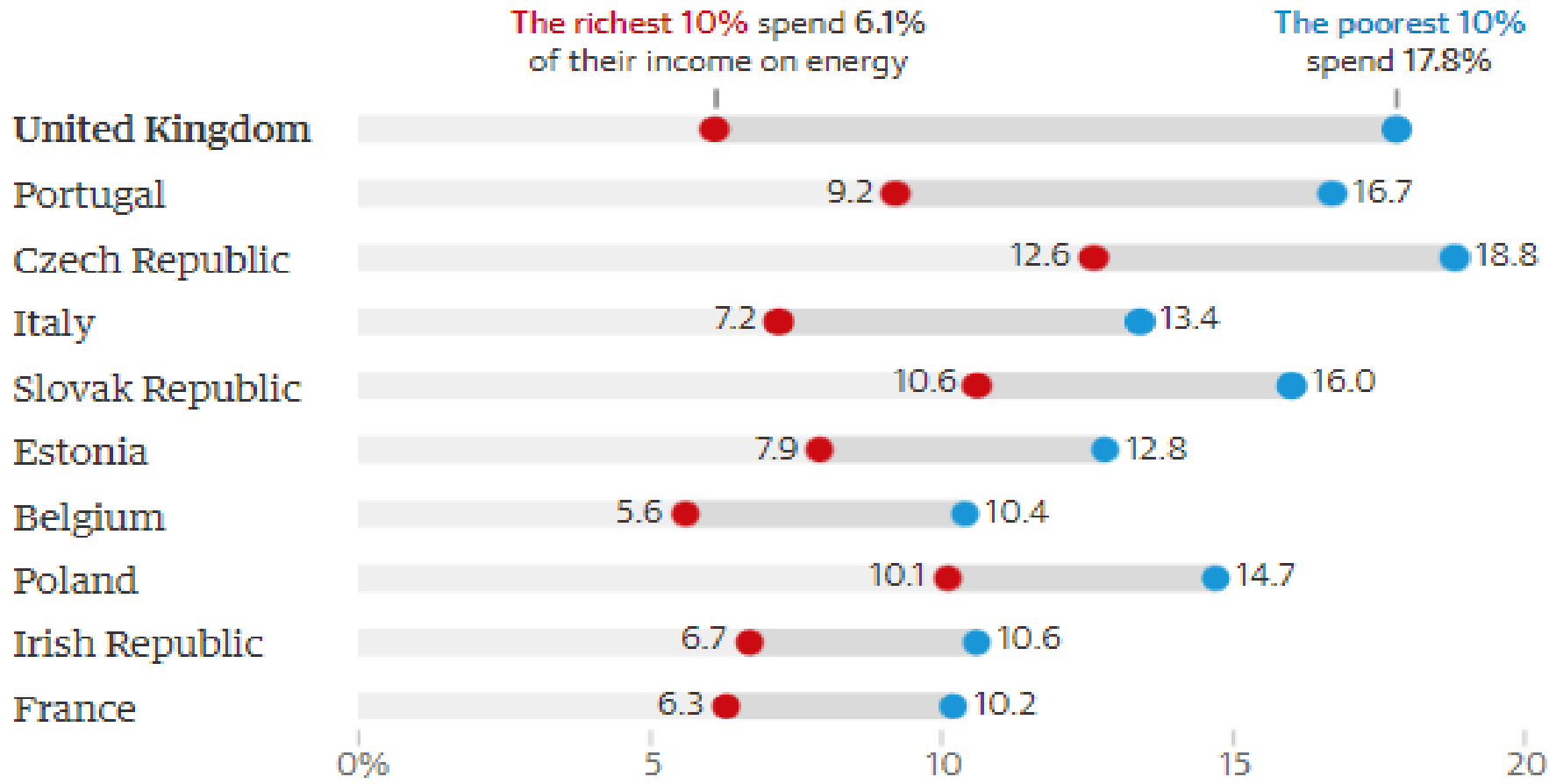
An imperfect storm - causes of cold homes



INSTITUTE of HEALTH EQUITY

The UK has the biggest gap between richest and poorest in energy costs as a proportion of income

Percentage of household budget spent on energy, 2022, top 10 countries

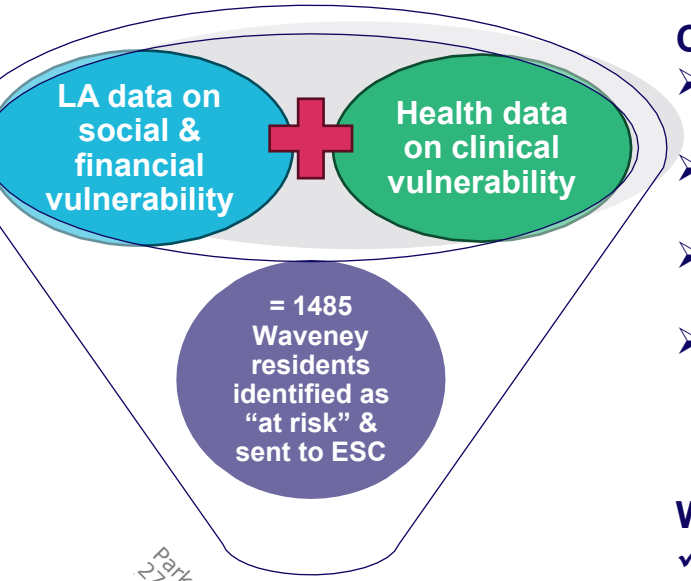


Guardian graphic. Source: IMF

Waveney - Keeping warm and well

* ECO4 & HUG2 government backed grants schemes and administered by local authority partners, such as Warm Homes Healthy People at East Suffolk Council (ESC)

Gt Yarmouth and Waveney (GY&W) Place has developed a data-driven, preventative scheme to support clinically vulnerable Core20 communities in Waveney, 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 population health management approach demonstrates the benefits of linking health and local authority data, to identify specific vulnerable households eligible to receive non-clinical support, which will improve their health.



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 directly with East Suffolk Council, to enable their Housing teams to proactively contact residents and help households to understand their eligibility for grants and wider social and welfare support.

What's next?

- ✓ Evidence the impact of improving home energy efficiency upon health outcomes, alongside social and welfare support.

Impact so far = Dec 24 to June 25

Phase 1 - poorest EPC homes in Kirkley

670 vulnerable residents in 391 households in Kirkley, Lowestoft contacted

200 people responded = 29%. Significantly higher than traditional mailout response rate

72 household (151 total cohort) with need identified. 67 home survey visits completed

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

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.

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 provision. Work underway on the data sharing approach

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?

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, ESC

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

Score	Energy rating	Current
92+	A	
81-91	B	87 B
69-80	C	
55-68	D	
39-54	E	
21-38	F	
1-20	G	

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

Suffolk Healthy Homes

Waveney Health & Wellbeing Partnership

EASTSUFFOLK COUNCIL

Parker Rachael 27/08/2021 13:12:42

Project: Kirkley, Lowestoft

Heath and Housing Support Officer

All Age Carers Strategy Norfolk and Waveney

2024-2029

Carers Voice Norfolk & Waveney

Improving lives together
Norfolk and Waveney Integrated Care System

Norfolk County Council

CONTENTS

FOREWORD

Carolyn Fowler
Director of Nursing and Quality,
Norfolk Community Health and Care NHS Trust.
Executive Sponsor for Carers in the
Integrated Care System

It's with great pleasure that I write the foreword for the All Age Carers Strategy – a vital document that has been co-produced in partnership and collaboration with Carers of all ages, backgrounds, and experience.

We have listened to Carers experiences of different challenges, be it with their own health and wellbeing, their access to education, the impact of inequalities in our population, and how it can often be difficult to be heard. The co-produced 'As a Carer' statements within the strategy come from our Carers and talk about what they need, and how we can best demonstrate that we value what they do.

We will strive to focus on what matters to Carers, recognising that without them we could not care for people in the community as we do. The strategy identifies the importance of the health and wellbeing of carers, only if we look after them can they look after those they care for. The strategy will be implemented systemwide with measurable outcomes to improve support and services for Carers of all ages across Norfolk and Waveney.

PREFACE

Sharon Brooks - Chief Officer, Carers Voice Norfolk and Waveney

Carers Voice Norfolk and Waveney are privileged to have been able to work with Carers to co-produce the first All Age Carers Strategy for Norfolk and Waveney.

The strategy includes Young Carers, Young Adult Carers, Adult Carers and Parent Carers whilst recognising their different support needs. Carers Voice is a well-established charity with a membership of over 2400, working to empower the voices of Carers in the design and delivery of services across Norfolk and Waveney. Carers and co-production are at the heart of the work of Carers Voice (see appendix 6 for examples of co-production).

There is an absolute need for an All Age Carers Strategy now. Carers need our support at all times but, with the aftermath of Covid, the increased cost of living and pressures on our health and care services, Carers are desperately in need of support now so that they can stay well and continue to look after the people they care for should they wish to do so.

Carers across Norfolk and Waveney have given much of their time and shared their lived experience to inform this piece of work. Carers have seen that Carers Voice Norfolk and Waveney commit to improving the health and wellbeing of Carers. We understand that support for Carers has to encompass getting the best and most appropriate care at the right time for those they care for as well as supporting the Carer directly.

Carers are in the unique position of balancing not only the needs of the person they care for but often their own support needs too, enabling them to see how well or not systems support the person they look after and themselves as a Carer.

This strategy has had the continued support of the Norfolk and Waveney Integrated Care Partnership (ICP) and its members who have committed to work with Carers on the focus areas and recommended actions to improve support for Carers so that they and the people they care for live their best possible lives. This strategy aligns with the agreed priorities of the Norfolk and Waveney Integrated Care System strategies including the Norfolk and Waveney Integrated Care Strategy and Norfolk Joint Health and Wellbeing Strategy 2024, the Ageing Well Strategic Framework and Health Inequalities Strategic Framework for Action 2024-2034 (See appendix 1 for further information).

We believe that through this work, change can happen systemwide and we are committed to continue to work and co-produce with Carers to develop and achieve the relevant actions through the Monitoring Group and associated activities.

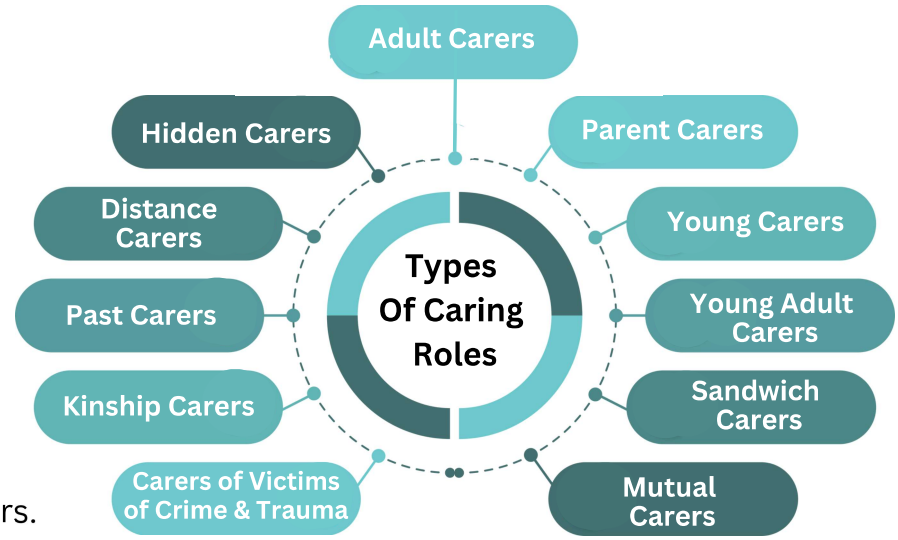
Special thanks are due to all the Carers who have supported the development of the strategy and particularly our Carer Ambassadors.

December 2024

BACKGROUND

Who Is A Carer?

A Carer is anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid. When we refer to carers in this document, this is inclusive of both adult and Young Carers. (NHS England). Information about types of caring roles can be found in Appendix 3.



The National Picture

There are **5.8 million Carers in the UK** according to the most recent Census 2021. This equates to around 9% of the population who are providing unpaid care. However, Carers UK research estimates that the number of people providing unpaid care could be as high as 10.6 million with a further 12,000 people becoming Carers every day. (Carers UK, 2022). Carers Trust (2023) suggest there are 1 million Young Carers, under the age of 18, in the UK. Carers in the United Kingdom are estimated to save the government **£184.3 billion per year or over £500 million per day** which is equivalent to a second NHS (Petrillo, Zhang & Bennett, 2024).

The cost of living crisis has caused increasing pressure on Carers finances. **28%** of Carers have cut back on essentials such as food or heating, whilst **61%** are worried about living costs and managing in the future and **60%** have cut back on seeing family and friends. (Carers UK, 2024)

Over half of Carers said that their financial situation is negatively impacting their mental health (Carers UK, 2024). One in seven people in the workplace are also unpaid Carers. (Carers UK, 2019). Within the NHS, this increases to one in three employees also providing unpaid care. (NHS Staff Survey, 2022).

50,000 children and young people spend at least **50 hours a week** providing care with an estimated two Young Carers in every classroom in the UK.

Without the continued support of Carers, the health and social care services would face further formidable challenges. Supporting Carers enables hundreds of thousands of people to be cared for in their own homes with a reduced pressure on the NHS.

BACKGROUND.....

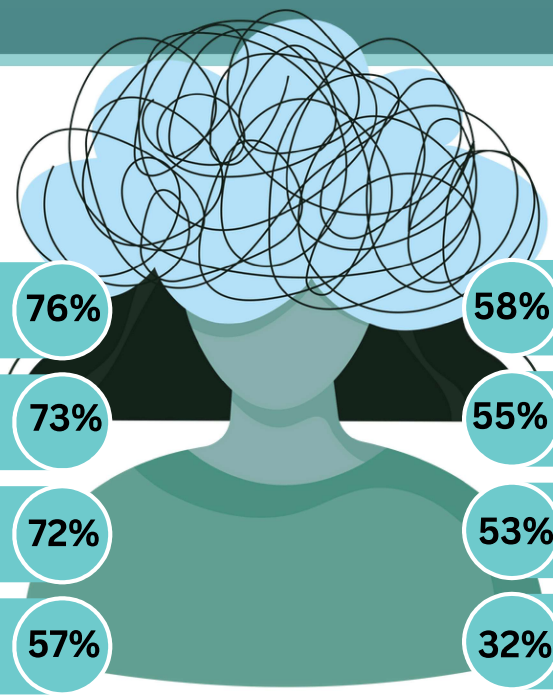
Carers in Norfolk and Waveney

Following the Health and Care Act of 2022, the NHS Integrated Care Board for Norfolk and Waveney has a duty:

- To involve unpaid Carers when decisions are made about changing or developing a service
- To involve unpaid Carers when it comes to decision-making around a patient's care that is provided by commissioned services, such as prevention, treatment, diagnosis and care.

According to the 2021 census, there are approximately 95,000 Carers in the Norfolk and Waveney Integrated Care System with a fifth of these being Young Carers and Young Adult Carers. Many of these Carers are providing over 50 hours of care a week and care for more than one person. Findings from the Carers Voice Co-produced Engagement with All Age Carers in Norfolk and Waveney Report 2022 state that almost half of respondents (47.5%) provide more than 50 hours of care per week. Some of this will result from the number of respondents caring for more than 1 person (25.6%). Nearly 50% of Carers taking part in this survey had not received a Carer's Assessment. A further 20% were unsure if they had received an assessment, meaning that the number of respondents without an assessment could be as high as 70%.

Carers in Norfolk and Waveney reported negative changes to the following aspects of their lives.....



Time For Themselves	76%	58%	Relationships
Mental Health	73%	55%	Finances
Day To Day Life	72%	53%	Employment
Physical Health	57%	32%	Education*

*including separate Young Carers Engagement Survey

CO-PRODUCTION

In September 2022, having co-produced the Carers Engagement Report (go to www.carersvoice.org to read this report in detail), Carers Voice continued to develop and co-produce the All Age Carers Strategy on behalf of the Norfolk and Waveney Integrated Care Partnership.

Building on the evidence base provided by extensive research with Carers, Carers Voice has worked systemwide with partners within Norfolk and Waveney. Throughout this period, the research has been supported by Norfolk County Council and NHS Norfolk and Waveney Integrated Care Board.

Ongoing engagement has been facilitated through various methods to ensure broad participation including:

'AS A CARER'

The 'As a Carer' statements have been co-produced with Carers and are the overarching aims of the Strategy. They are accompanied with 'what would this look like/feel like' points. The following statements formed the basis for the key focus areas and recommended actions for the first stage of delivery.

As A Carer I have rights that will be upheld.

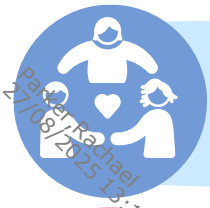
As a Carer I am identified, recognised, valued and respected. I am an equal partner in the care of the person I look after which includes clear communication with me

As a Carer I am made aware of, and have access to, good quality information and services including a single and reliable point of contact.

As a Carer I have access to good and appropriate support for my mental health, physical health and wellbeing.

As a Carer I am an equal partner in the creation, development, monitoring and evaluation of services where my experience is recognised and valued. This will enable Carers, and the people we care for, to receive the services we need and want. This is vital to support our health (including mental health) and wellbeing.

As a Carer I can access education, employment and training.



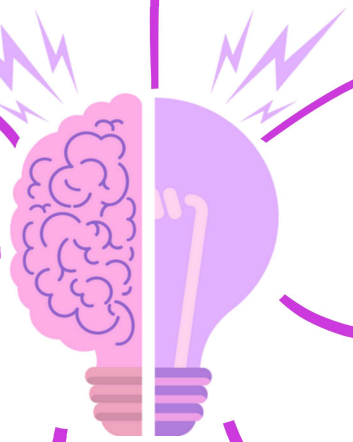
As A Carer I am able to have time for myself/away from my caring role including access to peer support and community groups.

As A Carer I know the person I care for will be safe and have access to a good quality of life if I am no longer able to care on a temporary or permanent basis.

FOCUS AREAS

Focus areas and recommended actions across the Norfolk and Waveney Integrated Care System

We have worked with Carers and practitioners across health and social care to co-produce seven **Focus Areas** for the first stage of the strategy along with their **Recommended Actions**.



Focus Area 1

To identify and raise awareness of all ages of Carers, their rights and their value (including hidden Carers).

Focus Area 2

To improve access to good quality information and services including a single point of contact.

Focus Area 3

To recognise and involve Carers as equal partners in the care of those they look after.

Focus Area 4

To co-produce services with Carers wherever possible, recognising their expertise and ability to influence and shape services that they need and want to support their health and wellbeing.

Focus Area 5

To recognise the importance of peer support and access to services which enable Carers to have a break from their caring role.

Focus Area 6

To have a framework and knowledge of commissioned services for all age Carers.

Focus Area 7

To develop a Carers pathway

Focus Area 1

To identify and raise awareness of all ages of Carers, their rights and their value (including hidden Carers).

Recommended Actions

- Recognise and promote the Carers Identity Passport.
- Organisations, including all educational settings, to have or be working towards local and national Carers accreditation.
- Carer Awareness Training (including information on Carers Rights) to be embedded in staff induction and regular training in all organisations including educational settings.
- Awareness of Carers Rights within mental health services.
- Participate in annual Carers Conference.
- Recognise national Carers weeks/days including Carers Week, Carers Rights Day and Young Carers Action Day.
- Identify and build support for Carers in community settings.
- Promote Carers Leave legislation and the right to discuss flexible working options.
- Work with Carers UK- Employers for Carers.
- Support the employment of Carers in the recruitment and selection process, recognising Carers transferrable skills and experience.
- Have in place or be working towards a Carers Policy, which details Carers Rights and support available within the organisation.
- Norfolk and Waveney Integrated Care System Carers Page to include
- information on Carers Rights
  Carers Rights to be included in the All
- Age Carers Handbook.
  Promote a whole family approach to identification and support. Awareness of supporting parents with disabilities and identification of Young Carers not in school.

Focus Area 2

To improve access to good quality information and services including a single point of contact.

Recommended Actions

- Resources in different formats that are accessible to everyone (large print, easy read, screen reader accessible, translated).
- All communication to be in language that is familiar, precise and appropriate i.e. no use of acronyms.
- Ensure access to information and resources are available for those who do not have digital access.
- Identify a single, named and ongoing point of contact for Carers. For example, a Carers Lead identified within each educational setting.
- Emergency planning to be available to Carers of all ages including Young Carers and Parent Carers.
- Promote Norfolk County Council Carer Safeguarding toolkit. Inclusion of safeguarding information in the All Age Carers Handbook.
- Promote the 'Making Every Contact Counts' approach across statutory and Voluntary Community and Social Enterprise (VCSE) services, recognising that caring roles change.
- Promote the NHS 'Think Carer' principle across statutory and Voluntary Community and Social Enterprise (VCSE) services.
- Agree to contribute to the All Age Carers Handbook as appropriate.
- Promote Carers Assessments and the commissioned support services for Carers of all ages.
- Improved information for Carers of self funders.

Focus Area 3

To recognise and involve Carers as equal partners in the care of those they care for.

Recommended Actions

- Ensure Advocacy Services include support for Carers.
- Develop a guide to involve Carers of all ages, recognising the additional complexities of identifying and including Young Carers.
- Ensure record of support Carers provide is captured - long term support planning record.
- To give realistic and clear information so Carers can make informed decisions.

Focus Area 4

To co-produce services with Carers wherever possible, recognising their expertise and ability to influence and shape services that they need and want to support their health and wellbeing.

Recommended Actions

- Agree to a standardised protocol for co-production ensuring Carers of all ages have an equal voice.
- Carers Lead identified within organisations, including all educational settings, who champions co-production with Carers and has capacity to drive appropriate change.
- Involve Carers in service creation, development, monitoring and evaluation, recognising the impact on Carers when the support for the person they care for does not meet their needs.
- Staff completing co-production training i.e. 'Making it Real training'.
- NHS Norfolk and Waveney Integrated Care Board to safeguard Executive Sponsor for Carers position within the Norfolk and Waveney Integrated Care System (Currently Director of Nursing and Quality, Norfolk Community Health and Care NHS Trust).

Focus Area 5

Recognise the importance of peer support and access to services which enable Carers to have a break from their caring role.

Recommended Actions

- Clarity on eligibility from Social Services and commissioned services around breaks and respite offer for Carers for all ages.
- Recognise the importance of Carers Groups and maintaining an updated record.
- Support available digitally for Carers who cannot access support in the community due to availability of transport, alternative care or shielding.
- Recognise the rurality of Norfolk and Waveney and the need for viable options of transport when commissioning services.
- Support available to groups to help them continue.

Focus Area 6

To have a framework and knowledge of commissioned services for all age Carers.

Recommended Actions

- Identify interventions available and how these are accessed through the commissioned services.
- Commissioning organisations in the Norfolk and Waveney Integrated Care System to ensure Carers are involved in the commissioning process and ongoing when services have been commissioned.
- All services being commissioned for Carers to be presented to All Age Carers Strategy Monitoring Group to allow for continuity of service join up and avoiding duplication.
- The local authorities and the NHS Norfolk and Waveney Integrated Care Board commit to adopting "No Wrong Doors for Young Carers". Go to carers.org to view the No Wrong Doors for Young Carers Memorandum of Understanding.
- Research bodies to work with Carers at an early stage to design projects that are meaningful to Carers and the people they care for.

Focus Area 7

Develop a Carers pathway.

Recommended Actions

- Develop and increase identification of clear pathways to support Carers of different ages and stages of caring.
- Pathway of service commissioning.
- Promote transition needs for Young Carers moving schools and moving into adulthood.
- Promote positive transitions for Parent Carers between services.
- Promote commissioned services in Norfolk and Waveney as a one stop shop for Carers of all ages.
- Explore commissioned support for Kinship Carers.
- Encourage Carers to have a Carers Assessment to inform them of the support that they are entitled to.
- Encourage Care Act assessments and reviews to enable a discussion and recording of a person's needs and the provision available when a Carer is no longer able to care.
- Develop and promote a systemwide process to capture the support a Carer provides and the support needed if they are not able to care on a temporary or permanent basis - long term care planning.

MONITORING & REVIEW

It is important that the strategy will be a living document and is adaptable.

Has the Strategy raised awareness?

Has the Strategy improved services?

Has the Strategy given rise to new ideas and projects

Based on the difference made to Carers, services, funders and commissioners.

Your VOICE MATTERS

Ongoing intelligence will be gained through engagement with all age Carers across Norfolk and Waveney via established groups, boards, forums and organisations.

All Age Carers Strategy Monitoring Group

- The Monitoring Group will meet annually with sub groups set up where necessary
- Annual Conference to be held sharing updates and successes
- Creation of Monitoring form and annual survey
- Representation from Adult Carers, Parent Carers, Young Carers, Services & Organisations, Funders & Commissioners
- Overall accountability and responsibility for the Action Plan
- Strategy outcomes reviewed
- Agreement on data to be collected to determine what success will look like
- Assurance that the actions are accountable

CONCLUSION

It is essential that support for Carers of all ages is addressed effectively and prioritised. They are the hidden backbone of society often referring to themselves as 'propping up' the health and social care system. By ensuring effective support for Carers across Norfolk and Waveney, we will not only empower Carers to live their best possible lives but also enhance the quality of care for the people they care for.

We have the opportunity to work together to create a sustainable future where Carers are respected and supported as invaluable contributors to society.

> Without the high level of care that unpaid Carers provide, our health and care systems would quite simply collapse - Helen Walker, Chief Executive, Carers UK.

On 4th December 2024 the Norfolk and Waveney Integrated Care Partnership agreed to.....

- Endorse and promote the All Age Carers Strategy for Norfolk and Waveney 2024 - 2029
- Commit to supporting the All Age Carers Strategy for Norfolk and Waveney by sending representatives to be part of the Monitoring Group as appropriate
- Ensure all partners commit to developing **action plans** based on the Focus Areas and Recommended Actions within the Strategy document.

The Norfolk and Waveney Integrated Care Partnership agreed to work in the following ways.....

- Promote and include the work of the All Age Carers Strategy systemwide through the Norfolk and Waveney Integrated Care System Strategies and Frameworks
- Review the commitment to Carers through the Strategy at regular intervals
- Commit to co-production within their organisations wherever possible
- Ensure Carers are treated as equal partners in the design, development and delivery of services that support Carers and those they care for.

APPENDIX

Appendix 1: Organisations Engaged

Access Community Trust, Active Norfolk, Age UK Norfolk and Norwich, Ageing Well, Anglia Ruskin University, ARC East of England (Applied Research Collaboration), Carer Research Network, ASD Helping Hands (Autism Spectrum Disorder), Bridges Outcomes Partnerships, Bridges Plus, Carers Charter, Carers Matter Norfolk, Carers UK, Carers Voice Members (approx. 2400), Carers Voice social media, Caring Together, Chief Nurses Norfolk and Waveney, Community Action Norfolk, Deaf Connexions, DIAL (Disability Information and Advice Line), EACH (East Anglia's Children's Hospices), East Coast Medical Healthcare, East of England Ambulance Service, East Suffolk Council, Equal Lives, Family Voice Norfolk, Great Yarmouth and Gorleston Young Carers, Headway Norfolk and Waveney, Health and Wellbeing Partnership Chairs (Breckland, Broadland, Great Yarmouth, Kings Lynn and West Norfolk, North Norfolk, South Norfolk, Norwich and Waveney), Healthwatch Norfolk, Healthwatch Suffolk, Independence Matters, James Paget University Hospitals NHS Foundation Trust, Later Life Partnership Network, Lowestoft Rising, Making it Real, MAP (Mancroft Advice Project), Mind, MND Association (Motor Neurone Disease), NCAN (Norfolk Community Advice Network), Norfolk and Waveney Dementia Support Service, NHS Norfolk and Waveney Integrated Care Board (Ageing Well Programme Board, Dementia Working Group, Children and Young People - Quality in Care, Patient Experience, Care Homes and Housing, Health Inequalities), Norfolk and Norwich University Hospitals NHS Foundation Trust, Norfolk and Suffolk Care Support, Norfolk and Suffolk Foundation Trust, Norfolk Autism Partnership Board, Norfolk Community Health and Care NHS Trust, Norfolk Community Law Service, Norfolk County Council Adult Social Care/Childrens Services, Norfolk County Council Care Provider Network, Norfolk County Council Development Workers networks, Norfolk Hospices, Norfolk Local Pharmaceutical Committee, Norfolk Learning Disability Partnership Board, Norfolk Older People's Strategic Partnership, Norfolk Primary Care, Norfolk Safeguarding Adults Board, Norfolk Young Carers Forum, Norfolk's All Age Autism Strategy 2024-2029, North Norfolk Dementia Working Group and Ageing Well Programme Board, Opening Doors, Patient Experience Network Norfolk and Waveney, Patient Experience - NHS England, Place Board Chairs (Great Yarmouth and Waveney, North Norfolk, Norwich, South and West), Police and Crime Commissioner for Norfolk, Police and Crime Commissioner Suffolk, Priscilla Bacon Hospice, Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust, Restitute, St Elizabeth Hospice, Suffolk County Council, Suffolk Family Carers, Suffolk Parent Carer Forum, Suffolk Safeguarding Partnership, Tapping House, University of East Anglia, Voluntary Norfolk, West Norfolk Deaf Association, West Norfolk Carers, Young Carers Matter Norfolk, Young Carers Norfolk Steering Group.

APPENDIX

Appendix 2: Norfolk and Waveney Integrated Care System Strategies

The All Age Carers Strategy aligns with the agreed priorities of the Norfolk and Waveney Integrated Care Strategy and Norfolk Joint Health and Wellbeing Strategy 2024 of Driving integration; Prioritising Prevention; Addressing Inequalities and Enabling Resilient Communities to enable systemwide support for the people of Norfolk and Waveney to live longer, healthier and happier lives. Go to improvinglivesnw.org.uk to read the Norfolk and Waveney Integrated Care Strategy and Norfolk Joint Health and Wellbeing Strategy 2024.

The work of the All Age Carers Strategy is key to the success of the ninth priority of supporting the needs of families and Carers in the Ageing Well Strategic Framework of the Norfolk and Waveney Integrated Care System which underpins the nine strategic goals of the framework. Go to improvinglivesnw.org.uk to read the Ageing Well Strategic Framework in detail.

Supporting Carers and the people they care for enables greater understanding of the experiences of living with health inequalities and what factors influence outcomes. This strategy supports the work of the Norfolk and Waveney Health Inequalities Strategic Framework for Action 2024 – 2034, in particular Young Carers who are identified as one of the Core20plus groups. Go to improvinglivesnw.org.uk to read the Norfolk and Waveney Health Inequalities Strategic Framework

Appendix 3: Types of Caring Roles

Working Carers

I support my Mum who has dementia. I support with all household tasks, shopping, collecting medication, arranging appointments etc. She lives on her own at the moment, but I am worried about the future as she is forgetting more and more. I also work full time so having to juggle everything is really hard. I feel guilty when I have to leave but I don't have any time for myself and I am exhausted. We have talked about getting care staff in but Mum doesn't want 'strangers' in the house. So, for now, it's just me.

Mutual Carers

I have been looking after my wife for over 20 years who has bipolar but only realised I was a Carer when someone said to me I was. When she is experiencing a low mood, I have to encourage her to get up from bed, make sure she is eating enough and encourage her to go outside as I know this helps her feel better. My wife is now supporting me as my physical health has deteriorated. We look after each other, this is part of our marriage vows.

Distance Carers

I live in Coventry which is over 3 hours away from my sister. I provide a lot of emotional support and reassurance over the phone and visit as much as possible. I coordinate all care and support over the phone. She is fortunate to have a good friend who lives nearby that takes her to appointments.

Parent Carers

I look after my son who is autistic. I provide emotional support, admin support with all bills and documents, help booking and attending appointments, prompting to take medication etc. I am so worried about how he is going to cope when I am not here.

Young Adult Carers

I help my parents look after my younger sister. I have recently learnt how to drive, and I take my sibling on drives around the block to help calm her. I am planning on going to university next year but am worried about how she will cope.

Carers of Victim of Crime and Trauma

I am a Carer for my child who is a victim of online grooming and sexual assault. I provide ongoing emotional support and help with everyday life. It is really difficult for me to talk to people about this. We are a group of Carers that are not always recognised.

Young Adult Carers

I help my mummy and daddy look after my brother who is autistic. He doesn't like loud noises and can get really upset.

Adult Carers

I have found myself in a situation where I am caring for someone I have no emotional attachment to.

Changing Caring Role

I have been looking after my wife for over 15 years but she has gradually needed more care and moved into a care home at the start of the year.

Kinship Carers

I am an adult looking after my younger sibling who is a child. It is difficult for me to access support as I don't fit in a box.

Parent Carers

I am a Carer of a child with SEND. I also have a disability myself.

Past Carers

I was looking after my partner for over 10 years. Once a Carer, always a Carer.

Hidden Carers

‘People who do not realise they have a caring role’.

I am just a: Parent, Spouse, Partner, Child, Sibling, Relative, Friend, Neighbour.

People do not always want the label. Cultural expectations differ.

Sandwich Carers

‘Carers with responsibilities for different generations, for example both children and parents’.
I am looking after my child who has SEND and my dad who has dementia. My dad has paid carers coming in three times a day to support with personal care and making sure he has a meal. They often only have time to give him a microwave meal so I try and cook him a home cooked meal once a week. Me and my siblings go round when we can to sit and chat with him, so he’s not lonely. This year my child is 18 and I am worried about moving from Children to Adult Services.

Appendix 4: Example roles shared by Carers in the Engagement Report

Appendix 5: Co-produced 'As a Carer' statements with accompanying 'what would this look like/ feel like' points

1. **As a Carer, I have rights that will be upheld.**

What would this look/feel like:

- All Age Carers are provided with access to information and training about their rights and support with getting these.
- Training on Carers Rights (for all age Carers) and support available is included in staff induction and regular training.

1.a **Information about Carers Rights.**

Care Act 2014 and Children and Families Act 2014

Adults caring for other adults

Under the Care Act, you are entitled to a Carer's Assessment where you appear to have needs for support. The person you care for is entitled to a 'needs assessment' if they appear to have needs for care and support.

Young Carers and Parent Carers

The Children and Families Act 2014 gives Young Carers and Parent Carers in England a right to an assessment of their own needs. Young Carers are equally entitled to have a Carers Assessment. There are different types of assessments for Young Carers depending on how old they are; Young Carer's assessment for Carers under 18 and the Transition assessment for Young Carers before they are 18 (Care Act 2014). Parent Carers are also entitled to have a Parent Carer Needs Assessment.

Equality Act 2010

The Equality Act 2010 was introduced to stop discrimination and promote equality. The Act could help you if you care for someone who is elderly or disabled. It could protect you against direct discrimination or harassment because of your caring responsibilities. This is because you are counted as being 'associated' with someone who is protected by the law because of their age or disability. If you're treated less favourably than someone else because you're caring for an elderly or disabled person, it is called 'Discrimination by Association'.

The Health and Care Act 2022

This legislation reinforces Carers' rights when it comes to hospital discharge. If someone is likely to need ongoing care and support after they leave hospital, NHS trusts and foundation trusts have a duty, where appropriate, to involve patients and Carers (including Young Carers) at the earliest opportunity in decisions and plans around their ongoing care needs.

Flexible Working Act 2023

If you are juggling work with your caring responsibilities, you have the right to request flexible working. The introduction of the new Employment Relations (Flexible Working) Act means that anyone, including unpaid carers, can ask their employer for changes to their working hours, times of work, or place of work, from day one. They will also be able to change their flexible working arrangement more than once a year, which will be a huge help too.

Carers Leave Act 2023

The Carer's Leave Act came into effect on the 6 April 2024. Employees are entitled to one week's unpaid leave per year if providing or arranging care for someone with a long-term care need. This leave can be taken flexibly (in half or full days) for planned and foreseen caring commitments. It is available from the first day of employment. It provides the same employment protections to employees as other forms of family-related leave, including protection from dismissal.

The right to ask your GP practice to identify you as Carer

People providing unpaid care can ask their GP practice to identify them as a Carer on their patient record. The benefit of this is that they may then fall into a priority group for vaccines or other public health campaigns.

2. As a Carer, I am identified, recognised, valued and respected. I am an equal partner in the care of the person I look after which includes clear communication with me.

What would this look/feel like:

- Carers are identified and recognised (including Young Carers, Parent Carers and Carers of victims of crime and trauma) as a key partner across health and social care.
- Professional practice and processes are developed across the Norfolk and Waveney Integrated Care System for raising awareness of Carers of all ages (and the wider family) and the All Age Carers Strategy for Norfolk and Waveney.
- A whole family approach to identification and support will be promoted across health and social care.
- The knowledge and experience of Carers of all ages is valued and they are supported and included in plans of those they care for at the earliest possible stage.
- Language is used that is recognised (are you looking after someone?).
- Language needs to be inclusive and understood by Carers of all ages and those who do not recognise themselves as a Carer.
- Increased communication and data between health and care services so Carers only have to tell their story once.
- Awareness and support for Carers of all ages in community settings.
- Carers are an equal part of the team in the triangle of care (partnership between practitioners, the person being cared for, and their Carers).

3. As a Carer, I am aware of and have access to good quality services including a single and consistent point of contact.

What would this look/feel like:

- Carers of all ages can easily access information (available in different formats and languages), advice, guidance and good quality support when and how they need it, early in their caring role.
- Improved communication between services and departments with consistent messages.
- Carers of all ages have equal and appropriate access (no wrong door). There is a clear route to access support.
- Positive transitions for Young Carers and Parent Carers between services.
- The need for human contact is recognised.
- Improved navigation of services including identifying and maintaining a single point of contact.
- Information about pathways for specific conditions.
- Awareness of the need for more recognition of all age Carers amongst community and wider advice services i.e. employment support.
- GP surgeries, hospitals and educational settings recognised as often the first point of contact.
- Recognise how community infrastructure can support Carers of all ages.
- Self-funders have access to information and support in their caring role.

4. As a Carer, I have access to good and appropriate support with my mental health, physical health and wellbeing.

What would this look/feel like:

- Access to support is available for all age Carers which is flexible and personalised.
- Recognise the impact caring can have on a person's mental health, physical health and wellbeing. If support is not appropriate and timely for the person being cared for, this may contribute to Carer breakdown and/or crisis and negatively affect their finances.
- Staff have a working knowledge about the support available to Carers and are able to signpost and refer. Making every contact count.
- Regular contact/ check ins with Carers to touch base and check they are receiving the support they need.
- Mental health is everyone's responsibility.
- Always check that Carers are willing and able to continue in their caring role
- Support for all age Carers to access flexible appointments.
- All age Carers have access to a break from their caring role to have time to focus on their own health and wellbeing.

- Identify the importance of peer support, companionship, listening ear and time for themselves. Support all age Carers to improve connections to reduce social isolation.
- Coordinated support for Carers of all ages and people they care for. Services need to be person centred to enable people to live their best lives possible.
- Packages of care and support are appropriate at the outset and flexible to reflect change. Safeguards in place to avoid delays and inappropriate levels of support.
- Consistent support including when a caring role changes or ends.
- Young Carers have the same opportunity to achieve their aspirations (recognising the Norfolk County Council Flourish Ambition in Norfolk).

5. **As a Carer, I am an equal partner in the creation, development, monitoring and evaluation of services where my experience is recognised and valued. This will enable Carers and the people we care for to receive the services we need and want. This is vital to support our health (including mental health and wellbeing).**

What would this look/feel like:

- Carers of all ages are included in the design and delivery of services from the start and through to ongoing decision making.
- Carers of all ages receive the support they need to be involved in decisions for the person they Care for and for themselves.
- Organisations across the Norfolk and Waveney Integrated Care System work together and pool knowledge to share expertise. Consultations are not repeated.

6 **As a Carer, I can access education, employment and training**

What would this look/feel like:

- Early identification of Carers of all ages in educational and workplace settings.
- Allow for flexible arrangements to be made to support Carers of all ages with education, employment and training. A Carers Lead/ Carers policy is identified within educational and workplace settings.
- Recognising and creating opportunities for employment, training and volunteering.
- Support for all age Carers and organisations to recognise Carers' transferable skills and experience.
- Carers of all ages have access to employment, financial and benefit advice and support.
- Training for Carers on their rights to enable and empower them to carry out their caring role.

7. **As a Carer, I am able to have time for myself/ away from my caring role including access to peer support and community groups.**

What would this look/feel like:

- Availability of and access to services so Carers of all ages can have a break and time to focus on their own health and wellbeing. This is flexible to meet the needs of the Carer and the people they care for.
- Carers of all ages can access peer support within the community.
- Support and encourage Carers to access a Carers Assessment and the people they care for to have a needs assessment.
- Awareness and links with support in the community.

8. **As a Carer, I know the person I care for will be safe and have access to a good quality of life if I am no longer able to care on a temporary or permanent basis.**

What would this look/feel like:

- A clear process is in place for long term care planning and this is linked systemwide to allow for multi-agency support.
- Planning is person centred.
- Recognition of complex needs and range/depth of support required in planning for the future.
- Recognising the continued role of all age Carers when the person they care for is in an alternative place of care.
- Early identification of requirements.
- Awareness of emergency planning.
- Emergency planning to be available to Carers of all ages including Young Carers and Parent Carers.
- Carers of all ages and people being cared for have access to an advocate.

Appendix 6: Examples of achievements since co-produced Engagement Report - Carers Identity Passport

Carers Identity Passport for Norfolk and Waveney

The Carers Identity Passport has been co-produced with Carers and practitioners across the Norfolk and Waveney Integrated Care System to ensure Carers are identified and recognised within healthcare settings. It is for all age Carers, including Young Carers and Parent Carers, in Norfolk and Waveney. It is available both physically as a card and a lanyard and digitally as an image Carers can save onto their phones.

Apply Now!

The Carers Identity Passport is free for Carers to request. Carers can apply for a Carers Identity Passport by completing a short form available at: https://www.carersvoice.org/carers-identitypassport/

The Carers Identity Passport is aimed to be a conversation starter to ensure Carers are:

- **recognised**
- **respected**
- **valued**
- **included in the care of the person they are looking after**

> I wear the Carers Identity Passport wherever I go with the person I care for, it helps to show I am a Carer... it has been recognised without question, which makes me feel empowered as an unpaid Carer.

Appendix 6: Examples of achievements since co-produced Engagement Report - Carers Discharge Project

Carers Discharge Project

A multi-agency discharge group was set up following feedback received from Carers about the discharge process. This work is being co-chaired by a Carers Voice Carers Ambassador, Graham Goodwin and the Executive Sponsor for Carers within the Norfolk and Waveney Integrated Care System (currently Director of Nursing and Quality, Norfolk Community Health and Care NHS Trust). The Health and Care Act 2022 places a duty on NHS Trusts and Foundation Trusts to involve Carers, where appropriate, in planning for hospital discharge as soon as is feasible.

Sessions were held to provide a platform for Carers to articulate their experiences, address concerns and explore factors that could improve the discharge experience for Carers.

Providers shared their existing work to support Carers in the discharge process, highlighting both successful practices and areas needing improvement.

The work has culminated in the co-production of a booklet for Carers to use when the person they care for is admitted to hospital through to when they are discharged and beyond. The goal is to generate tangible improvements for Carers, enhancing their overall experience with discharge. The booklet will contain sections covering:

- Supporting the person you are caring for during their hospital stay
- Support for Carers
- Preparing for discharge
- Checklist

The Discharge Booklet will be piloted in the Queen Elizabeth Hospital in Kings Lynn and Norfolk Community Health and Care NHS Trust in West Norfolk (Swaffham Community Hospital).

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Norfolk and Waveney
Integrated Care Board

Agenda item: 11

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:	**28th August 2025**

Purpose of paper:

Provide an update on the VCSE Assembly.

Executive Summary:

This report highlights some potential changes within the VCSE Assembly as well as push forward to engage with the wider sector. It also highlights some key work across the system to help support integration and involvement of the sector in key ICS workstreams.
Key points are:

- A new monthly newsletter has been established to communicate key messages to the VCSE sector.
- The first VCSE Assembly webinar is scheduled for October to engage with partners on key workstreams.
- Productive meetings have taken place with our Suffolk counterparts ahead of the ICB merger.
- A paper has been submitted to streamline the board's membership and potentially include the Suffolk VCSE Assembly Chair.
- An action plan has been published, outlining five key areas to support the sector's resilience and capacity.
- The Assembly has been involved in key initiatives, including the West Norfolk Marmot Place work and the Get Norfolk Working Plan.
- Advocacy led to the creation of a remunerated VCSE representative role on the Marmot Place steering group.
- The Assembly is supporting the National Neighbourhood Health Implementation Programme in Great Yarmouth and Waveney.

Report

One of the VCSE Assembly's core ambitions has always been to engage with the diverse voluntary, community, and social enterprise (VCSE) sector. To this end, we have focused on providing clear and consistent communication across the region for all organisations.

A monthly VCSE Assembly newsletter has been launched to provide key messages from the wider system and highlight opportunities for engagement and involvement in key workstreams. This serves as a vital channel for the Integrated Care System (ICS) to share important information. The newsletter is published on the VCSE Assembly webpage, emailed to a newly developed membership list, and distributed through key sector networks, reaching over 500 organisations. We are continuing to work with colleagues to expand the reach and membership of the Assembly.

In addition, the first VCSE Assembly webinar is scheduled for October. This will bring together the sector to engage with ICS partners on key workstreams and updates. While the agenda is being finalised, we are hopeful that Ed Garrett will provide an update. We are also in discussions with the Acute Hospital Group Chair and Adult Social Care leaders, and the potential for a session on the new Social Impact Procurement Framework to be part of the October session. We plan to hold these webinars every two months. This engagement model has been successful for other VCSE Assemblies, including those in Suffolk and North East Essex (SNEE) and Cambridge and Peterborough.

Given the ongoing changes within the Integrated Care Board (ICB) and the planned merger leading to a Norfolk and Suffolk ICB, we have held several productive meetings with our SNEE counterparts. This has allowed us to share best practice and align key messages as we transition towards a shared leadership team within the ICB. While we do not intend to merge the VCSE Assemblies at this time, we are being pragmatic about how a shared ICB might shape our models in the future. We are building a strong and mutually beneficial relationship.

A paper has been submitted regarding a new structure for the VCSE Assembly, which would result in a more streamlined membership for the VCSE Assembly Board. A key proposal within the paper is to include the Chair of the SNEE VCSE Assembly on our board to facilitate greater integration and shared understanding of risks and concerns across the region, reflecting the new ICB structure. This will provide clear direction and help us deliver on our action plan.

To ensure the voices of VCSE leaders are not lost, we are proposing the creation of a Steering Group composed of current board members. This group of eight VCSE leads will meet monthly to drive key agenda items and amplify the sector's voice. We are also keen to use this opportunity to diversify the steering group by bringing in new members from across the sector. These monthly meetings are scheduled to begin in September 2025.

An action plan has been published that aligns with our risk register and serves as a mitigation plan for identified risks. It outlines five key areas of work to build resilience, enhance capacity, and foster a greater understanding of the VCSE sector's work and impact:

- Commissioning & Procurement

- Knowledge and awareness of the VCSE sector
- Data Sharing and Embedding VCSE data for decision-making
- Engagement mechanisms for key workstreams and innovation
- Clear communication with the VCSE sector

In my role as Chair, I have been part of the West Norfolk Marmot Place advisory group. I successfully advocated for a local VCSE representative to be appointed to the steering group. I am pleased to report that a remunerated recruitment is underway for this crucial role, which will help shape this important work and champion the local community.

The VCSE Assembly has been actively involved in the Get Norfolk Working Plan. I have sat on the advisory group and facilitated engagement with the sector, including an event in June that was attended by approximately 50 organisations. Further sessions are planned for September to ensure the VCSE sector's voice is at the heart of this initiative, working alongside the Department for Work and Pensions (DWP), Local Authority, ICB, and business colleagues.

I was also pleased to be involved in the National Neighbourhood Health Implementation Programme, supporting the application for a pilot in Great Yarmouth and Waveney. As part of this, I am working with a VCSE-led network in Great Yarmouth to facilitate a session in October on how the sector can be effective within this work. We plan to invite colleagues from across the system to speak with the sector once dates are confirmed.

Recommendation to the Committee:

- Acknowledge the action plan
- Raise awareness of the VCSE engagement mechanisms across the ICB and ICS, encouraging colleagues to utilise to engage with the sector

Norfolk and Waveney
Integrated Care Board

Agenda item: 12

Subject:	Update on the work of the Norfolk and Waveney Ageing Well Programme
Presented by:	Dr Frankie Swords, Executive Medical Director
Prepared by:	William Lee, Clinical Programme Manager
Submitted to:	N&W ICB Patients and Communities Committee
Date:	28th August 2025

Purpose of paper:

To provide an update to the Patients and Communities Committee on the work of the Norfolk and Waveney Ageing Well Programme.

Executive Summary:

This report provides a high-level overview of significant progress and key achievements across the four core workstreams of the Norfolk and Waveney (N&W) Ageing Well Programme. The Programme continues to demonstrate tangible benefits through collaborative, system-wide initiatives focused on frailty, prevention, care home support, and dementia.

Report

Workstream Update: Frailty Attuned Care

Workstream objectives: *"1. Undertake a survey of frailty services and assessment tools across the three Trusts. 2. Agree upon a system wide definition of Frailty and single assessment tool. 3. Lead on frailty attuned acute care."*

The current focus of this workstream is to agree and implement a standardised frailty screening tool for use across the ICS. This aims to improve recognition of people with frailty. By ensuring that people with frailty are identified and coded in the same way wherever they receive care across our system, this will enable proactive targeted support to be put in place.

Progress Update:

- **Rockwood Clinical Frailty Scale**: Following the adoption across acute wide, we have received data which supports Rockwood. NNUH has shown that since adoption it has resulted in a 17.5% reduction in falls with an associated cost saving of £515,000 and crucially 166 less patients harmed through avoidable falls, this has also contributed to shorter hospital stays (average length of stay down from 9.7 to 8.2 days). Our goal within this workstream is to expand to community & primary care.

- **Frailty & Falls Audit**: The Ageing Well team have improved their links with Place, we have conducted a Frailty and Falls Audit which involved Place teams inputting their work that fits under the Ageing Well strategy. It has allowed a better oversight of projects on-going and enabled shared learning and best practice to be shared. This was presented on July's Ageing Well Programme board and will be continually monitored and updated monthly.
- **Falls/Frailty workshop**: Innovating Together for Frailty took place in July with stakeholders from all acute, community, general practice, voluntary and ICB representation. Several prevention-based options were discussed to improve falls. These has been discussed with Falls lead Lee Watson, following the confirmation that falls prevention will be incorporated into existing workstreams within Ageing Well.

Workstream Update – Prevention

Workstream objectives: *"1. To define public health approach to healthy ageing in Norfolk. 2. To understand current position of preventative commissioned and non-commissioned services. 3. To make evidence-based recommendations for future preventative activity."*

This workstream is led by Lee Watson, Consultant in Public Health at Norfolk County Council (NCC). A key part of this workstream is to identify activities currently supporting those aged 50 and above to improve and maintain health and well-being including commissioned services, as well as to identify the needs of our residents.

Progress Update:

- **Warm and Well Campaign**: A collaborative effort with Public Health and Norfolk County Council to support residents during winter, including vaccination promotion.
- **Falls**: Following the Frailty workshop in July, the prevention workstream has focussed on several key suggestions around falls prevention and mapping exercises which are being mapped out.
- **Health Connect Initiative**: The Programme aims to help residents recover more quickly following a hospital discharge and avoid hospital readmissions by providing practical and emotional support at home, while also linking them to broader health, social, and community services. Now in its second year, the service has contacted over 9,000 residents following a hospital discharge or NHS community intervention and provided one-on-one follow-up support to over 2,000 residents. Feedback from residents has been positive, highlighting the importance of adopting a holistic approach and why linking clinical and social needs is critical to ensure continued health improvement
- **Forward Plan:** Norfolk County Council, in collaboration with this workstream, are developing a forward plan that will support initiatives focussed on physical activity, communications and engagement and improving public health

Workstream Update - Care Homes & Housing with Care

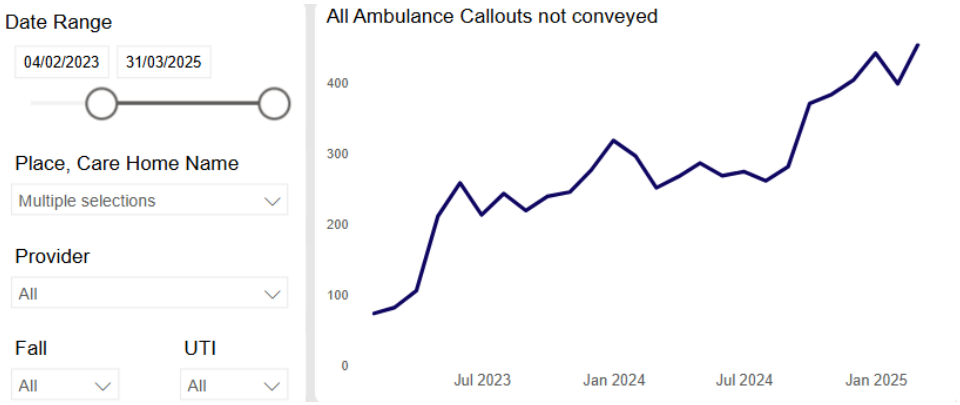
Workstream objectives: *"1. Reducing inappropriate conveyance from care market to the acute. 2. Support the promotion of healthy living across the care market. 3. Supporting providers/EEAST to sign post to clinical pathways. 4. Support development of pathway redesign to support care at home."*

Paul Benton, Director of Quality Assurance in Complex Care from the ICB is leading this workstream, focusing on supporting residents in care home and housing with care to live well. Specific areas of focus include the promotion of healthy living across the care market, supporting care providers to sign post residents to the most appropriate proactive clinical

pathways, and supporting pathway redesign to provide more care at home for example using our virtual wards.

Progress Update:

- ***Ambulance Service Collaboration****: Achieved a* ***58% non-conveyance rate*** *(Oct 2024–Mar 2025) by identifying care homes with high emergency service usage and providing targeted support, the best recorded.*



- ***Ambulance Discharge Pathway****: Local first responders now discharge patients at care homes, preventing* ***160 unnecessary ambulance conveyances*** *(Jul 2024–Jan 2025).*
- ***Guidance Documents****: Drafted to help care homes access healthcare support more efficiently.*

Workstream Update - Dementia

Workstream objectives: *"1. System Wide Leadership for the Dementia Programme. 2. Education & Upskilling in relation to patients living with Dementia, their families and carers. 3. Development of Dementia Data. 4. Review and redesign the Dementia Pathway across partner organisations, and the associated commissioning model."*

Progress Update*:*

- **Dementia NeuHealth App**: Funding secured to implement pilot for North Norfolk for up to 150 patients to improve early detection and therefore improve memory assessment wait times (rollout pending).
- **Dementia Information Pack**: This Blue Information pack will be similar in concept to that of Yellow Folders for Palliative patients, this is aligned with one of the key identified areas in need of improvement, that of signposting. It will house the most important information in an easily accessible pack. Funding has been secured to deliver the work required to develop this and the Ageing Well team will assist Central/North Place in this delivery.

Recommendation to the Committee:

For assurance and information

Key Risks	
Clinical and Quality:	• A consistent approach to frailty and a review of anticipatory care for older people will improve care and reduce unwarranted clinical variation.
Finance and Performance:	• A consistent approach, with a strong clinically led review and evaluation of effectiveness and value for money, will ensure there is equitable investment of resources across the ICS (which in turn will lead to equitable demands on acute resources)
Impact Assessment (environmental and equalities):	• Age is a protected characteristic. The Integrated Care System will be able to demonstrate an appropriate and equitable response to the health needs of this population.
Reputation:	• Risk of damage to reputation if service failure occurs. • There will need to be an appetite for change as this is about professionals working differently together, and in partnership with families and carers
Legal:	• No issues identified
Information Governance:	• Issues may be identified in the course of this work. The ICB and partners are asked to ensure appropriate teams are involved and engaged in a timely manner.
Resource Required:	• Input from the Integrated Care Board and system partners to the Integrated Care of Older People Programme Board • Appropriate Programme and administrative support
Reference document(s):	• Please see paper
NHS Constitution:	• No issues identified
Conflicts of Interest:	• No issues identified
Reference to relevant risk on the Board Assurance Framework	• No specific risk

Ageing Well - Overview: Programme Workstreams

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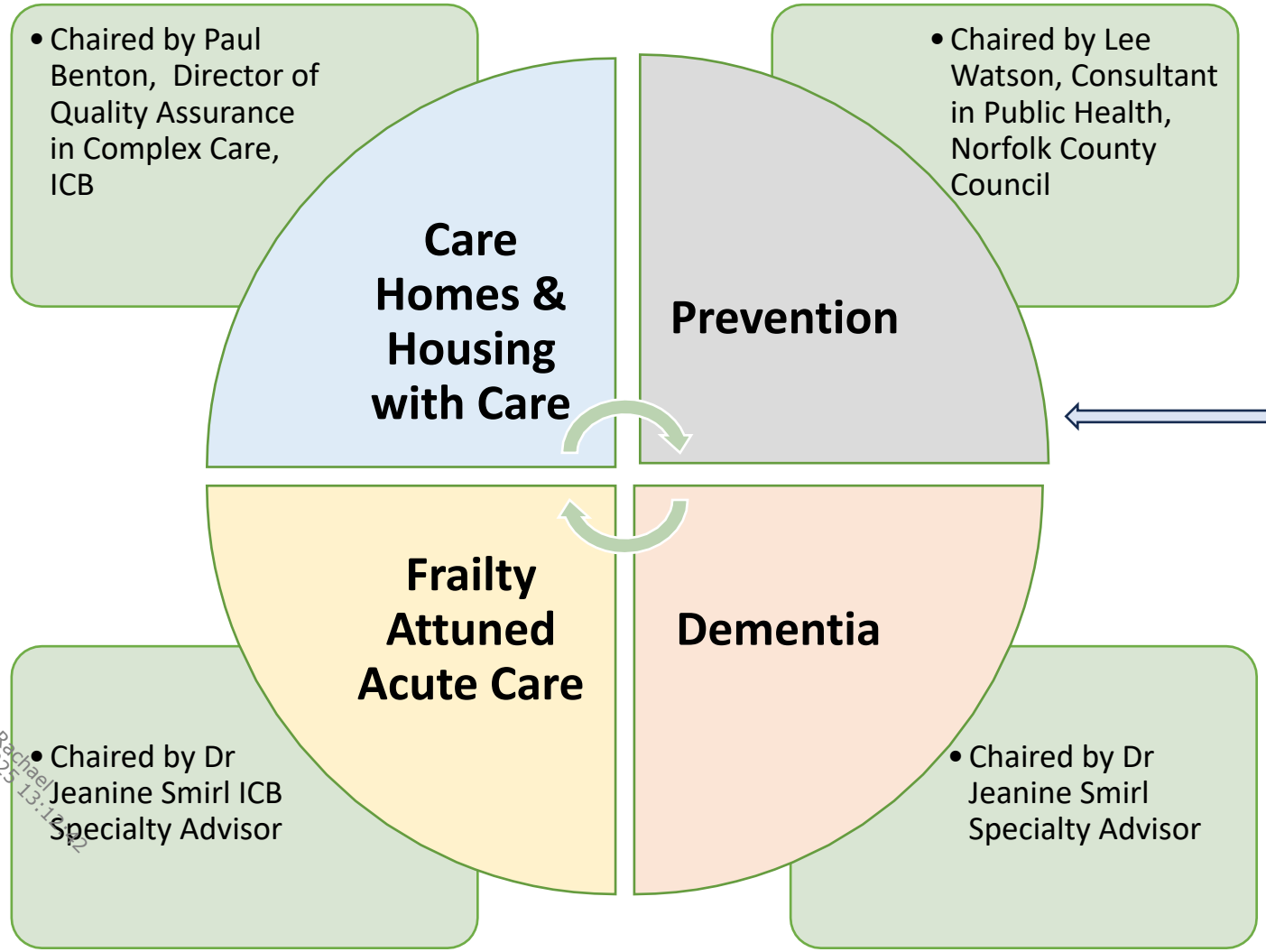

Senior Responsible Officer:
Dr Frankie Swords

Senior Programme Manager
Zoe Nash

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) - August 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	10/07/2025	The Ageing Well team have improved their links with Place, we have conducted a Frailty and Falls Audit which involved Place teams inputting their work that fits under the Ageing Well strategy. It has allowed a better oversight of projects on-going and enabled shared learning and best practice to be shared. This was presented at July's Ageing Well Programme board and will be continually monitored and updated monthly.	To note	No	No	For assurance
2	Ageing Well Programme Board	10/07/2025	SNEE ICB representative provided a presentation and overview of their 'Age Well' programme. It was noted the similarities between their programme and our Ageing Well. We have agreed next steps of unifying our projects to share best practice and begin co-operating where appropriate.	Agreement to attend SNEE tactical groups & N&W ICB to present at their board in October.	No	No	For assurance and to note inclusion SNEE.
3	Ageing Well Programme Board	10/07/2025	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	10/07/2025	Following the success of the frailty attuned acute care workstream delivery of Rockwood across QEH, NNUH and JPUH. It was agreed this would be monitored by the Frailty SCN and the Ageing Well programme would support the delivery across community and General Practice. 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. This work will build on the delivery of a successful frailty education programme with 200+ attendees to date. Jeanine Smirl has taken on this role as lead for Frailty and has presented at Board and to stakeholders the benefits of Rockwood, using NNUH data on improved length of stay and reduction in falls. Meetings scheduled for October with community providers to discuss their adoption.	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	10/07/2025	Ageing Well Programme team have begun to work with Central/North Place on Dementia focussed efforts following the securing of funds, these will help fund NeuHealth App Dementia pilot aimed at promoting early diagnosis and reducing reliance on Memory Assessment clinic, alongside developing a Dementia Information Pack, similar to that of Yellow Folder for Peolc patients.	To note	No	No	For assurance

N&W ICS Patients & Communities Committee

Ageing Well - Assurance/Escalation Update (2) - August 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	10/07/2025	Falls/Frailty workshop: Innovating Together for Frailty took place in July with stakeholders from all acute, community, general practice, voluntary and ICB representation. Several prevention-based options were discussed to improve falls. These has been discussed with Falls lead Lee Watson, following the confirmation that falls prevention will be incorporated into existing workstreams within Ageing Well.	To note	No	No	For assurance
7	Ageing Well Programme Board	10/07/2025	For assurance, the care homes workstream which priority objective is based around *"1. Reducing inappropriate conveyance from care market to the acute.* Has managed to achieve *a 58% non-conveyance rate (Oct 2024–Mar 2025) by identifying care homes with high emergency service usage and providing targeted support, the best recorded.*	To note	No	No	For assurance

N&W ICS Patients & Communities Committee

Ageing Well - Existing Risks Update - August 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
9 - BAF05	Ageing Well Programme Board	10/07/24	**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 (4 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 InPhase risk system • Further investment in health improvement schemes has reduced mitigated scored to a 12.	To Note	Yes	Yes	For assurance

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Project Management across Norfolk and Waveney

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Ageing Well Programme

Care Homes & Housing with Care Workstream Progress Report

as of August 2025

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Ageing Well Programme Summary
Headline Scope and Priorities August 2025

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Programme	**Ageing Well Programme** **Care Homes & Housing with Care Workstream**	**SRO**	**Ian Hutchison**	**Overall Prog RAG**
		Programme Lead	**Paul Benton**	
		Provider Leads	**Quality Improvement Nurses (QINS)**	

What have we achieved since last report (time period)

- Liaised with system partners to draft the deteriorating patient handbook.
- The QIN Toolkit is now in place and being shared with place -based leaders
- Heat map now produced which using the limited data we have, shows the homes we need to target the most. This will be demonstrated at the next AW meeting
- Working with UEC hub to continually monitor activity.

Activities planned for next reporting period

- Working with place -based leads to target the homes we have jointly identified to see a demonstrable improvement in Quality
- The continuation of data gathering to build a reliable data set.
- Developing the next champions programme which was hugely successful last quarter

Key Programme Milestones (for this time period)

Improved data quality for internal mechanisms

Obtained data to use as benchmark

Supporting the UCCH with admission avoidance schemes

Improving pathway and referrals for the care market to access.

System now aligning and working on the same objectives

Workstream Objectives

1. Reduction in inappropriate conveyance from care market to the acute
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Innovation Ideas/Projects

Revised model being drafted to manage activity from the Care sector over winter. This has been a significant shift in moving activity which will be evaluated post winter, using all the data available.

Key Programme Risks (Description)	Mitigation Action	Issues to be escalated	RAG
National insurance and living wage increase likely to destabilise some elements of the program.	Work is ongoing to summarise the needs of the market and identify those providers in need of most support. Joint engagement with NCC and SCC to fully understand risk and impact	Engagement with providers likely to reduce as the focus moves to Business Continuity planning	Amber
Homes still not likely to invest in training	The Care Market and Care providers have been engaged in the sessions and meetings that have been provided. There are several events that are taking place across the month which are well attended and the new way of working has been welcomed.		Green

None at this time.

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Project Management across Norfolk and Waveney

Ageing Well Programme Summary
Headline Scope and Priorities August 2025

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None at this time.			

Focus Areas for the NNUH

Top Providers:

- Identify top CH/NH providers of ED attendance and emergency admissions
- Working with specialist nursing team to carry out gap analysis on nursing skills and provide support and training where possible (e.g. canular training)

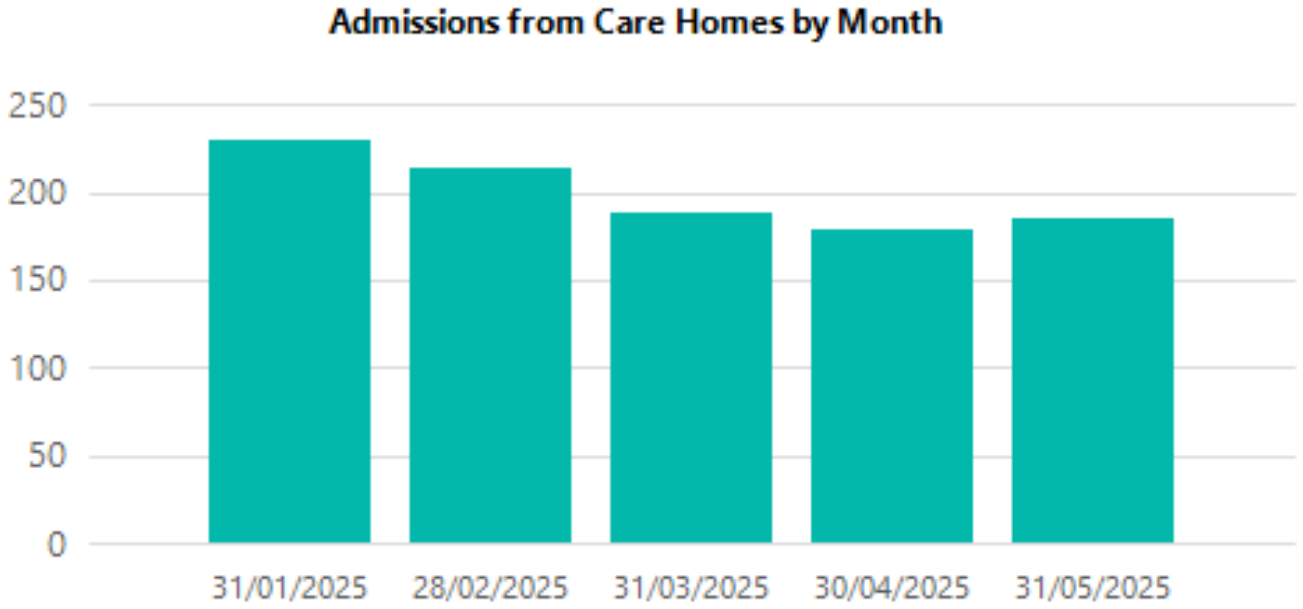
Deaths within 24hrs to 72hrs:

- Identify top CH/NH providers, identifying trends (day of the week, time of day etc.)
- Discuss with NNU palliative care for advice and potential in house at CH/NH
- Review RESPECT forms and levels of “risk aversion” with other system partners

Inappropriate Conveyancing:

- Working with UCCH (Unplanned Care Community Hub)
- Case review and lessons learnt meetings between NNUH and UCCH

Results (Early Days)



Monthly Care Home Admissions

Admission Month	Admission Count
31/01/2025	230
28/02/2025	214
31/03/2025	189
30/04/2025	178
31/05/2025	185

Parker Rachael
27/08/2025 13:12:42

- The top 20 care homes is a red herring
- While activity has increased, non conveyance has remained relatively the same
- Alternative pathways are being utilised for example UCCH
- 10.6% of UCCH patients are for care homes UCCH had 341 care home contacts, whereas EEAST were deployed to a care home on 864 occasions with 434 (50%)left at home. The top reason for conveyance, currently is a 111 dispatch (likely C2) and falls, making up half of the dispatches.
- The need to increase/strengthen call before conveyance (CB4C) for care homes to make a bigger impact on ED attendance/admission. This is dependant on many factors.

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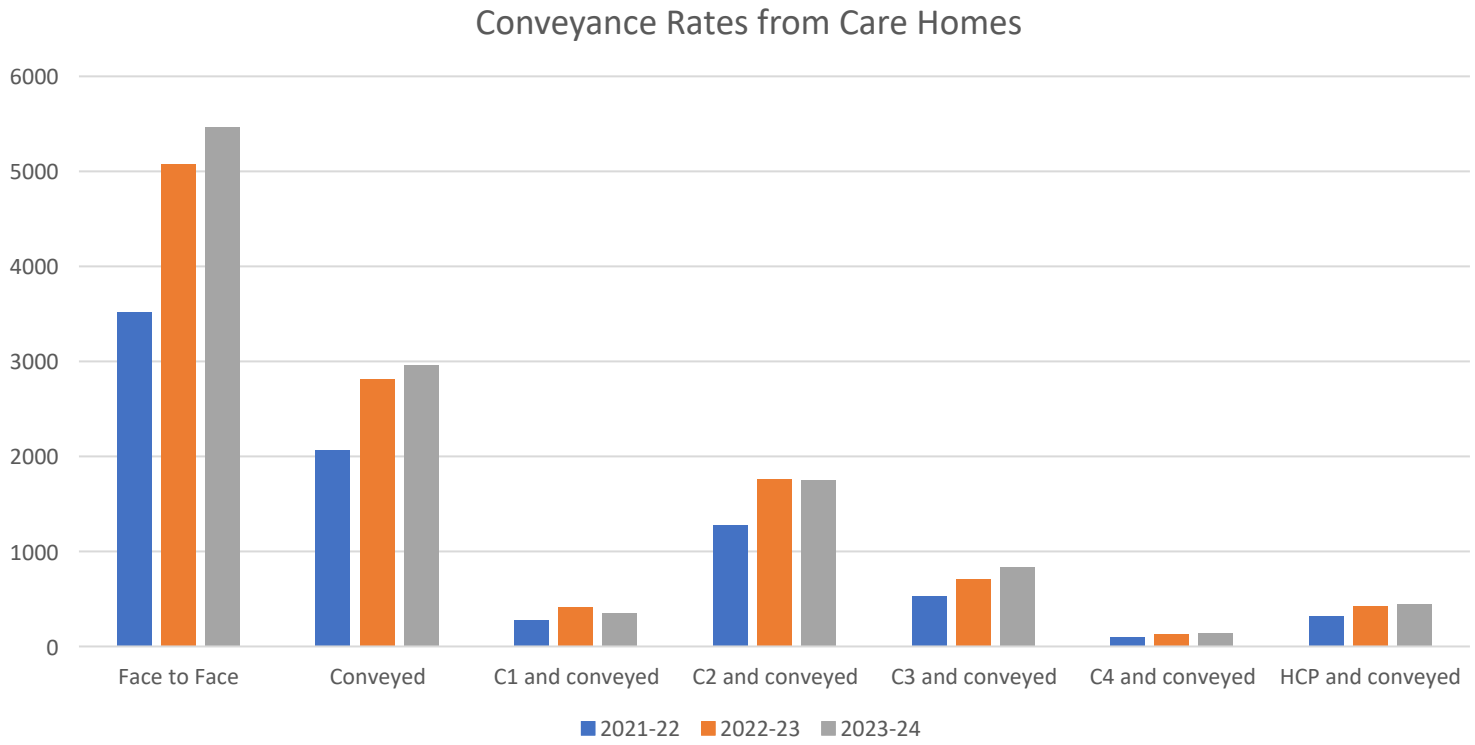
Quality Improvement Nurses Tool kit Demonstration

Data from May's meeting included below



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Year	Face to Face	Conveyed	C1 and conveyed	C2 and conveyed	C3 and conveyed	C4 and conveyed	HCP and conveyed
2021-22	3517	2064	279	1281	527	99	325
2022-23	5073	2817	414	1766	708	127	421
2023-24	5471	2966	355	1755	834	146	448

Autumn and winter 24/25 not yet available

Care Homes Dashboard

Care Home Detail

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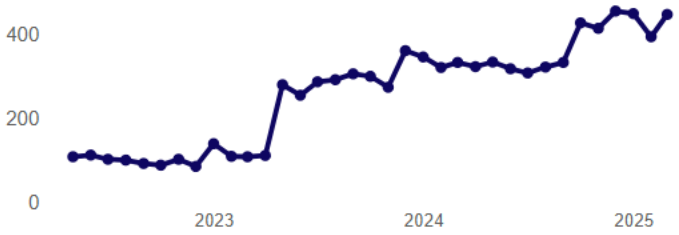
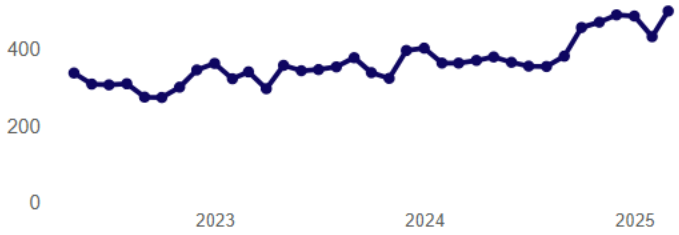
Date Range	Place, Care Home Name	Provider	Fall	UTI	Conveyed	CQC Rating	Number of Beds
01/05/2022 – 31/03/2025	All	All	All	All	Yes	N/A	12K

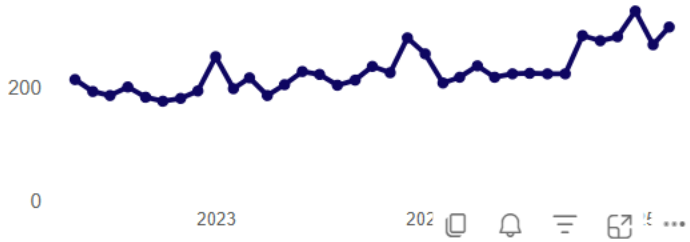
All Ambulance Conveyances



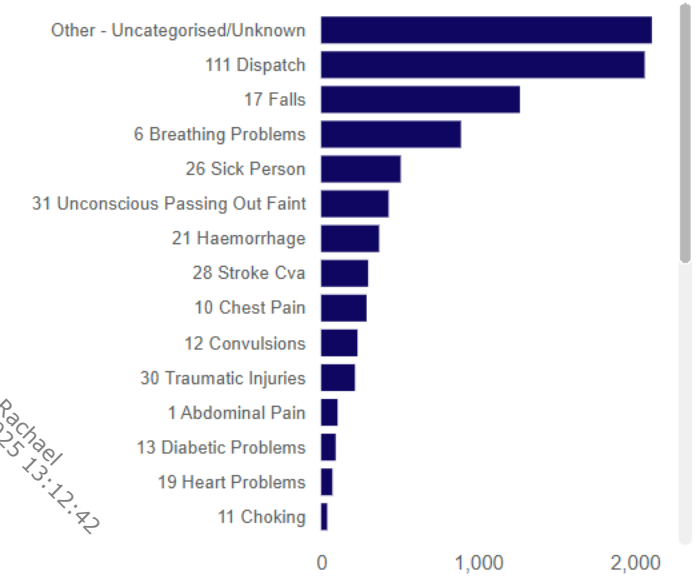
All A&E Attendances



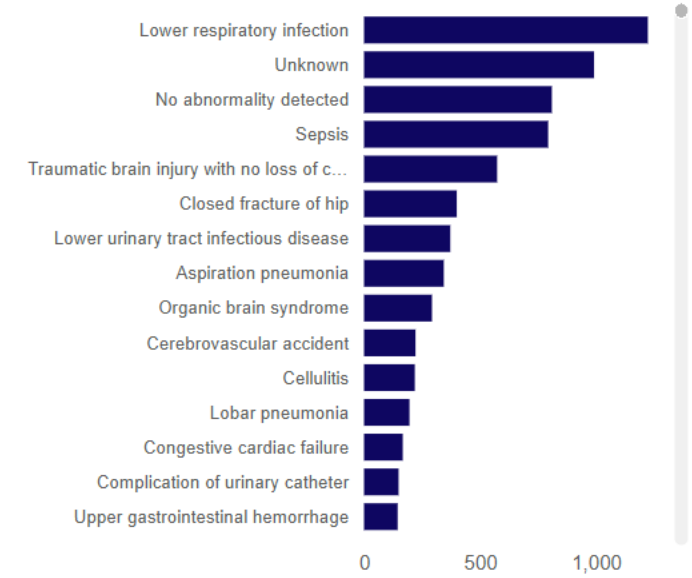
All Emergency Admissions



All Ambulance - Problem Grouped Conveyances



All A&E Attendances - Primary Diagnosis



All Emergency Admissions - Primary Diagnosis

All Admissions

Avoidable Admissions

Parker Rachael
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84%

Care Homes Dashboard

Care Home Detail

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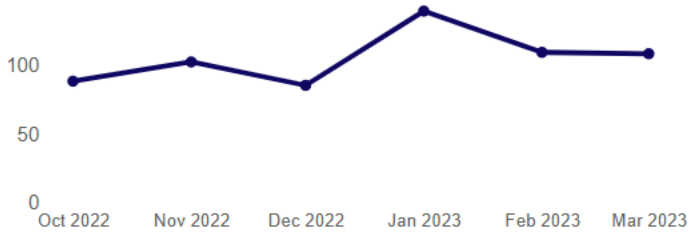
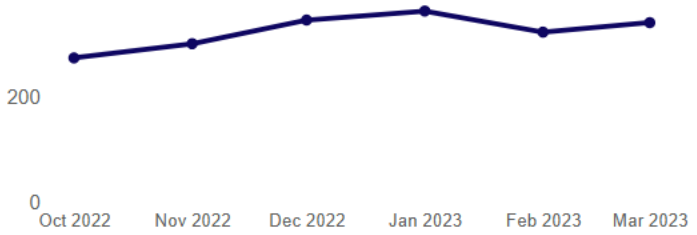
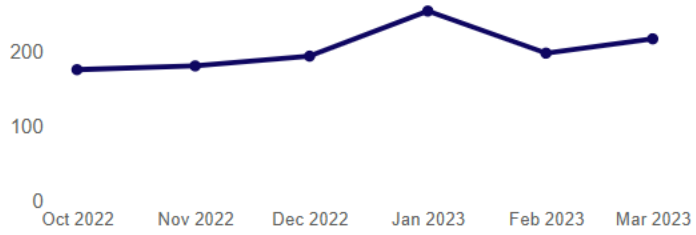
All Ambulance Conveyances



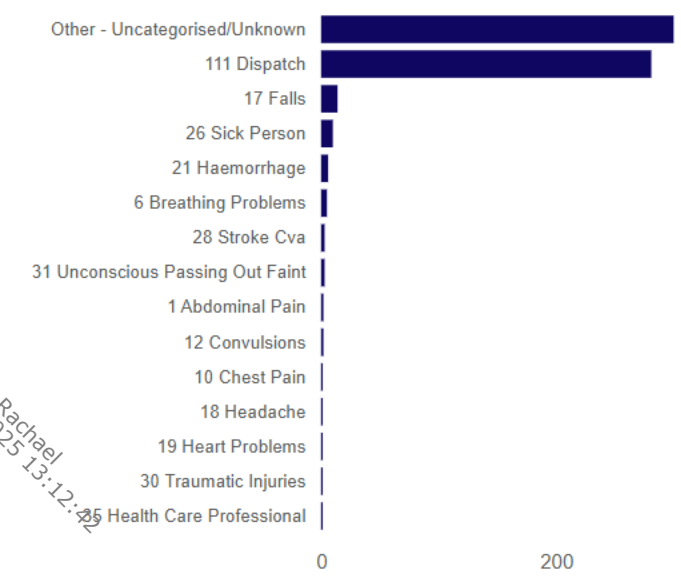
All A&E Attendances



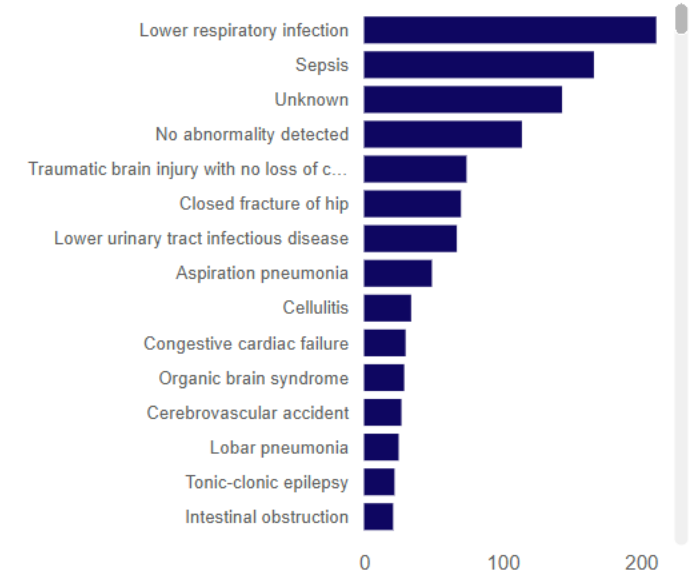
All Emergency Admissions



All Ambulance - Problem Grouped Conveyances



All A&E Attendances - Primary Diagnosis



All Emergency Admissions - Primary Diagnosis

All Admissions

Avoidable Admissions

84%

Click here to follow link

Care Homes Dashboard

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Improving lives together
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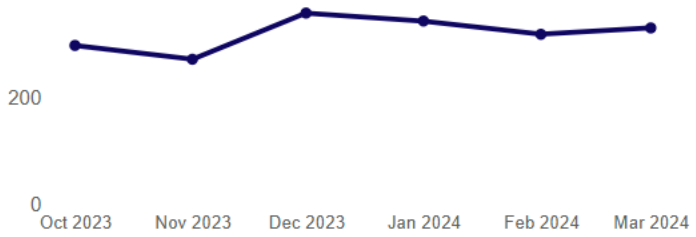

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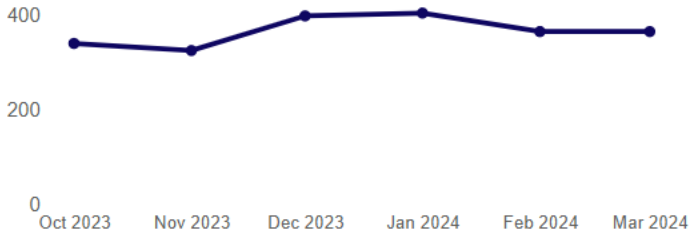
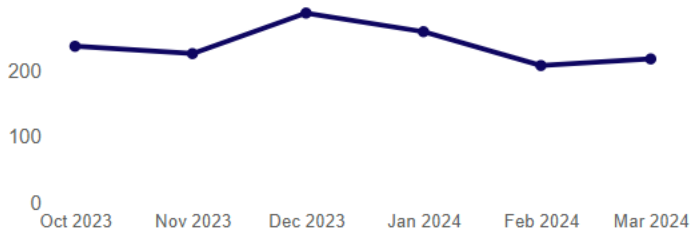
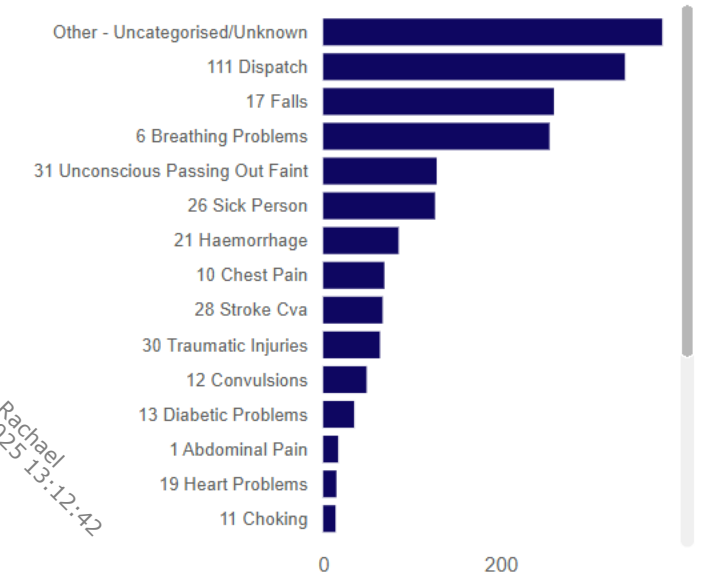


All Emergency Admissions



All Ambulance - Problem Grouped Conveyances



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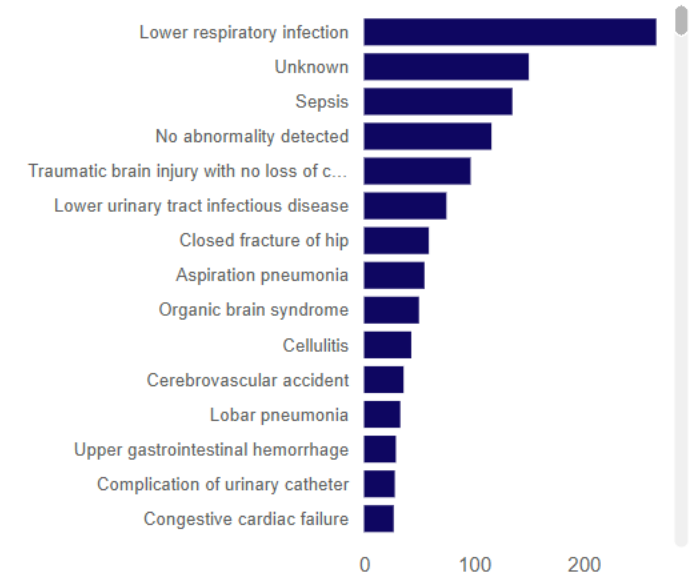
All A&E Attendances - Primary Diagnosis



All Emergency Admissions - Primary Diagnosis

All Admissions

Avoidable Admissions

84%

Care Homes Dashboard

Care Home Detail

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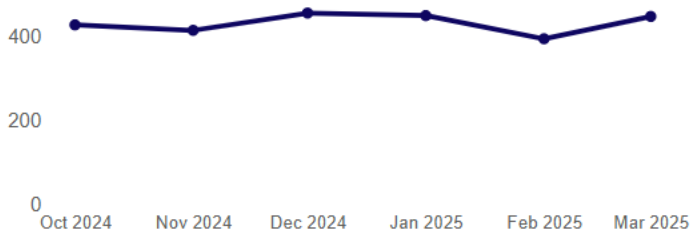
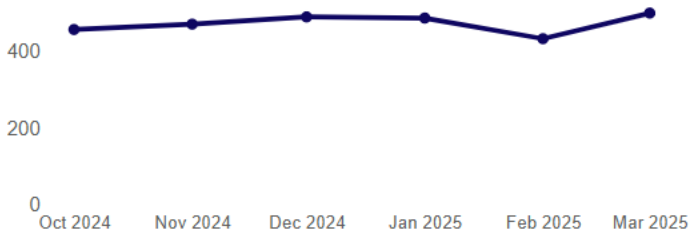
Date Range	Place, Care Home Name	Provider	Fall	UTI	Conveyed	CQC Rating	Number of Beds
01/10/2024 – 31/03/2025	All	All	All	All	Yes	N/A	12K

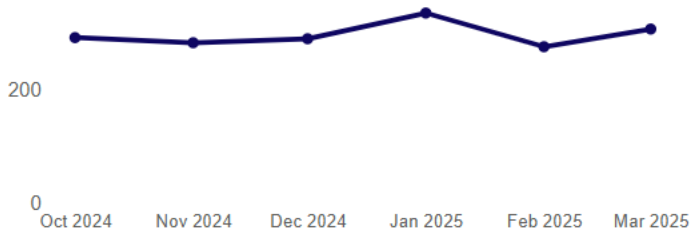
All Ambulance Conveyances



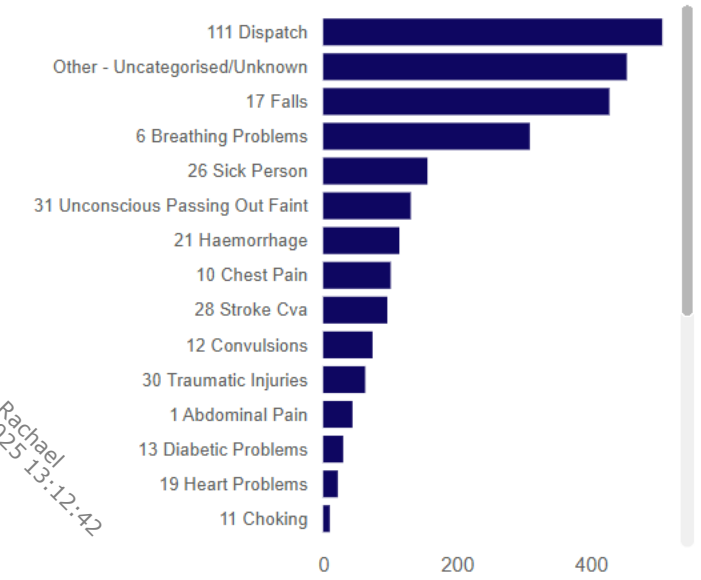
All A&E Attendances



All Emergency Admissions



All Ambulance - Problem Grouped Conveyances



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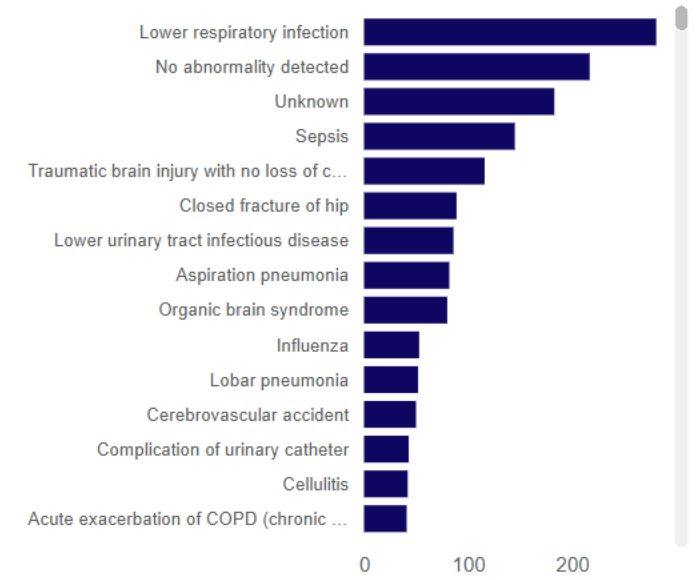
All A&E Attendances - Primary Diagnosis



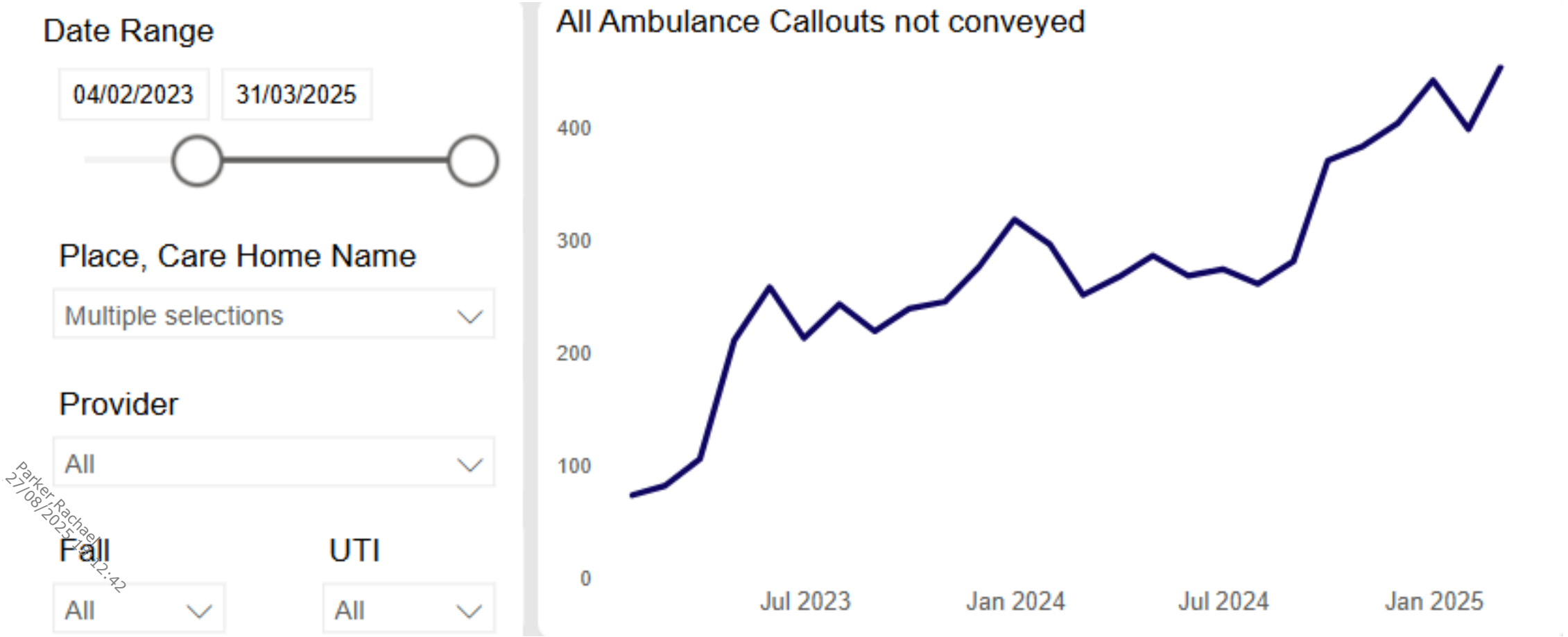
All Emergency Admissions - Primary Diagnosis

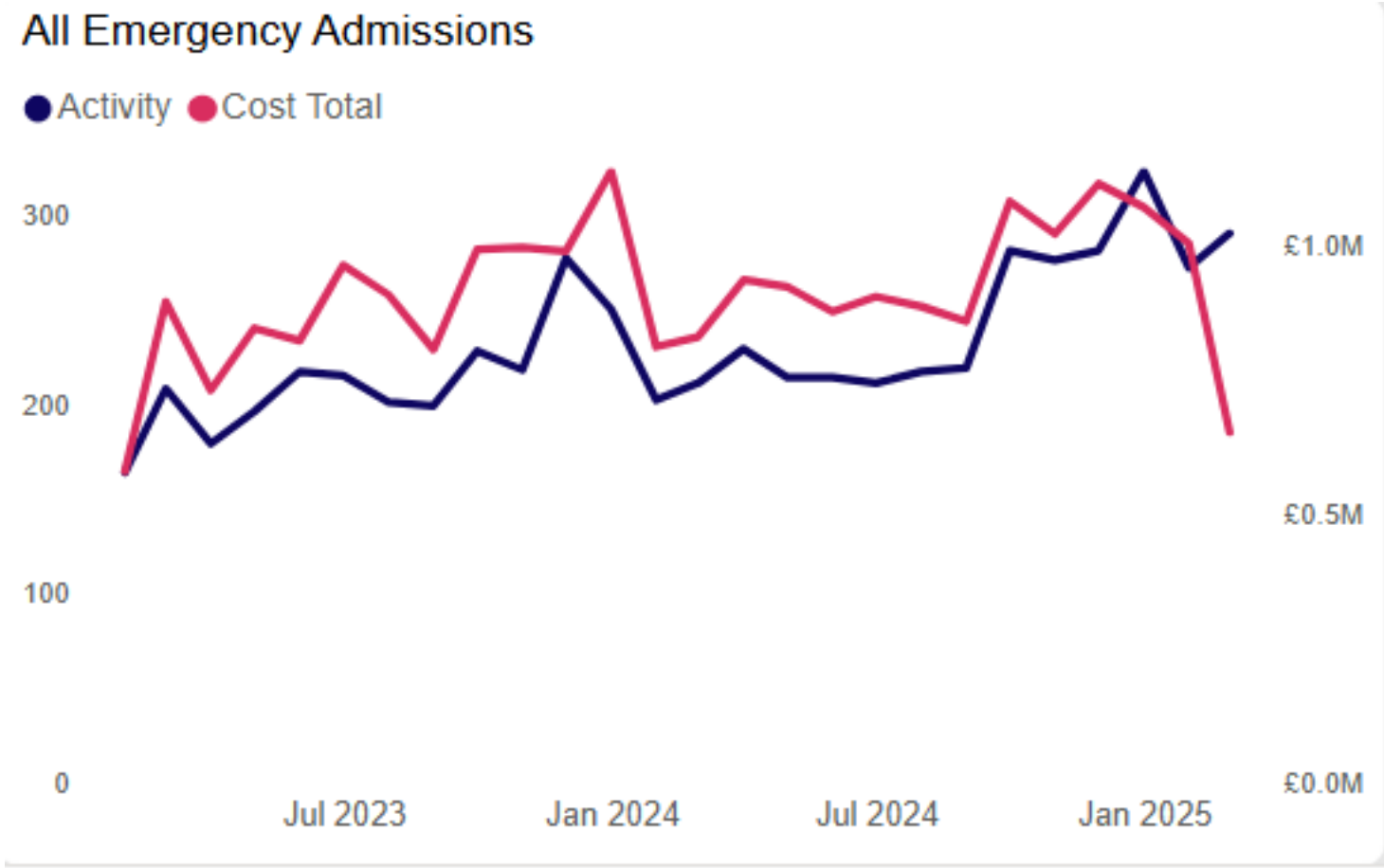
All Admissions

Avoidable Admissions

84%

Net result in improved non conveyance





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Norfolk and Waveney
Integrated Care Board

Agenda item: 13

Subject:	**Population Health & Inequalities (PH&I) Board – 17/06/2025 & 19/08/2025– Assurance & Escalation Report**
Presented by:	**Dr Frankie Swords, Executive Medical Director**
Prepared by:	**Dr Frankie Swords, Executive Medical Director**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**28 August 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) meets every two months, with the last meeting on 19 August 2025. This report provides assurance and escalation points, along with a summary of high-level risks from the June and August 2025 meetings, as the July Patient and Communities Committee was postponed.

Report

Please find attached document.

Recommendation to the Committee:

To note the contents of the report.
To approve BAF01 risk target score increase from 4 to 8 (As per June 2025 PH&I Board request)

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 [19/08/2025]

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Item No.	Meeting Name	Date of meeting where item was first raised	Details of Item for Escalation	Requested Outcome/Support	Financial Implication (if any)	Is item recorded on Risk Register	"EXAMPLE" Board Decision	Fed back to Meeting Group Date
100.	PH&I Board	19/08/2025	New PHM Project - NHS Health Checks – Provider Reed	A new project has begun, targeting regions with low NHS Health Check uptake, in partnership with Public Health, starting with West Norfolk	N/A	N/A	For assurance	
101.	PH&I Board	19/08/2025	Digital Weight Management Programme (DWMP) – Phase 2	Project is progressing well, Norfolk and Waveney ICB now highest ranked referrer for DWMP nationally	N/A	N/A	For assurance	
102.	PH&I Board	19/08/2025	Protect NoW Virtual Support Team (VST) Capacity	Temporary staffing challenges are affecting ability to complete all projects. Triple lock process to be followed to seek support	N/A	PHMI19	For escalation	
103.	PH&I Board	19/08/2025	NHSE Statement on Information report - Published	This has now been published (detail provided in item 98 previously) Health Inequalities Reports - Norfolk & Waveney Integrated Care System (ICS	N/A	N/A	For assurance	
104.	PH&I Board	19/08/2025	Core 20 plus Ambassador network	Cohort 4 not proceeding, but Health Inequality Advocate Network in Norfolk and Waveney being developed and extended to interested people across ICS	N/A	N/A	For assurance	
105.	PH&I Board	19/08/2025	VCSE Assembly	Newsletter has now been published and will be distributed monthly Action plan agreed and in implementation	N/A	N/A	For assurance	
106.	PH&I Board	19/08/2025	Marmot Place in Kings Lynn	Marmot Place in Kings Lynn is currently recruiting a VCSE advisor to support remuneration work. This recruitment is a direct consequence of VCSE Assembly influence	N/A	N/A	For assurance	
107.	PH&I Board	19/08/2025	Volunteering support	Significant work noted to support volunteering, training for carers, scoping work to involve people in contact with justice system	N/A	N/A	For assurance	

Population Health & Inequalities (PH&I) Board - Points of Assurance / Escalation [19/08/2025]

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Item No.	Meeting Name	Date of meeting where item was first raised	Details of Item for Escalation	Requested Outcome/Support	Financial Implication (if any)	Is item recorded on Risk Register	"EXAMPLE" Board Decision	Fed back to Meeting Group Date
108.	PH&I Board	19/08/2025	PHM High Impact / Delivery Opportunities Report	A report based on analysis from the PHM team in conjunction with PSL was presented identifying significant opportunities to reduce emergency admissions using defined medical interventions, particularly for the over-65 population. Largest opportunities come from optimising CVD and vaccination coverage. Detailed mapping/gap analysis exercise will be undertaken and recommendations for how to address any gaps will be undertaken	N/A	N/A	For assurance	
109.	PH&I Board	19/08/2025	Inequalities, Prevention and Outreach Strategic Review	The PH&I Board agreed on need to better coordinate and refine outreach efforts: initial focus agreed on ethnic minority communities, inclusion health groups, and coastal and rural communities. Method agreed to be via place based approach. Further work to define scope of the project through additional data sources required, for update in October.	N/A	N/A	For assurance	
110.	PH&I Board	19/08/2025	Community Voices Women's Health Project	The project identified menopause as a significant topic and listed key barriers for underserved communities in accessing care, including negative experiences with healthcare professionals and limited consideration of cultural factors. These insights have already been used to inform service design and HCP training in compassionate, trauma-informed, and culturally sensitive care.	N/A	N/A	For assurance	

PH&I Board - New Risks [19/08/2025]

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Programme Risks as of 19/08/2025 – PH&I Board

BAF01 Health Inequalities and Population Health Management Risk (August 2025)
Overarching BAF01 (previously BAF06) PHM &HI risk, updated and mitigated risk reduced from 12 to 8 and target score increased from 4 to 8.

Population Health Management Risk Register (July 2025)
The PHM team reported 1 risk. No new risks were added, the risk scoring remained the same (as previously reported) and below 15. The PHM team have taken an action to update the risk summary wording.

1 risk scores remained the same though narrative needs to be updated to reflect recent VST gaps:
- 'PHMI19 PHM team resources to respond to system demand' risk score 9.

Health Inequalities Risk Register (August 2025)
The HI team reported 4 risks. No new risks were added, the risk scores remained the same (as previously reported) and below 15. HI team have taken an action to update the risk summary wording.

4 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, and inclusion health and anchor institution framework development' risk score 6.
- 'HI05 Resource limitations with challenged ICB financial position, lack of NHSE health inequalities funding ring fence, new money for transformation, processes that support investment into inequalities and financial position impacting on existing services/interventions' risk score 12
- 'HI07 Lack of Place resources and mandate to support HI strategy development & implementation at Place ' risk score 12.

VCSE Assembly Operational Risk (August 2025)
The VCSE team reported 5 risks. No new risks were added, 1 risk scoring reduced and the others remained the same (as previously reported) and below 15.

1 risk score reduced:
- VA02 'Lack of engagement across wider sector' risk score reduced from a 12 to a 8. .

4 risk scores remained the same:
- VA01 'Lack of understanding about Assembly role and function' risk score 8.
- VA03 'Representation gaps' risk score 9.
- VA04 'Managing conflicts of interest in Board' risk score 6.
- VA05 'Resources to further develop model' risk score 9.

Population Health & Inequalities (PH&I) Board - Points of Assurance / Escalation [17/06/2025]

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Item No.	Meeting Name	Date of meeting where item was first raised	Details of Item for Escalation	Requested Outcome/Support	Financial Implication (if any)	Is item recorded on Risk Register	"EXAMPLE" Board Decision	Fed back to Meeting Group Date
89.	PH&I Board	17/06/2025	PHM approach to maximising access to the NHS Bowel Cancer Screening Programme	Project recently live, the project aims to encourage people to complete and return their tests. Initially focusing on 11 practices with the lowest screening uptake	N/A	N/A	For assurance	
90.	PH&I Board	17/06/2025	PHM CVD Programme Support	Progress to implement the CVD flagship programme is continuing. The Procurement of the clinical pharmacist provision is underway .	N/A	N/A	For assurance	
91.	PH&I Board	17/06/2025	PHM Strategy Implementation – Year One Actions	All actions now completed. PHM team in the process of developing their year two actions	N/A	N/A	For assurance	
92.	PH&I Board	17/06/2025	Health Inequality Strategic Framework for Action - Year two	Year two priority actions endorsed by the Integrated Care Partnership (ICP). A shared post with the Norfolk County Council team is supporting to take forward these actions. The actions will be further published and communicated to all leadership groups	N/A	N/A	For assurance	
93.	PH&I Board	17/06/2025	ICB's Health Inequalities Improvement Plan	This has been launched and is seen as an exemplar. The NHS Anchors Group is taking forward the development of their own and an ICS NHS Anchor Improvement Plan	N/A	N/A	For assurance	
94.	PH&I Board	17/06/2025	Get Norfolk Working plan	Multiple organisational engagement is underway to develop this plan, which focuses on getting people back into employment and also supporting health and well-being	N/A	N/A	For assurance	
95.	PH&I Board	17/06/2025	VCSE Risk Register and Action Plan	This has been developed and is being presented to the Patient and Communities Committee	N/A	N/A	For assurance	

Population Health & Inequalities (PH&I) Board - Points of Assurance / Escalation [17/06/2025]

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
96.	PH&I Board	17/06/2025	Two HI Risk Score Reductions	HI04, 9 to 6 and HI05, 16 to 12. Detail included in slide 3 of report.	N/A	N/A	For assurance	
97.	PH&I Board	17/06/2025	Maternity Population Health Management Pilot– Interim Evaluation	Presentation provided, full evaluation to be undertaken following project completion in November 2025.Pilot commenced in August 2024. It has increased trust and awareness of services among pregnant people and their families. It also emphasised the need for proactive and preventative care, understanding the wider determinants of health, and improving data flow processes	N/A	N/A	For assurance	
98.	PH&I Board	17/06/2025	NHSE Statement on Information on Health Inequalities	The PH&I Board supported this report. The report is a legal annual requirement for the ICB and other NHS providers and aims to inform strategic planning, commissioning decisions, and service transformation to address inequalities	N/A	N/A	For escalation	
99.	PH&I Board	17/06/2025	BAF01 – Risk target score amendment request	Chair's action taken following the PH&I Board, from the ICB's Private Board discussion and recommendation, to request Patients and Communities Committee approval of the BAF01 risk target score increase from 4 to 8	N/A	BAF01	For approval	

PH&I Board - New Risks [17/06/2025]

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Norfolk and Waveney Integrated Care System

Programme Risks as of 17/06/2025 – PH&I Board

BAF01 Health Inequalities and Population Health Management Risk (June 2025)
Overarching BAF01 (previously BAF06) PHM &HI risk, updated and continues to score at 12.
Chair's action taken following the PH&I Board, following the ICB's Private Board discussion and recommendation, to request the approval of the BAF01 risk target score increase from 4 to 8

Population Health Management Risk Register (May 2025)
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 score:
- 'PHMI19 PHM team resources to respond to system demand' risk score 9.

Health Inequalities Risk Register (June 2025)
The HI team reported 4 risks. No new risks were added, 2 risk scores were reduced and all risks scored below 15.

2 risk scores reduced:
- 'HI04 Risk of not delivering against NHSE directives e.g. Core20plus5 health inequalities improvement framework for adults and CYP, and inclusion health and anchor institution framework development' reduced from a risk score of 9 to 6. Risk reduced due to the development of the NHS England statement and improvement plans
- 'HI05 Resource limitations with challenged ICB financial position, lack of NHSE health inequalities funding ring fence, new money for transformation, processes that support investment into inequalities and financial position impacting on existing services/interventions' reduced from a risk score of 16 to 12. Risk reduced due to the allocation of the health inequalities budget to key programmes and the establishment of dedicated capacity

2 risk scores remained the same:
- 'HI02 Incomplete data picture for health inequalities' risk score 6.
- 'HI07 Lack of Place resources and mandate to support HI strategy development & implementation at Place ' risk score 12.

VCSE Assembly Operational Risk (June 2025)
The VCSE team reported 5 risks. No new risks were added, the risk scoring remained the same (as previously reported) and below 15.

5 risk scores remained the same:
VA01 'Lack of understanding about Assembly role and function' risk score 8.
VA02 'Lack of engagement across wider sector' risk score 12.
VA03 'Representation gaps' risk score 9.
VA04 'Managing conflicts of interest in Board' risk score 6.
VA05 'Resources to further develop model' risk score 9.

Norfolk and Waveney
Integrated Care Board

Agenda item: 14

Subject:	**Patient Experience (Complaints and Enquiries) activity – summary of 2024-25**
Presented by:	**Jon Punt, Senior Lead for Patient Experience**
Prepared by:	**Jon Punt, Senior Lead for Patient Experience, and Sarah Bedford, Patient Experience Manager**
Submitted to:	**N&W ICB Patients and Communities Committee**
Date:	**28 August 2025**

Purpose of paper:

The purpose of this paper is to provide a summary of complaints, concerns and queries managed by the NHS Norfolk and Waveney Integrated Care Board's (ICB's) Patient Experience Team during the period 1 April 2024 to 31 March 2025.

The report aims to provide assurances that the ICB has fulfilled its statutory responsibilities regarding complaints management and provide further context around patient contacts received.

Executive Summary:

The ICB continues to experience an overall upturn in the volume of contacts. This report looks at how the ICB is performing against its own key performance indicators and the themes and lessons learned behind complaints.

It is particularly apparent in this report that pressure on dental services and general practice continues to be a regular theme of enquiry.

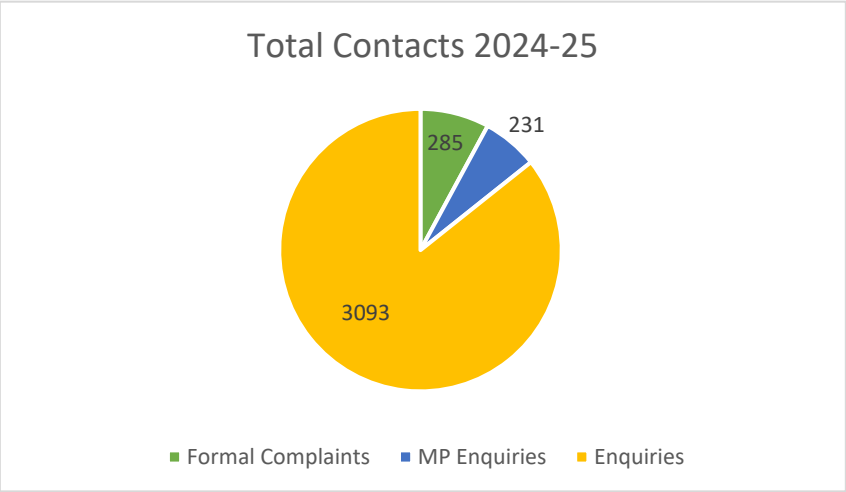
Volumes

Compared to 2023-24, volumes of complaints and enquiries have increased from 3093 to 3609, an upturn of 16.7 percent.

All commissioners and providers of NHS and Adult Social Care services adhere to 'The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.' Under these regulations, complainants can raise a complaint or concern to either the provider or the commissioner – The ICB - of the service. The complaint volumes in this report therefore relate to those complaints received and managed as the 'commissioner.'

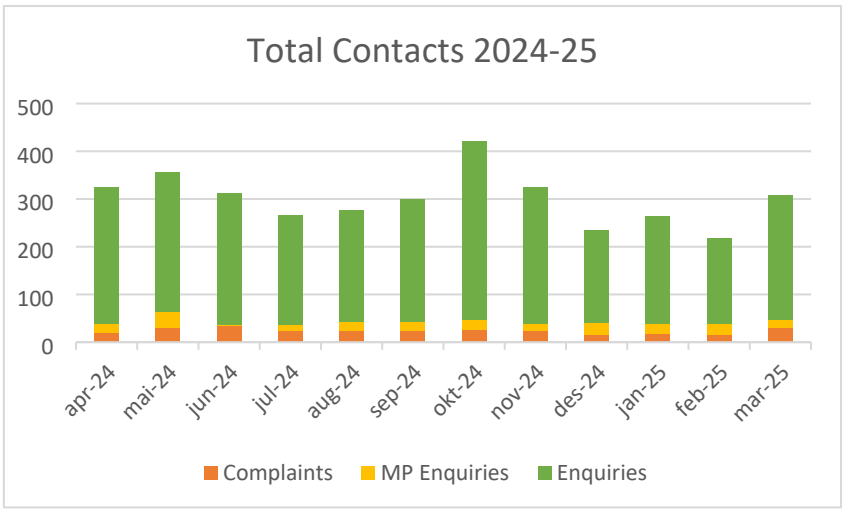
The number of formal complaints received reduced slightly by 5 percent from 300 to 285, with informal enquiries increasing by 23 percent from 2514 to 3093. MP enquiries reduced by 18 percent, from 282 to 231.

A breakdown of each type of query can be found below:



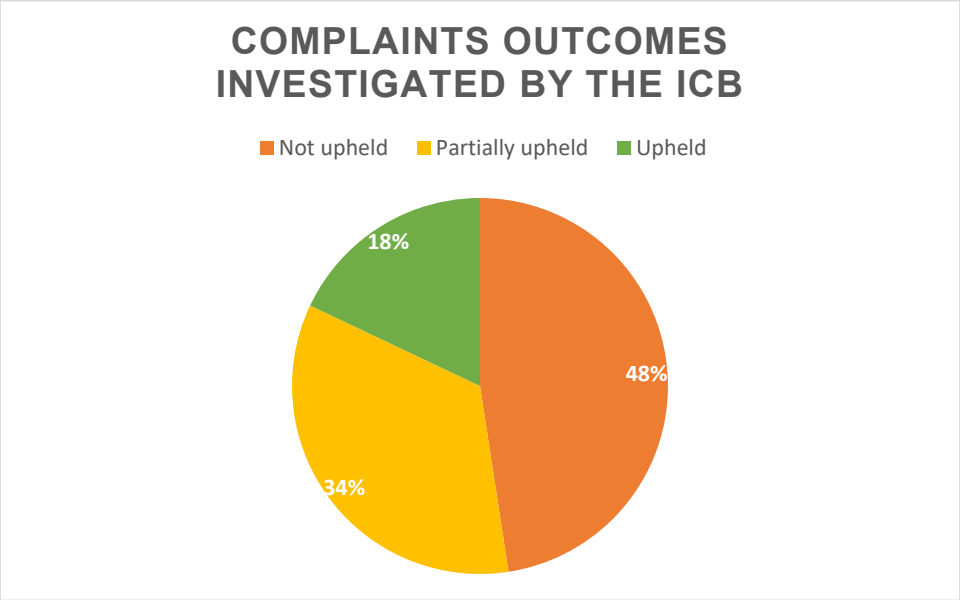
The reduction in formal complaints can possibly be attributed to the Patient Experience team taking a more proactive approach to concerns received, looking to identify early resolution for the patient/complainant, rather than taking them down a formal process which on occasion might not offer the quick solution the person is looking for.

The total volume of contacts received on a month-by-month basis is displayed in the graph below.



Outcomes of Complaints

In line with the Parliamentary Health and Service Ombudsman (PHSO) approach to categorising the outcome of complaints, the ICB records complaints as either 'upheld', 'partially upheld' or 'not upheld'. The following graph demonstrates that just over half the complaint investigations that have been concluded were either upheld or partially upheld.



Parliamentary and Health Service Ombudsman (PHSO)

During 2024/25, the PHSO reviewed eight cases handled by the ICB. At the time of writing, five cases were closed without further action; one case was referred back to the ICB as premature (meaning the PHSO felt the ICB could undertake more work to resolve the complaint); while a further two are awaiting the outcome of the PHSO's investigations.

Performance against Key Performance Indicators

Acknowledgements - of the 285 formal complaints received, 280 (98.25 percent) were acknowledged within the target timescale of three working days. Acknowledging complaints within three working is a requirement of requirement of the National Health Service Complaints (England) Regulations 2009.

Response times - of the 285 complaints received, 269 complaints have been closed. 113 have been responded to within the target timescale the ICB sets of 30 working days.

At the time of writing, 90 were sent after the 30 working days, while the remaining 66 cases were closed either due to consent not being received, insufficient detail

available to proceed with the complaint, or an alternative means of resolution was found.

Therefore, of the applicable cases responded to, 56 percent were within the target timescale.

The average time taken to respond to complaints was 27 working days, well within the ICB's target timescale.

Following a review of the cases where responses were sent after the 30-working day timescale, it was noted the highest proportion of delays originated from General Practice (GP) services. These delays were often due to internal pressures and the need to address further queries that arose after the initial response had been provided to the ICB by the practice. In several instances, cases were returned to the practice for clarification or expansion, extending the overall resolution timeline. Dental and Continuing Healthcare (CHC) services also featured prominently among delayed complaints, with many complex issues raised that required coordination between multiple stakeholders such as providers, commissioning teams, and administrative leads, adding additional layers to the response process.

The team currently has an open caseload of 16 complaints from the 2024/25 period, 15 of which exceeded the 30-working day target timescale and are therefore not included in the figures above. These cases are being actively reviewed, with many involving complex circumstances that require detailed investigation and ongoing coordination. Each case is being monitored to support resolution within a reasonable timeframe.

There are no specific target timescales for the ICB to handle informal enquiries or queries from Members of Parliament.

The team look to resolve these as swiftly as possible and at the time of writing 3084 of the 3093 enquiries received during the reporting period had been resolved.

In addition, of the 231 MP queries received, 229 have been responded to, with the remaining two cases being live matters.

Themes arising from patient contacts

Continuing Healthcare (CHC)

Contact feedback over the year has highlighted several key areas where families and professionals have sought support and resolution through the Continuing Healthcare (CHC) pathway.

Issues raised reflect pressures around both care coordination and assessment processes. Families reported challenges with discharge planning, inconsistent support, and limited access to appropriate placements or equipment. At the same time, concerns were expressed about decision-making during assessments, including lack of family involvement and unexpected outcomes. Delays in appeals

and funding queries were also cited, such as fast-track payments, Personal Health Budgets, and retrospective claims.

Families and patients sought greater clarity and guidance following their contact with the service, particularly in understanding how their concerns will be managed and what to expect next.

Access to Weight Management Services and Medications

A significant number of public enquiries were received concerning access to Tier 3 weight management services and medications such as semaglutide (Wegovy) and tirzepatide (Mounjaro). These reflected patient frustration over limited NHS provision, unclear referral routes, and inconsistent communication regarding eligibility, particularly confusion around BMI thresholds.

Delays in accessing weight management services were directly impacting patients' ability to proceed with time-sensitive medical treatments such as fertility procedures and planned surgery, leaving patients feeling unsupported.

Access to General Practice

Patient access remains one of the most frequently raised concerns. Many individuals report long wait times for appointments, particularly for urgent issues, follow-ups, or routine screenings. Digital booking systems, phone triage lines, and strict online-only registration processes often exclude digitally vulnerable or older patients. Patients describe barriers for housebound individuals unable to attend in-person and not offered alternatives.

Prescribing and Medication Management

Patients describe changes to repeat prescriptions without explanation, delays in issuing time-sensitive medications, and confusion regarding which clinician or service is responsible for ongoing prescriptions, particularly in shared care arrangements. A number of cases involve mental health medications, ADHD treatments, gender-affirming hormone therapy, and end-of-life symptom control. In some cases, patients have reported that prescribing decisions recommended by specialist services were not followed through at the practice level, resulting in delays or changes to their treatment plans.

General Practice - Communication and Complaints Handling

Patients reported difficulties in communicating with their GP practice, especially when raising complaints or seeking administrative support. Some received no acknowledgment of formal complaints, unclear guidance on escalation routes, or impersonal responses that failed to address core concerns. When practices do not respond, patients often approach MPs or NHS bodies directly. Improvements in complaints visibility, follow-up and resolution timelines are needed to rebuild trust and ensure that feedback leads to service improvement.

Other patients reported they perceived staff to be rude or dismissive of the concerns they were bringing to the practice's attention.

Access to dentistry - Access to NHS dentistry was one of the largest area of formal complaint and received the highest number of contacts across the year. Proportionately, there was a reduction on 2023/24 volumes, which may in part be due to additional urgent treatment capacity being made available.

A review of the contacts received highlights persistent barriers to NHS dental care across Norfolk and Waveney. Most cases relate to patients being unable to register with an NHS dentist, despite sustained attempts. This affects all demographics, including families, children, pregnant women, disabled individuals, and those with chronic health conditions.

Urgent dental needs, such as abscesses, infections, and severe pain, frequently remain untreated. Patients describe challenges accessing support via NHS 111 and the local urgent treatment service.

Learning from complaints

Communication Issues

Several cases cited communication breakdowns, which caused issues for patients. Learning was identified in many of these cases, as outlined below:

- The interface between Community Services, Primary Care Network teams and GP practices was improved.
- More accurate information provided to GP reception teams to ensure effective signposting.
- Customer service training provided for GP practice staff to enhance patient experience.
- Practice made changes to the composition of their Patient Participation Group/s, to better recognize the health needs of veterans.

Pharmacy/prescribing processes

Providers, in conjunction with the ICB, managed to identify customer service and safety improvements in prescribing processes as outlined below:

- Pharmacy implemented improved systems to keep patients informed of manufacturer shortages of medications.
- Staff reminders were issued to heighten awareness of priority systems for prescribing.
- Changes made to patient information leaflets to improve understanding.
- Additional prescribing safeguards implemented to avoid issues with similarly named medications.
- Systems improved to avoid future electronic prescription errors.

Digital Development

- Clearer online information made available, informing patients how they can access out-of-hours dental services.
- Changes made to GP practice telephony systems, implementing cloud-based technologies to enhance access.
- System changes made by an acute hospital to ensure patients cannot be removed from waiting lists in error.
- Hospital information governance processes reviewed, following staff accidentally accessing a family member's health records.

Primary Care Staff Development

- Several instances of general practice staff behaviour were highlighted in complaints, whereby they undertook additional training as a result.
- Protocols for processing patient samples revisited because of errors made which were highlighted in a complaint.
- Awareness training offered to staff to better highlight the challenges sight impaired patients face.

Procedural Changes

- The local mental health trust reviewed and developed their University Transfer of Care processes following failures identified in a complaint investigation.
- Protocols changed around how abnormal/borderline test results are flagged by the laboratory/GP practices.
- Referral management processes reviewed and changed to help quicken processes, across several different disciplines/providers.

Recommendation to the Committee:

To consider whether the following areas could be focused on in future committees:

Access to Primary Care services – with ongoing work to improve access to dental services, and imminent changes to the GP contract, it may be useful for the committee to look at the impact of this in future sessions.

CHC services – given complaints about CHC are received regularly, a trend which is consistent across previous years too, a further detailed look at the areas of concern could be beneficial, to look at where communication and process could be improved.

The impact of digitising – many services, most notably primary care, will be making digital enhancements in the coming months and years. Opportunities and development areas in this space could also be explored.

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)	

Agenda item: 15i

NHS
Norfolk and Waveney
Integrated Care Board

Subject:	**Complaints Handling Policy and Procedure**
Presented by:	**Jon Punt, Senior Lead, Patient Experience**
Prepared by:	**Jon Punt, Senior Lead, Patient Experience**
Submitted to:	**Patients and Communities Committee**
Date:	**28 August 2025**

Purpose of paper:

To note that the Complaints Handling Policy and Procedure has been reviewed as part of the yearly schedule. All content is still relevant. The policy is being shared with the committee to provide assurance this has been reviewed within the timescales.

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):	Complaints Handling Policy and Procedure
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the GBAF	N/A

GOVERNANCE

Process/Committee approval with date(s)	To be tabled for P&CC approval on 28.8.25

NHS
Norfolk and Waveney
Integrated Care Board

Norfolk and Waveney ICB

Complaints Handling Policy and Procedure

Document Control Sheet

This document can only be considered valid when viewed via the ICB's intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one online.

Approved documents are valid for use after their approval date and remain in force beyond any expiry of their review date until a new version is available.

Name of document:	**Complaints Handling Policy and Procedure**
Version:	**4**
Date of this version:	**July 2025**
Produced by:	Corporate Affairs
What is it for?	If a person is unhappy about any matter reasonably connected with the exercise of the Integrated Care Board's (ICB's) functions, they are entitled to make a complaint, have it considered, and receive a response. This policy details that process.
Evidence base:	Parliamentary and Health Service Ombudsman – Principles for Remedy
Who is it aimed at and which settings?	The policy is for use by all patients, carers and service users of Norfolk and Waveney.
Impact Assessment:	N/A
Other relevant approved documents	N/A
References:	• The Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009 • Mental Capacity Act 2005 • Human Rights Act 1998 • Data Protection Act 1998 / 2018 • Freedom of Information Act 2000.
Monitoring and Evaluation	This policy will be monitored and reviewed for effectiveness by the Complaints and Enquiries Manager in August 2023.
Training and competences	N/A
Consultation	N/A
Reviewed by:	
Approved by:	ICB Board
Date approved:	18 July 2023
Signed:	
Dissemination:	NWICB Intranet and Internet
Date disseminated:	
Review Date:	July 2026 or before if there are any changes to guidance/legislation.
Contact for Review:	Corporate Affairs

Version Control

Revision History	Summary of changes	Author(s)	Version No
November 22	Voiceability updated to POHWER.	Jon Punt	2
July 23	Policy updated to reflect primary care commissioning functions now fully delegated to ICB	Jon Punt	3
July 25	Policy reviewed, no changes required.	Jon Punt	4

Contents

1. INTRODUCTION

NHS Norfolk and Waveney Integrated Care Board (hereafter known as 'the ICB') complaints policy and procedure is written in accordance with **The Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009** which came into force on 1st April 2009.

If a person is unhappy about any matter reasonably connected with the exercise of the ICB's functions, they are entitled to make a complaint, have it considered, and receive a response. In particular, these complaints may relate to the commissioning of health care or other services under an NHS contract, or making arrangements for the provision of such care or other services with an independent provider or with an NHS trust,

Matters excluded from consideration under these arrangements are listed in Appendix 4.

The ICB aims to manage complaints by the procedure of local resolution. The primary objective of this process is to provide the opportunity for investigation and resolution of the complaint, as quickly as is sensible in the circumstances and minimising the need for the complainant to escalate concerns to the Parliamentary and Health Service Ombudsman (PHSO). It aims to satisfy the complainant while being fair to staff. Local resolution should be open, honest, fair, flexible and conciliatory.

Complaints are recognised by the ICB as a vital form of feedback to help improve both the service the organisation and providers offer. The ICB aims to ensure all complainants feel listened to, have their complaint investigated thoroughly and that any response is delivered in a personalised way.

2. POLICY STATEMENT

NHS Norfolk and Waveney ICB is committed to providing an accessible, fair and effective means for people (and/or their representatives) to express their views. It is also recognised staff have the right to make a complaint to senior managers on behalf of, or in the interests of, a patient.

The ICB aims to promote a culture in which all forms of feedback are listened to and acted upon. Complaints, compliments, general comments and suggestions are encouraged. It is recognised such information is invaluable as a means of identifying both problems and areas of good practice and as such can be used as a tool for improving services.

Being open: Often, all that is required is a simple apology and/or explanation. This should, wherever possible, be given at the earliest opportunity by all front-line staff. Patients have a right to expect openness in their healthcare.

No discrimination: Patients should always be reassured that making a complaint will not affect their eligibility for, or the nature of, current or future treatment. This is achieved through the complete separation of complaint documentation from the patient's medical records. Complainants and members of staff are asked to inform the ICB's Complaints and Enquiries Manager if they have any concerns about this.

Complaints about care that is felt to discriminate against a person will be reported to the ICB's Patient and Communities Committee.

Dignity and respect: Complaints about care that compromises the dignity of, or respect shown to, a person will be overtly reported to the ICB's Patient and Communities Committee.

Mindful of people's human rights: The ICB respects and observes the Absolute, Limited, and Qualified Rights contained in legislation and applies these rights to all its business undertakings. The Rights are set out at Appendix 1.

Mental Capacity Act 2005, revised 2007: The ICB is also mindful of the statutory principles contained in this legislation, an overview of which is set out at Appendix 2.

Legal Action: Should a complainant explicitly indicate an intention to take any form of legal action the matter will be treated under the appropriate procedure.

The ICB's Complaints and Enquiries Manager may investigate the complaint if it does not compromise or prejudice the concurrent investigation, but this can be discontinued at any time if circumstances change.

3. COMPLAINTS HANDLING POLICY

3.1 Responsibilities

The Chief Executive is accountable for the quality of the care commissioned and will, therefore, have an overview of all recorded dissatisfaction expressed by patients and service users.

Director for Corporate Affairs and ICS Development is the senior person appointed by the Chief Executive to ensure the process for handling and reporting on complaints on behalf of the ICB complies with this policy.

3.2 What is a complaint?

A complaint is a verbal or written expression of concern or dissatisfaction about a matter relative to the ICB's functions or decisions, which requires a response and/or redress.

3.3 Who can complain?

A complaint can be made under this policy by:

- A patient or person affected or likely to be affected by the actions or decisions of the ICB;
- someone acting on behalf of the patient or person concerned, with their consent;
- someone acting on behalf of a person mentioned above, and in any case where that person has died;
- a child, or in the case of a child, someone acting on their behalf, who must be a parent, legal guardian or other adult person who has care of the child. Where the child is in the care of a local authority or a voluntary organisation, the representative must be an authorised person identified by the local authority or voluntary organisation, and must be making the complaint in the best interests of the child;
- someone who is unable by reasons of physical or mental incapacity to make the complaint themselves.

3.4 Local Resolution

The first stage of the NHS complaints procedure is called 'local resolution' and concerns should be brought to the attention, in the first instance, to the organisation providing the service.

Local resolution aims to resolve complaints quickly and as close to the source of the complaint as possible, using the most appropriate means; for example, the use of conciliation. Local resolution enables concerns to be raised immediately by speaking to a member of staff who may be able to resolve issues without the need to make a formal complaint.

3.5 Making a Formal Complaint

A complaint about the ICB or a service the ICB pays for can be made in writing, including by email, over the phone or in person / remotely via an online meeting upon request.

If local resolution does not resolve matters and the complainant wishes to continue with their complaint they can do this formally to the organisation concerned or, if the complainant wishes, to the ICB. This can be done orally or in writing (including e-mail) to the Complaints and Enquiries Manager for NHS Norfolk and Waveney ICB at the following address:

The Complaints and Enquiries Manager
Norfolk and Waveney Integrated Care Board
County Hall
Norwich
Martineau Lane
NR1 2DH

Tel - 01603 595857

Email – nwicb.complaintsservice@nhs.net

The complaint will be recorded as being made on the date on which it was received by the Complaints and Enquiries Manager.

3.6 Time limit for making a complaint

A complaint should be made within 12 months of the event(s) concerned, or within 12 months of the date on which the matter came to the notice of the complainant. The Complaints and Enquiries Manager has discretion to waive this time limit if there are good reasons for the complaint not having been made within that time frame.

3.7 Duty of Candour

The ICB welcomes the government's commitment to introducing a duty of candour within the NHS. This recommends that all providers of NHS care should owe a duty of candour to their commissioners under which they provide, amongst others;

- Timely reports, prepared to an agreed protocol, of all complaints made by NHS patients;
- In cases when complaints are upheld, Complaints Action Plans to address the weaknesses that have been identified;

- Progress reports in relation to implementation of complaints action plans

The ICB is committed to improving the quality of care and the services it commissions. The Clinical Quality team will review and monitor the reports received from providers and will report to the Patient and Communities Committee to ensure the quality of services provided is of a high standard and they continually strive for further improvement. This will be addressed with providers through the existing quality monitoring mechanisms.

4. COMPLAINTS HANDLING PROCEDURE

4.1 Acknowledgement and record of complaint

The Complaints and Enquiries Team will send to the complainant a written acknowledgement of the complaint within **three working days** of the date on which the complaint was received. This acknowledgement will include:

- if necessary, a consent form to be signed and returned by the patient if they are not the person who has identified the concerns to be investigated;
- information concerning how to access the local NHS advocacy provider, POHWER
- information concerning how to access the Parliamentary and Health Service Ombudsman;

4.2 Complaints in Writing

The ICB's Complaints and Enquiries Team will review the complaint, then identify the appropriate senior manager to investigate the matter.

Where the complaint involves services or care commissioned from or provided by more than one organisation, the ICB's Complaints and Enquiries Manager will liaise with the complaints manager(s) of the other organisation(s) to ensure all aspects of the complaint are appropriately investigated and responded to. This is provided appropriate consent has been provided by the complainant/patient to do so.

4.3 Verbal Complaints

When a verbal complaint is made to the ICB's Complaints and Enquiries Team, the letter of acknowledgement and associated enclosures must be accompanied by a written file note summarising the issues raised, with an invitation to the complainant to sign and return it. This will ensure all aspects of the complaint have been thoroughly understood.

4.4 Investigation

The ICB's Complaints and Enquiries Manager will discuss the investigation of high-risk cases with the ICB's Chief Executive and Director of Nursing. The investigation must be of sufficient rigour and detail to enable the ICB to provide an open, honest and comprehensive response to the complainant. The investigating officer will request the review of patient records and statements from the staff involved as necessary and provide a response to the complaint to the ICB's Complaints and Enquiries Manager.

Investigating managers will share a copy of the written complaint response with any person who was the subject of the complaint.

4.5 Response

The complainant should receive a full written response from the ICB's Chief Executive as soon as reasonably practical following completion of the investigation and within a preferred timescale of 30 working days following receipt of the complaint if possible. It should be noted that in stances where consent is required from a complainant to proceed with the complaint, the 30 working day timescale will start on the date formal consent is received.

If it is not achievable to respond with the target timescale, the ICB's Complaints and Enquiries Team will write to the complainant explaining the reason, and an achievable date will be negotiated. A response must be sent within six months of the date of a complaint being received.

If a complainant is not happy with aspects of the response, they are encouraged to contact the ICB's Complaints Team in the first instance, but they will also have the option of escalation to the PHSO.

5. PHSO AND PRINCIPLES FOR REMEDY

The ICB will follow the principles of good administration outlined by the PHSO and will consider the impact of the organisation's actions on the individual concerned. The key principles are as follows:

i. Getting it right

- Acting in accordance with the law and with due regard for the rights of those concerned
- Acting in accordance with the public body's policy and guidance (published or internal)
- Taking proper account of established good practice
- Providing effective services, using appropriately trained and competent staff
- Taking reasonable decisions, based on all relevant considerations

ii. Being customer focused

- Ensuring people can access services easily
- Informing customers what they can expect and what the public body expects of them
- Keeping to its commitments, including any published service standards
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly including, where appropriate, co-ordinating a response with other providers

iii. Being open and accountable

- Being open and clear about policies, procedures and decisions, and ensuring that information and any advice provided is clear, accurate and complete
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately
- Keeping proper and appropriate records
- Taking responsibility for its actions

iv. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests
- Dealing with people and issues objectively and consistently

- Ensuring that decisions and actions are proportionate, appropriate and fair

v. Putting things right

- Acknowledging mistakes and apologising where appropriate
- Putting mistakes right quickly and effectively
- Providing clear and timely information on how and when to appeal or complain
- Operating an effective complaints procedure, this includes offering a fair and appropriate remedy when a complaint is upheld

vi. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective
- Asking for feedback and using it to improve services and performance
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

6. ROLE OF THE PHSO

The PHSO is completely independent of the NHS and of government and derives his powers from the Health Service Commissioners Act 1993. The Ombudsman is the final arbiter in the complaints process where it has not been possible to resolve concerns locally. The ICB will co-operate fully with any investigation undertaken by the Ombudsman. Further information on the role and work of the Ombudsman is available at:

Parliamentary and Health Service Ombudsman
Citygate
Mosley Street
Manchester
M2 3HQ

Tel: 0345 015 4033
e-mail: phso.enquiries@ombudsman.org.uk Website: www.ombudsman.org.uk

7. ROLE OF THE COMPLAINTS ADVOCACY SERVICE (POHWER)

POHWER have an important role in helping complainants at each stage of the process. Their contact details can be found below:

POHWER

- Telephone: 0300 456 2370
- Email: pohwer@pohwer.net
- Letter: PO Box 14043, Birmingham, B6 9BL

Under the Mental Capacity Act 2005, the role of advocacy for patients who lack capacity is undertaken by the Independent Mental Capacity Advocate Service (IMCA). All complainants are sent information with POHWER's details to inform them of their role in providing support and information.

8. COMPLAINTS AND DISCIPLINARY PROCEDURES

The complaints procedure is concerned only with resolving complaints and not with investigating disciplinary matters. Whether disciplinary action is warranted is a separate matter for management outside of the Complaints Procedure and there must be a separate process of investigation.

9. MONITORING AND LEARNING FROM COMPLAINTS

- All complaints will be recorded on the ICB's database and complaint files maintained for a period of not less than ten years;
- The Complaints and Enquiries Manager will provide regular reports, to the Patient and Communities Committee. The report will provide information about the number of complaints; the services involved; the reasons for complaints and any ongoing trends.
- The ICB's Complaints and Enquiries Manager will prepare information regarding complaints handling which will be included in the ICB's Annual Report as and where necessary.

10. STAFF SUPPORT

The ICB acknowledges the importance of supporting those involved in complaints and recognises the need to ensure that all parties are provided with timely and appropriate support.

11. HABITUAL, UNNECESSARILY AGGRESSIVE OR REPETITIVE COMPLAINANTS

Habitual, unnecessarily aggressive or repetitive complainants are an increasing problem for staff, reflecting a pattern experienced throughout the NHS. The difficulty in handling such complainants can place a strain on time and resources and cause undue stress for staff that may need support in difficult situations. Staff are trained to respond in a professional and helpful manner to the needs of all complainants. However, there are times where nothing further can reasonably be done to assist the complainant or to rectify a real or perceived problem. Appendix 3 sets out the procedure for the management of habitual, unnecessarily aggressive or repetitive complainants.

12. REVIEW

The Complaints Policy and Procedure will be reviewed every two years, or sooner, if changes occur in legislation. The effectiveness of the policy will be reviewed in the light of performance against response timeframes; numbers resolved and referred complaints as well as implementation of lessons learned.

The procedure will also be reviewed in the light of any audit recommendations, learning and developments cycles or changes to organisational structure that may impact on how the procedures operate.

APPENDIX 1: ARTICLES OF HUMAN RIGHTS

Articles of Human Rights

The Human Rights Act 1998 gives further effect to the rights and freedoms contained in the European Convention on Human Rights. Article 1 of the European Convention is introductory and is not incorporated into the Human Rights Act.

Article 2: Right to Life
A person has the right to have their life protected by law. There are only certain very limited circumstances where it is acceptable for the state to take away someone's life, e.g. if a police officer acts justifiably in self-defence.

Article 3: Prohibition of Torture
A person has the absolute right not to be tortured or subjected to treatment or punishment which is inhuman or degrading.

Article 4: Prohibition of Slavery and Forced Labour
A person has the absolute right not to be treated as a slave or to be required to perform forced or compulsory labour.

Article 5: Right to Liberty and Security
A person has the right not to be deprived of their liberty except in limited cases and provided there is a proper legal basis in UK law.

Article 6: Right to a Fair Trial
A person has the right to a fair and public hearing within a reasonable period of time.

Article 7: No Punishment without Law
A person normally has the right not to be found guilty of a crime arising out of actions which, at the time they committed them, were not criminal.

Apart from the right to hold particular beliefs, the rights in Articles 8-11 may be limited where that is necessary to achieve an important objective.

Article 8: Right to Respect for Private and Family Life
A person has the right to respect for their private and family life, their home and their correspondence.

Article 9: Freedom of Thought, Conscience and Religion
A person is free to hold a broad range of views, beliefs and thoughts and to follow a religious faith.

Article 10: Freedom of Expression
A person has the right to hold opinions and express their views on their own or in a group. This applies even if those views are unpopular or disturbing.

Article 11: Freedom of Assembly and Association
A person has the right to assemble with other people in a peaceful way. They also have the right to associate with other people, including the right to form a trade union.

Article 12: Right to Marry
Men and women have the right to marry and start a family; however, national law will still govern how and at what age this can take place.
(Article 13 is not included in the Human Rights Act)

Article 14: Prohibition of Discrimination
A person has the right not to be treated differently because of their race, religion, sex, political views or any other personal status unless this can be justified objectively.

APPENDIX 2: MENTAL CAPACITY ACT 2005, REVISED 2007

Introduction

The Mental Capacity Act 2005 (the Act) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with this Act when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for themselves. The same rules apply whether the decisions are life-changing events or everyday matters.

The Act's starting point is to confirm in legislation that it should be assumed that an adult (aged 16 or over) has full legal capacity to make decisions for themselves (the right to autonomy) unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made. This is known as the presumption of capacity. The Act also states that people must be given all appropriate help and support to enable them to make their own decisions or to maximise their participation in any decision-making process.

The underlying philosophy of the Act is to ensure that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves is made in their best interests.

The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. But the Act also aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack capacity to make decisions to protect themselves.

The Act sets out a legal framework of how to act and make decisions on behalf of people who lack capacity to make specific decisions for themselves. It sets out some core principles and methods for making decisions and carrying out actions in relation to personal welfare, healthcare and financial matters affecting people who may lack capacity to make specific decisions about these issues for themselves.

Many of the provisions in the Act are based upon existing common law principles (i.e. principles that have been established through decisions made by courts in individual cases). The Act clarifies and improves upon these principles and builds on current good practice which is based on the principles.

The **five statutory principles**, contained in Section 1 of The Act, are:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

APPENDIX 3: THE MANAGEMENT OF PERSONS WHO ARE IDENTIFIED AS HABITUAL, UNNECESSARILY AGGRESSIVE OR REPETITIVE COMPLAINANTS

1. Introduction

This guidance should only be used as a last resort and after all reasonable measures have been taken to assist the person concerned. All staff are expected to be familiar with the NHS Complaints Procedure.

The decision to categorise a person as a habitual, unnecessarily aggressive or repetitive complainant will follow discussion between the ICB's Chief Executive, Complaints and Enquiries Manager and an appropriate member of the Executive Management Team.

It should be emphasised that the classification of an individual as a 'habitual, unnecessarily aggressive or repetitive' complainant will NOT mean that any new issues, having no connection with original concerns, will not be dealt with through the usual process.

2. Criteria for definition of a habitual, unnecessarily aggressive or repetitive caller or complainant

Complainants may be deemed to be habitual, unnecessarily aggressive or repetitive callers where previous or current contact with them shows that they meet two or more of the following criteria:

- Persist in pursuing a complaint where the NHS Complaints Procedure has been fully and properly implemented and exhausted
- Change the substance of a complaint or continually raise new issues or seek to prolong contact by repeatedly raising further concerns or questions upon receipt of a response whilst the complaint is being addressed. (Care must be taken not to discard new issues that are significantly different from the original complaint. These might have to be addressed separately)
- Do not clearly identify the precise issues they wish to be investigated, despite reasonable efforts by staff and others (e.g. advocacy agencies) to help them specify their concerns
- The complaint or issue is trivial or appears to consume an excessive amount of resources
- Having, in pursuing their concerns, had an excessive number of contacts with the ICB by telephone, letter or fax. Staff should be instructed to keep a clear record of the number of contacts to demonstrate their excessive nature
- Display unreasonable demands or expectations and fail to accept these may be unreasonable, for example insist on immediate responses from senior staff when they are not available and this has been explained
- Have threatened or used actual physical violence. All such cases must be documented on an incident form in accordance with policy, in case of further action
- Have harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with them. All cases must be documented on an incident form in accordance with policy, in case of further action.

The use of actual physical violence, albeit on one occasion only, will result in the application of measures described under (3) to limit the personal contact ordinarily available to complainants.

2. Procedure for staff handling habitual, unnecessarily aggressive or repetitive callers or complainants

- Ensure all relevant procedures and reasonable action has been correctly implemented. If you are at all uncertain, please check with the ICB's Complaints and Enquiries Manager or Director for Corporate Affairs and ICS Development.

- Even the most difficult of callers may have issues that contain genuine substance.

- Remain professional and polite. This does not mean that you have to listen continually to the same story of complaint, nor that you cannot politely, but firmly terminate the call.

- Record the date, time and how long you were on the telephone and inform the ICB's Complaints and Enquiries Manager as soon as possible.

- When a caller has been officially declared a habitual, unnecessarily aggressive or repetitive caller, the ICB's Chief Executive may decide no further telephone communication will be accepted.

- Where there is ongoing correspondence or investigation, the ICB's Complaints and Enquiries Manager will write to the caller setting the parameters for a code of behaviour and the lines of communication. These will be communicated to all appropriate staff to ensure consistency of approach.

Where investigation or correspondence is completed, the ICB's Complaints and Enquiries Manager will, at an appropriate stage, write to the caller informing him/her the ICB has responded fully to the points raised and that there is nothing further that can be added, therefore correspondence is at an end. The ICB may wish to state that further correspondence will be acknowledged, but not answered.

It should be emphasised that the classification of an individual as habitual, unnecessarily aggressive or repetitive will not mean that any new issues having no connection with the original complaint or dispute will not be dealt with in the normal way.

APPENDIX 4: MATTERS EXCLUDED FROM CONSIDERATION UNDER THIS POLICY

The following complaints are excluded from the scope of the arrangements described within this policy:

- A complaint made by an NHS body which relates to the exercise of its functions by another NHS body.

- A complaint made by a primary care provider which relates either to the exercise of its functions by an NHS body or to the contract or arrangements under which it provides primary care services, unless those arrangements fall within the ICB's sphere of responsibility. In such cases, the ICB's Dispute Resolution Procedure should be invoked.

- A complaint made by an employee about any matter relating to his/her contract of employment.
- A complaint made by an independent provider or an NHS trust about any matter relating to arrangements made by the ICB with that independent provider or NHS trust.
- A complaint which is being or has been investigated by the PHSO or Local Government Ombudsman.
- A complaint arising out of the ICB's alleged failure to comply with a data subject request under the Data Protection Act 1998 / 2018 or a request for information under the Freedom of Information Act 2000.
- A complaint about which the complainant has stated in writing that s/he intends to take legal proceedings.

Agenda item: 15 ii

Norfolk and Waveney
Integrated Care Board

Subject:	**Media Policy and Our approach to working with people and communities**
Presented by:	**Chris Williams, Head of Comms and Engagement**
Prepared by:	**Chris Williams, Head of Comms and Engagement**
Submitted to:	**Patients and Communities Committee**
Date:	**28 August 2025**

Purpose of paper:

To note that the Media Policy has been reviewed as part of the yearly schedule. All content is still relevant. The policy is being shared with the committee to provide assurance this has been reviewed within the timescales.

Consideration has also been given to reviewing 'Our approach to working with people and communities'. With national changes being made to how the NHS is organised and the move towards creating a new ICB for Norfolk and Suffolk, it has been decided that rather than amend the current approach, efforts will need to be put into creating a new approach for the new ICB. In the meantime, NHS Norfolk and Waveney ICB will continue to operate in line with the current approach.

Our current approach to working with people and communities, as well as an Easy Read summary, can be found on our website here: https://improvinglivesnw.org.uk/get-involved/working-with-people-communities/.

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 GBAF	N/A

GOVERNANCE

Process/Committee approval with date(s)	To be tabled for P&CC approval on 28.8.25

Norfolk and Waveney
Integrated Care Board

Norfolk and Waveney Integrated Care Board

MEDIA POLICY

Document Control Sheet

This document can only be considered valid when viewed via the ICB's intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one online.

Approved documents are valid for use after their approval date and remain in force beyond any expiry of their review date until a new version is available.

Name of document	**Media Policy**
Version	**3**
Date of this version	**July 2025**
Produced by	Communications and Engagement Team, NWICB
What is it for?	This media policy sets out how the ICB will align it's communications planning and activity with the organisation's emergency preparedness, resilience and response (EPRR) planning and activity.
Evidence base	• Norfolk Resilience Forum major incident communications plan 2019 • Norfolk and Waveney health major emergency communications guidelines 2019
Who is it aimed at and which settings?	Communications leaders across the ICS and senior leadership within the new ICB.
Consultation	N/A
Impact Assessment:	
Other relevant approved documents	• NWICB Social Media Policy • NWICB Business Continuity Plan • NWICB Incident Management Plan
References:	• Civil Contingencies Act 2004 (CCA) • Control of Major Accident Hazards Regulations 2015
Monitoring and Evaluation	
Training and competences	
Reviewed by:	
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Contact for Review:	Communications and Engagement Team, NWICB

Version Control

Revision History	Summary of changes	Author(s)	Version Number
06/06/23	Policy reviewed. No changes required	Paul Hemingway / Emily Arbon	V2
TBC	Updates to the introduction, communications lead and media handling sections.	Chris Williams / Amy Metcalf	V3

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Contents

1 INTRODUCTION / PURPOSE

1.1 NHS Norfolk and Waveney Integrated Care Board (ICB)

NHS Norfolk and Waveney Integrated Care Board (ICB) is a statutory NHS organisation established on 1 July 2022. It is responsible for developing a plan for meeting the health needs of the population, managing the local system NHS budget and arranging for the provision of health services in the ICS area. It is a category 1 responder, which means that it will play a leading role in responding to incidents which affect the NHS in the Norfolk and Waveney area.

1.2 Norfolk and Waveney Integrated Care System (ICS)

Norfolk and Waveney ICS is comprised of an Integrated Care Board working with an Integrated Care Partnership formed jointly with local authority partners. Partnership working will be integral to the ICS's success as it helps people lead longer, healthier and happier lives.

1.3 Standards covered by the media policy

This media policy sets out how the ICB will meet the following standards:

- The organisation aligns communications planning and activity with the organisation's emergency preparedness, resilience and response (EPRR) planning and activity;
- The organisation has a plan in place for communicating during an incident which can be enacted;
- The organisation has in place arrangements to communicate with patients, staff, partner organisations, stakeholders, and the public during and after a major incident, critical incident or business continuity incident;
- The organisation has an incident media and social media plan to enable rapid and structured communication via the media and social media; and
- The organisation reviews and learns from communications in relation to major incidents.

The Civil Contingencies Act 2004 (CCA) makes it a requirement for agencies to engage with the public before, during and after an emergency. The Control of Major Accident Hazards Regulations 2015 (COMAH) requires the public are informed of the risks and suggested actions prior to any emergency. This plan sets out how the ICS would meet its obligations during emergencies or other incidents.

2 THE ROLE OF COMMUNICATIONS DURING AN INCIDENT

Organisations have a duty to warn and inform the public during an incident so they can take appropriate action to keep safe or act in accordance with the needs of the situation.

The role of communications is to make sure the public (patients, visitors and the wider population) and staff have accurate and clear information that is received in a timely fashion and to show that the ICB understands and is responding to the needs of patients and residents.

During an incident, communication professionals will work together to:

- Set the communication strategy and develop consistent, clear strategic messaging, in line with any national / regional communications guidance and materials.

- Provide factual and timely information through corporate channels.
- Provide a proactive and reactive service to the media, giving updates, interviews and briefings, and responding to any queries. Also, rebut any inaccuracies in reporting.
- Monitor media and social media coverage and analyse its content for senior leaders.
- Co-ordinate and liaise with partners' media teams.
- Provide information to staff through corporate internal channels.

3 PREPARING FOR AN INCIDENT

3.1 Issues and incidents mapping

While the precise nature and timing of an incident can be difficult to predict, the ICB has a suite of plans in place, including a Business Continuity Plan and Incident Management Plan. It tests these and other associate plans on a regular basis through multi-agency exercises.

The ICS should develop and maintain a list of potential incidents and issues, in order to plan and prepare for them. This list should be developed by a cross-system group and be shared with Communications.

Scenarios could potentially include:

- Acute hospital system capacity pressures
- Severe weather warnings that could impact service delivery
- Flu / coronavirus / communicable diseases
- National drug or medicine recall.

The most likely incidents and issues should go through a scenario-planning workshop so that the ICS understands:

- Likely **triggers** for such an incident
- **Escalators** that could make it worse
- The **worst case** scenario
- **Potential impacts** to the organisation and the public.

Of those incidents or issues thought to be most likely, outline communications strategies will be developed as part of the planning and preparation process.

3.2 Incident planning

The ICB Communications team will do everything it can to prepare for an incident in advance.

This will mean that plans are put in place for the most likely scenarios.

Designated contact lists have been established that the media team can speak with in an emergency in all directorates in the ICB.

3.3 Oasis planning

Communications plans should follow the Government Communications Service's Oasis campaign planning structure.

Oasis is a simple, five-step method of logically designing a communications campaign, which can be used rapidly in a crisis situation:

O	**objectives** – defining what the communication aims to achieve and its scope
A	**audience** – including residents, staff and partners
S	**strategy** – defining the overall approach, including communication channels and strategic messages
I	**implementation** – how the approach will be carried out. This should include a RACI matrix to define who has Responsibility, Accountability, and who should be Consulted and Informed
S	**scoring** – how success will be measured. This should ideally be a mixture of qualitative and quantitative measures.

3.4 Media relations

The media can contact a trained comms representative within core working hours by emailing the Press Office email address - nwicb.pressoffice@nhs.net.

It is essential that the ICB communications team has a positive working relationship with all key media in the region, across print, online and broadcast media. These relationships should be developed and maintained for many reasons, in this instance to allow for rapid dissemination of messages in the event of an incident.

3.5 Media training

The ICB has identified trained spokespeople who can talk with the media in the event of an incident. These include the:

- Chief Executive
- Medical Director
- Director of Nursing
- Executive Leadership Team
- 2nd on call (Gold) Directors

The ICB communications and engagement team facilitate all media activity and ensure that spokespeople are regularly refreshed on their media training. An external training provider is used to deliver comprehensive tailored sessions that support confidence and consistency in public communications. We recommend this is scheduled annually to maintain confidence and train any new starters.

3.6 Social media

The ICB has a Social Media Policy in place and social media channels are managed with daily monitoring to look for any external issues that may impact on the ICB and/or partner organisations across the ICS. The Communications and Engagement Team respond to genuine queries on the same day wherever possible.

3.7 Internal communications

Internal communication channels have been established and are regularly evaluated to understand what are the best ways to rapidly communicate with all staff.

In line with the ICB's Business Continuity Plan, a staff call down list is available. In an emergency situation, staff can be contacted via SMS messaging. This process is managed by the Corporate Affairs Team and Director (2nd) on call.

3.8 Website

The website has an 'urgent messages' section that can be rapidly enacted and easily updated. This should be the hub for all the latest messages.

4 PRINCIPLES OF COMMUNICATION DURING AN INCIDENT

While plans can be developed rapidly when an incident occurs, the basic principles of communication are agreed in advance.

4.1 Staff first

While it might not always be possible, colleagues should be communicated to first if an incident arises so that they understand what is happening and what the organisation is doing about it.

4.2 Open and honest

It is essential that communications is open and honest in order to build trust and confidence. This means being clear about what the incident is, in terms of type, size and scale, and what actions have been taken and will be taken by the organisation. Information should be communicated rapidly, at the earliest practicable opportunity. Any inaccuracies should be clarified as soon as possible.

4.3 Accountability

It is important to establish who is the lead spokesperson for the incident. This is likely to be the Chief Executive but it could be another senior leader. Communications input and leadership will be agreed when the Incident Management Team is established. Norfolk Constabulary will lead on communications for Norfolk Resilience Forum (multi-agency) incidents.

4.4 Clarity and empathy

Public messages should be clear and concise. They should provide the factual information that is required, while also providing empathy for those directly affected. Messages should be able to put the incident into context and be in line with any national or regional NHS England messaging.

4.5 Inclusion

We will always consider how to communicate to hard-to-reach groups and distinct groups, including:

- People with a disability or a learning disability
- Children and young people
- Those for whom English is a second language
- Digitally excluded residents.

4.6 Regular updates

It is necessary to put out regular messages, particularly at the start of an incident to provide reassurance and to make sure residents come to the ICS/ICB for information.

4.7 Working in partnership

The ICB Communications and Engagement Team has established links with Norfolk and Suffolk Constabulary, and Norfolk Fire and Rescue Service. In an incident that requires partnership input, the ICB would take the lead or be guided by the Norfolk or Suffolk Resilience Forum. This would be the case for a weather-related incident such as flooding.

Where the ICB leads, there would be a requirement for partner organisations to work together, to share information and align messages. There is a contact list of communications leads at each of the partner organisations that can be contacted in the event of an incident. Press releases, statements or any other messages will be shared with partners to keep them aware of messages. If they need to take any actions this should be clearly detailed on the email. This allows partner agencies to be kept up to date before messages go public, provides consistency and allows messages to be amplified through multiple agencies' communications channels.

5 WHEN AN INCIDENT IS DECLARED

When an incident is declared, the following actions should be taken:

- The lead agency should be the ICB unless it falls narrowly and discreetly within the remit of one of the partner organisations. If this is not clear, a quick meeting should be held between relevant partner communications leads to establish the overall the communications lead for the incident.
- The communications lead should form a sub-group of the incident management team, with lead and support officers named with responsibility for media relations, social media, internal communications and website.
- An Oasis plan should be developed from the basis of one of the plans prepared in advance.
- Information should be shared with audiences proactively to keep people updated. Ideally a detailed media statement should be sent to the media. This would follow the normal ICB press release template. This should form the basis of messages through other communication channels.
- The comms lead should work in an agile fashion, working with a small group of decision-makers in the organisation to the direction for the communications of the incidents.

6 ROLES AND RESPONSIBILITIES

6.1 COMMUNICATIONS LEAD

The comms lead will typically be the Head, or Deputy Head, of Communications and Engagement at the ICB or a member of the Senior manager/director on-call rota.

Responsibilities

- Setting the overall strategic communications response
- Keeping NHS England informed about incident response as required (although the ICB takes the lead as Category 1 responder)
- Linking with other operational and strategic leaders to align response
- Defining channels, outputs, strategic messaging and spokespeople
- Reporting to the chief executive and other senior leaders on media activity and overall campaign performance
- Providing escalation point for channel owners.

6.2 Media team

The team will be staffed by communications managers and officers.

Responsibilities:

- Developing proactive press statements based on warn and inform messages
- Proactively sending statements to media outlets
- Logging and responding to media calls
- Liaising with other communications functions including social media and internal communications and partner media teams
- Arranging and supporting media interviews and reactive statements
- Monitoring media activity and provide analysis to senior leadership.

6.3 Social media

Staffed by communications managers and officers from all agencies involved in the incident.

Responsibilities:

- Developing tailored messages for specific social platforms
- Responding to queries
- Monitoring social for the latest information which can be shared with the media team and escalated if thought to be particularly relevant
- Creating digital content to support key messages
- Amend planned content if it is not relevant in the context of an incident.
- Provide analysis of online conversations and sentiment.

6.4 Internal communications

Staffed by communications officer(s) or internal communications specialist(s).

Responsibilities:

- Disseminating messages to staff timed to either be slightly in advance or in alignment with external messages. This enables staff to be able to respond to the incident
- Signposting to information or services to support colleagues' health and wellbeing
- Communicate messages from senior leaders to staff
- Inform staff not directly involved in the response of what they need to know or do.

6.5 Website

Staffed by communications officer(s) or internal communications specialist(s).

Responsibilities:

- Creating and managing an incident response page
- Keeping the page updated with the latest information from the incident
- Making sure content is clearly written and accessible
- Creating a banner or similar content on the ICS website to signpost to the updates page.

6.6 Spokespeople

A spokesperson will be made available for interviews in relation to incident response, where appropriate. It is good practice to have a lead and one or two support spokespeople who can be interviewed on a subject, so that there is flexibility to deal with a range of enquiries.

The spokespeople will receive a full and up-to-date briefing on the situation and, ideally, have spoken to colleagues or patients directly affected. Consideration should be given to who the most relevant spokesperson would be for a particular interview. This could be the chief executive of the ICB, but it could be someone speaking from a more clinical perspective, or someone with detailed expertise on the subject in question.

7 MESSAGES

Messages should always be:

- Clear and consistent
- Based on the latest facts
- Show empathy
- Give the bigger picture context.

There are four main types of messages, although these are often combined into a single media release or statement:

- **Warning and informing** – what does the public need to know / what action should they take
- **Reassurance / empathy** – how agencies are responding and what the public can expect to see.
- **Signposting** – where to go for the latest information / who to contact
- **Factual updates** – giving the latest information

8 REVIEWING AND LEARNING

After a communications plan has been enacted, regular reviews should take place to make sure it is serving its purpose.

This should take into account:

- The latest facts about the incident
- How well communications and media activity is performing
- Actions that staff, patients and others are taking as a result of the communications
- Sentiment towards communications.
- Lessons learned

Regular reviews during the campaign should enable different approaches to be utilised if necessary.

After the campaign is over, a full post-project review should be carried out, including all of the key people. This review should analyse what happened during the campaign, any

successes and learnings to be drawn out. It should clearly describe any issues that emerged and make a series of recommendations for how the approach could be improved in future campaigns.